STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

(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 citations are the resutlt of a licensure re-survey with attached complaint at the above named home plus facility on 10/25/16 and 1026/16.	S 000		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: 5300 KAR 26-42-205(d) The facility reported a census of 11 residents. The sample included 3 residents, 6 focus review residents and 2 closed chart review residents. Based on observation and interview, the operator failed to ensure all medications and treatments	S5300		

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
	B089082	A. BUILDING: _____ B. WING _____	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

(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
S5300	Continued From page 1 were administered and stored in accordance with professional standards of practice and according to manufacturer ' s recommendations. Findings included: - On 10/25/16 from 8:55am to 9:20am during facility tour with licensed nurse #X, in the medication room, observed the following: On the left side of the counter, a stack of clear plastic medication cups containing pills and crushed powder. Each was labeled with a resident name written in black marker as follows: Resident #130 - contained powder (crushed medications) Resident #131 - contained powder (crushed medications) Resident #132 - contained 4 white medication tablets Resident #126 - contained 2 medication tablets Resident #133 - contained 2 medication tablets Resident #134 - contained 1 medication tablet On the right side of the counter, a stack of clear plastic medication cups containing pills and crushed powder. Each cup was labeled with a resident name written in black marker as follows: Resident #125 - contained powder (crushed medications) Resident #135 - contained 6 medication tablets Resident #130 - contained powder (crushed medications) Review of resident roster recorded all 11 facility residents receive medication administration assistance.	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

(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
S5300	Continued From page 2 Review of facility policy titled: Med Pass Policies recorded the following: 13. Medications are pre-poured or set up by the medication aide or nurse giving the meds. 14. Medications are charted when medications are set up 15. Medications are set up in labeled medication cups. Standard of practice for medication administration included in the certified medication aide curriculum include: - all medication must be identified to the point of administration. When preparing medications for a group of residents, for medications removed from a package or container with the prescription label, a medication card must be used which contains the resident ' s name, the name of the medication, the route of administration, special instructions for administration and time of administration. - Never leave a medication tray unattended. - Document the administration of the medication on the MAR immediately before or after the administration of the medication. Interview on 10/25/16 at 9:00am with certified staff # Y, confirmed he/she had prepared the medication for the residents ahead of time for the 8am and noon medication passes because he/she was busy getting residents up. For residents # 125, #126, #130, #131, #132, #133, #134 and #135 the operator failed to ensure all medications were administered according to professional standards of practice when staff placed medications in cups labeled	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

(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
S5300	Continued From page 3	S5300		

only with the resident name, set up medication for a future medication pass and left them unattended.

On 10/25/16 from 8:55am to 9:20am during facility tour with licensed nurse #X, in the medication room, observed the following:

Lorazepam liquid 2mg/ml bottle (prescription anti-anxiety medication), for resident #130, opened, in manufacturer ' s box, manufacturer ' s expiration date of April 2018, box reads: store at cold temperature. Refrigerate 36-46 degrees. Medication was located in the narcotic lock box, on top of a stack of plastic drawers.

Medication was not refrigerated per manufacturer ' s recommendations.

On 10/25/16 from 8:55am to 9:20am during facility tour with licensed nurse #X, in the facility kitchen refrigerator, observed the following:

A small locked tool box containing an open vial of TPPD (tuberculin purified protein derivative) used to test for tuberculosis, 5 units, 10 tests, manufacturer ' s expiration date 1/21/2018, no open date.

Interview on 10/25/16 at 9:15am, with licensed staff #X stated he/she did not know when the vial was opened or last administered.

Vial lacked label with date opened.

For residents #130 and for all staff and residents who required tuberculosis testing, the operator failed to ensure all medications were stored in accordance with professional standards of practice and according to manufacturer ' s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

(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
S5300	Continued From page 4 recommendations.	S5300		