Kansas Department on Aging

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 _____	R-C 06/26/2019

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
{S 000}	INITIAL COMMENTS The following citation is the result of a revisit for licensure conducted on 6/25/19 and 6/26/19 at the above named home plus facility in Topeka, KS.	{S 000}		
{S5313} SS=F	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g) (3) The facility reported a census of 4 residents. The sample included 3 residents. The resident roster identified all residents as receiving medication management. Based on observations for all residents, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on packages of over-the-counter medications. Findings included:	{S5313}		

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

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 _____	R-C 06/26/2019

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
{S5313}	Continued From page 1 - Observation during facility tour on 6/25/19 from 12:06pm to 12:23pm in the unlocked facility office/medication room, revealed the following over the counter (OTC) medications: In a locked closet on a shelf: Walgreens brand diphenhydramine (antihistamine) HCL (hydrochloride) 25mg (milligrams)24 count package, 8 tablets left; lacked resident name on medication. Biofreeze (muscle rub) 3ounce cream; lacked resident name on medication. On top of file cabinet (used for medication storage: Nature Plex brand maximum strength Hydrocortisone cream 1 ounce tube; lacked resident name on medication. Interview on 6/26/19 at 12:40pm with licensed nurse #B stated he/she did not know who the medications in the closed belonged to, the medication on top of file cabinet belonged to a resident. Resident roster recorded all resident received medication management. For all residents of the facility, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on packages of over-the-counter medications.	{S5313}		