STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KARAWAY, LLC	1815 SW WESTWOOD CIRCLE TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#150794 and #150890) at the above named Home Plus facility conducted on 3/11,12,16/2020.	S 000		
S 230 SS=E	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b) The facility reported a census of 5 residents and the sample included 3 residents. Based on record review and interview for 3 (#311, #312, #313) of 3 sampled residents, the operator failed to ensure at the time of admission facility staff	S 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 230	Continued From page 1	S 230		

informed the resident or the resident's legal representative, in writing, of the state statutes related to advanced medical directives.

Findings included:

- Review of resident # 311's record revealed an admission dated of 9/29/2019 with diagnoses of osteoarthritis, hypertension, Dementia, spinal stenosis, and wedge compression fracture at T-11 and T-12.

- Review of resident #312's medical record revealed se admitted to the facility on 12-10-2018 with diagnoses of chronic obstructive pulmonary disease, edema, bipolar disorder, and coronary artery disease.

- Review of resident #313's medical record revealed the resident admitted to the facility on 1-21-2019 with diagnoses of Bipolar disorder, hypertension, diabetes type 2 and fibromyalgia.

Review of all 3 resident's admission agreement information lacked evidence of being informed of their rights regarding the state statutes related to advanced medical directives.

During an interview on 3-12-2020 at 11:45 AM operator/licensed nurse A stated she spoke with residents on admission and asked if they had any advanced directives and get a copy of it if they do. Staff A stated she did not tell them additional information about advanced directives but had them sign that they did not want to formulate advanced directives. At 11:47 AM operator/ licensed nurse a looked through the resident's charts and could not find information regarding

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S 230	Continued From page 2 advanced directive directives in the resident's medical records. The operator failed to ensure at the time of admission, facility staff informed the resident or the resident's legal representative, in writing, of the state statutes related to advanced medical directives.	S 230		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a)(1)(2)(3) The facility reported a census of 3 residents. The sample included 3 residents and 1 focused record review. Based on record review and interviews for 3 (#311, #12, #313) of 3 sampled residents, the operator failed to ensure the	S5105		

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S5105	Continued From page 3	S5105		

development of a written negotiated service agreement based on the resident's functional capacity screening, service needs, and preferences which included a description of the services the resident would receive, and identification of the provider of each service.

Findings included:

- Review of resident # 311's record revealed an admission dated of 9/29/2019 with diagnoses of osteoarthritis, hypertension, Dementia, spinal stenosis, and wedge compression fracture at T-11 and T-12.

Review of resident #311's functional capacity screen dated 9-29-2019 revealed the resident required physical assistance with bathing, needed supervision with transfers, mobility and eating. The resident was unable to manage her own medications and medical treatments, had impaired cognition and communication. The resident also had impaired hearing, decision making and inappropriate behaviors.

Review of the resident's negotiated service agreement/health care service plan dated 9-29-2019 failed to address service staff needed to provide related to impaired cognition, impaired communication, impaired hearing, impaired decision-making abilities and inappropriate behaviors.

- Review of resident #312's medical record revealed se admitted to the facility on 12-10-2018 with diagnoses of chronic obstructive pulmonary disease, edema, bipolar disorder, and coronary artery disease.

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S5105	Continued From page 4 Review of the resident's functional capacity screen dated 12-10-2019 revealed the resident required physical assistance with bathing, and management of medications and medical treatments. The resident also had bladder incontinence, impaired cognition, problems with falls and unsteadiness and impaired decision-making abilities. Review of the resident's negotiated service agreement dated 12-10-2019 failed to address services staff needed to provide related to bladder incontinence, impaired cognition and decision-making abilities and problems with falls, unsteadiness. The negotiated service agreement identified the resident received therapy services from Interim but failed to identify what type of therapy service or who was responsible for payment of the service. The resident also received oxygen services from Breathe but did not include who was responsible for payment of the service. - Review of resident #313's medical record revealed the resident admitted to the facility on 1-21-2019 with diagnoses of Bipolar disorder, hypertension, diabetes type 2 and fibromyalgia. Review of the resident functional capacity screen dated 1-21-2019 revealed the resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and could not manage her own medications/medical treatments. The resident also had bladder incontinence, and problem with falls/unsteadiness. Review of the residents negotiated service agreement dated 1-21-20 identified the resident	S5105		

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S5105	Continued From page 5 had left-sided weakness but failed to identify services the staff needed to provide related to problems with falls/unsteadiness. Review of the faciliy's negotiated service agreement policy dated 11/017 revealed the ngotiated service agreement would be based on the resident's functional capacity screening, serv ice needs and prefernces. It would also descri e te services the resident would receive, identify the provider of each ervice and party responsible for payment if outside resources provided a service. The Operator failed to ensure the negotiated service agreement was based on the resident's functional capacity screening, service needs, and preferences which included a description of the services the resident would receive and identification of the provider of each service.	S5105		
S5155 SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility identified a census of 5 residents.	S5155		

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S5155	Continued From page 6 The sample included 3 residents. Based on observations, record review, and interview for 1 (#311) of 3 sampled residents, the operator/licensed nurse failed to ensure the provision of necessary health care services based on the resident's functional capacity screen and negotiated service agreement that met the needs of resident #311. On 2-27-2020, licensed nurse B improperly used the resident's 4 wheeled walker by having the resident sit on the seat as nurse B pushed the resident backwards up a wooden ramp, instead of allowing the resident to walk up the ramp with supervision or getting a wheelchair for the resident. The walker tipped over backwards when the wheel hit the edge of the wooden ramp causing the resident to fall backwards with the walker. This fall resulted in hospital admission on 2-27-2020 with diagnosis of T4 compression fracture secondary to fall and intractable back pain. Findings included: - Review of resident #311's functional capacity screen dated 9-29-2019 revealed the resident required supervision with transfers, walking and mobility. Review of the resident's negotiated service agreement/health care service plan dated 9-29-2019 revealed staff provided stand by assistance with transfers and used a walker as an assistive device with ambulation. The care service plan directed staff to provide stand by assistance with ambulation and the resident used a walker. Observation of the sidewalk and entry to the facility on 3-11-2020 at 11:40 AM revealed the following: The front yard is fenced with a short	S5155		

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S5155	Continued From page 7 white picket fence with a sidewalk that leads to a wooden ramp up the front steps to the porch. The sidewalk has multiple areas where it is not level between cuts and there are places where the concrete is chipped out and broken. The wooden ram goes up the front porch and is approximately 6 feet long. Where the ramp meets the sidewalk there is a ledge that is approximately 1/2-inch-high which could be a trip hazard. The left side of the ramp does not have safety rails and drops off to a dirt area with 3 large paving stones. The right side of the ramp has a safety rail that is half the length of the ramp from the top to the middle of the ramp. Review of the nurse's notes dated 2-27-2020 revealed staff (licensed nurse B) assisted the resident into the facility after an outing and the resident was tired. Licensed nurse B allowed the resident to sit on the seat of the 4 wheeled walker to get into the facility. As licensed nurse B pushed the resident up the sidewalk the wheels hit the edge of the ramp causing the walker, with the resident sitting on it, go over backwards with the resident hitting her back on the bar across the back of the walker. The resident needed to use the restroom, staff assisted the resident to the restroom and then the resident wanted to lay down in bed stating that her back hurt. The resident's back pain worsened, and the nurse then spoke with the resident's medical provider's nurse who directed staff to the local emergency room for evaluation. Review of the timeline of the resident's fall dated 2-27-2020 revealed the resident fell at 3:10 PM, staff called the residents medical provider at 3:12 PM and then contacted 911. Review of the investigation report revealed the	S5155		

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S5155	Continued From page 8	S5155		

resident sat on the seat of the walker when it fell over backwards. It also revealed certified staff C was present at the time of the incident and licensed nurse B currently on suspension during the investigation.

Review of certified staff C's written statement revealed as she assisted another resident into the facility, she saw licensed nurse B and the resident just inside the gate and told the nurse to remind the resident we are not in a hurry. As staff C assisted another resident in the restroom, she heard licensed nurse B state "oh no" loudly and looked out the door and observed the resident #311 laying on her back on the ramp. By the time certified staff C finished helping the other resident, licensed nurse B had brought the resident in the facility.

During an interview on 3-12-2020 at 12:47 PM certified staff C stated she did not actually see the resident sitting on the seat of the walker but could tell from how she was laying on top of the walker that she had been sitting on it. Staff C stated she did not know why the nurse had the resident sit on the walker because the resident could walk by herself.

During interview on 3-12-2020 at 12:14 PM operator/licensed nurse A reported licensed nurse B should not have had the resident sitting on the seat of the walker pushing her backwards. If the resident was that tired should have gotten a wheelchair for her to use. Operator/licensed nurse A reported that resident as laying down when she arrived at the facility and licensed nurse B had not called emergency medical services yet, so staff A called EMS.

Review of 3 different manufactures of 4 wheeled

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S5155	Continued From page 9 walkers with a seat include warning that the 4 wheeled walker is not intended to be used as a wheelchair or to transport someone. One manufacture notes "Failure to follow safety instructions may result in serious injury or death. The operator/licensed nurse failed to ensure the provision of necessary health care services based on the resident's functional capacity screen and negotiated service agreement that met the needs of resident #311. On 2-27-2020, licensed nurse B improperly used the resident's 4 wheeled walker by having the resident sit on the seat as nurse B pushed the resident backwards up a wooden ramp, instead of allowing the resident to walk up the ramp with supervision or getting a wheelchair for the resident. The walker tipped over backwards when the wheel hit the edge of the wooden ramp causing the resident to fall backwards with the walker. This fall resulted in a hospital admission on 2-27-2020 with diagnosis of T4 compression fracture secondary to fall and intractable back pain.	S5155		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and	S5215		

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S5215	Continued From page 10 (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 5 residents. Based on interview and record review for all residents, administrative staff A failed to provide quarterly reviews of the home's emergency management plan with all residents and facility staff. Findings included: - Review of the notebook provided by operator/licensed nurse A on 3-11-2020 as having the resident and employee quarterly reviews for the emergency management plan revealed the following: 1. included staff inservice on 4-1-2019 and another inservice on 1-29-2020. The notebook lacked any additional reviews with facility staff and had no record of reviews with residents who lived in the facility. On 3-11-2020 at 1:26 PM operator/licensed nurse A stated there was additional inservice information in the emergency management notebook on the piano. Review of the notebook on the piano on 3-11-2020 at 1:38 PM lacked evidence of review of the emergency management plan with residents or staff. On 3-12-2020 at 9:00 AM operator/licensed	S5215		

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S5215	Continued From page 11 nursing staff A reported she reviewed the information with residents on admission but not at any other times. The operator/licensed nurse A failed to conduct quarterly reviews of the homes emergency management plan with residents and staff which would affect all residents.	S5215		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by:	S5258		

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S5258	Continued From page 12 KAR-26-42-102 (d)(1) The facility reported a census of 5 residents. The sample included 3 residents. Based on interview and record review, the operator failed to ensure 5 of 5 newly hired employee records contained certification verification information upon hire. This had the potential to affect all residents in the facility. Findings included: - During an interview Review of employee files conducted revealed the following: Licensed nursing staff B hired to the facility on 1/2020, employee record lacked evidence of licensure check completed on hire. Certified nursing staff C hired to the facility on 2/2020, employee record lacked evidence of certification check completed on hire. Certified nursing staff D hired to the facility on 8/2019, employee record lacked evidence of certification check completed on hire. Licensed nursing staff E hired to the facility on 3/2020, employee record lacked evidence of licensure check completed on hire. Certified nursing staff F hired to the facility on 6/2019, employee record lacked evidence of certification check completed on hire During an interview on 3-12-2020 at 11:20 AM operator/licensed nurse A stated she checks everyone in the state system but had just never printed them off for the employee records. Review of the facilities staff qualifications policy dated 11/2017 revealed each employee record will contain evidence of licensure, registration, certification or certificate of successful completion	S5258		

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S5258	Continued From page 13 of training course. The administrator failed to ensure employee records contained licensure or certification verification information upon hire.	S5258		
S5325 SS=E	26-42-205 (l) Medication Regimen Review Frequency (l) Medication regimen review. A licensed pharmacist or licensed nurse shall conduct a medication regimen review at least quarterly for each resident whose medication is managed by the home and each time the resident experiences any significant change in condition. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (l) The facility reported a census of 5 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure 2 (#311, #312,) of 3 sampled residents whose medications were managed by the home had a pharmacist or licensed nurse conduct a medication regimen review at least quarterly. Findings included: - Review of resident # 311's record revealed an admission dated of 9/29/2019 with diagnoses of osteoarthritis, hypertension, Dementia, spinal stenosis, and wedge compression fracture at T-11 and T-12.	S5325		

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S5325	Continued From page 14 Review of resident #311's functional capacity screen dated 9-29-2019 revealed the resident was unable to manage her own medications and medical treatments. Review of the resident's negotiated service agreement/health care service plan dated 9-29-2019 revealed staff would provide management of medications. Review of the pharmacy review notebook on 3-12-2020 at 8:26 AM, provided by operator/licensed nurse A revealed the resident did not have medication regimen reviews conducted by a licensed pharmacist or a licensed nurse during her stay at the facility. - Review of resident #312's medical record revealed se admitted to the facility on 12-10-2018 with diagnoses of chronic obstructive pulmonary disease, edema,bipolar disorder, and coronary artery disease. Review of the resident's functional capacity screen dated 12-10-2019 revealed the resident required physical assistance with management of medications and medical treatments. Review of the residents negotiated service agreement dated 12-10-2019 revealed the staff provided administration of the resident's medications. Review of the pharmacy review notebook on 3-12-2020 at 8:45 AM that was provided by operator/licensed nurse A revealed the resident had 1 pharmacy review on 5-14-2019, but did not have quarterly reviews done by a licensed	S5325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089091	A. BUILDING: _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARAWAY, LLC	1815 SW WESTWOOD CIRCLE TOPEKA, KS 66604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5325	Continued From page 15 pharmacist or a licensed nurse. During an interview on 3-12-2020 at 8:48 AM Operator/licensed nurse A reported she had contacted the pharmacist to come but her didn't and she knew the reviews needed to be completed quarterly. The operator failed to ensure a pharmacist or licensed nurse completed a medication regimen review quarterly.	S5325		