STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 result of a Licensure Resurvey at the above named Home Plus Facility in Topeka, Kansas on 01/04/16, 01/05/16, 01/06/16, 01/11/16, 01/12/16, and 01/13/16.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S5028		

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
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5028	Continued From page 1 by: KAR 26-42-101(f)(3)(C) The census equalled four the sample included three Residents with two focused reviews completed. Based on interviews, and reviews of record, for one of three sampled (#185) who assaulted and hit another Resident (focused review #182), the Operator failed to ensure the alleged abuse reported to the Department within 24 hours, failed to start an investigation, failed to report the results of the investigation within five working days, and failed to maintain a written record of the abuse investigation. Findings included: - Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's, Schizophrenia, Hypothyroidism, Hypoparathyroid, Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia. Current 12/23/15 FCS assessed #185 in need of supervision (1) with bathing, dressing, mobility, and eating; in need of physical assistance (2) with medications; treatment management left empty; cognitive marked with long term memory and memory recall impairments; with Falls, unsteadiness. FCS of 12/23/15 contained note of "hospital stay 12/--/15 - 12/23/15." Medical record lacked documentation of reason for hospitalization. The 12/23/15 NSA documented facility staff to manage medications. On 01/05/16 at 10:45am, Medication aide #F stated #185 admitted to hospital because #185 hit	S5028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5028	Continued From page 2	S5028		

#182 on 12/19/15... #185 sent to hospital to make sure medications OK... #F stated no nurses' notes available in facility... stated Facility nurse #E may have that in book he/she writes in... not aware of any nursing assessment but Operator #G did take pictures, so did Police... I gave #182 an ice pack... Medication aide #F stated did not know if Operator #G made out an incident report.

The medical record of #182 lacked documentation of the incident, corrective actions taken, or assessment of the Resident for injuries.

By interview on 01/05/16 at 11:55am, asked Medication aide #F if an investigation started or completed, or if a report of Resident to Resident abuse made to department. #F stated "you would have to ask Operator #G and he/she is sick... wouldn't police report tell that?"... #F added, "you have the case number, as far as I know that is all I have..."

Contacted Department on 01/05/16 at 11:57am to inquire if any report made regarding Resident to Resident abuse; nothing logged.

On 01/06/16 at 9:10am, Facility Nurse #E stated I was notified after the fact of fight between #185 and #182... I went in next day to check #182... I kept asking questions and no one would answer me... Operator #G saw what was taking place... and according to #185 said #182 egging on "hit me is that all you got"... #182 was on the phone when I came to assess and declined... not aware of what reports made or what paper work completed... I told Medication aide #F to document the incident because I could only document "what was reported to me" since I was not there... as far as corrective action I think Operator #G told #185 regardless of what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5028	Continued From page 3 happens you don't hit... not aware of anything else... The Operator failed to ensure the alleged abuse of #182 by #185 reported to the Department within 24 hours, failed to start an investigation, failed to report the results of the investigation within five working days, and failed to maintain a written record of the abuse investigation.	S5028		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The census equalled four the sample included three Residents, two focused reviews completed. Based on observations, interviews, and reviews of records, for one of three sampled (#185), and for two of two focused reviews (#180 and #182), the Operator failed to ensure designated staff completed the FCS (functional capacity screen) accurately. Findings included: - Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's, Schizophrenia, Hypothyroidism, Hypoparathyroid,	S5095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5095	Continued From page 4 Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia. The current 12/23/15 FCS assessed #185 in need of supervision (1) with bathing, dressing, mobility, and eating; in need of physical assistance (2) with medications; treatment management left empty; Gender left empty; cognitive total score left blank; Falls, unsteadiness only item identified in section III with check mark;.Section IV Mobility Appliances/Devices cut off, not included. On 01/04/16 at 5:09pm and 5:20pm, observed Medication aide #F physically assist (2) #185 to a standing position (transfer) from the TV room couch... physically assisted #185 to walk to stairs (mobility) and to ascend the stairs to room and assisted into the bathroom... #F obtained a walker while #185 used the bathroom... #F then prompted and assisted #185 to side of bed with walker, prompted to turn and sit, then covered Resident with blanket, handed him/her remote control and filled water glass for #185's bedside table. By interview on 01/05/16 at 10:45am, Medication aide #F stated #185 admitted to hospital in December 2015 because #185 hit #182 (socially inappropriate behavior). When asked how often #185 physically assisted, Medication aide #F stated "#185 not usually like that... usually isn't shaky... gets nervous when State or Police here... probably once a month have to physically assist; help upstairs, help get to bed, help with whatever is going on at the	S5095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5095	Continued From page 5	S5095		

time... has a walker... bathroom close to bed... has cell phone to call me if needs help to bathroom... has not called in middle of night for help.

Review of 12/23/15 FCS determined;
Section "D." Gender inaccurate/incomplete;
Section II.A.4. Transfers, and II.A.5. Walking, mobility inaccurate;
Section II.B. Treatment management inaccurate/incomplete;
Section II. D. Cognition, incomplete;
Section III. 5. 6. Socially inappropriate disruptive behavior, Impaired decision making inaccurate; and,
Section IV. Mobility Appliances/Devices absent/inaccurate.

By interview on 01/05/16 at 10:45am, Medication aide #F stated I don't know if Operator #G has an FCS manual in the Regs... I don't have one on me right now...

By interview on 01/06/16 at 9:10am Facility Nurse #E stated I would love to have an instruction manual (FCS manual) to complete these... have never had one... worked at facility since 09/2014.

The Operator failed for #185 to ensure designated staff completed the FCS accurately.

- Review of record revealed #182 admitted to facility with diagnoses of Respiratory Sarcoidosis, Depression, Anxiety, and PTSD (post traumatic stress disorder).

The current 12/03/15 FCS assessed #182 independent (0) with bathing, dressing, toileting, transfers, mobility, eating; Medication and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5095	Continued From page 6 Treatment management not included on resident's form; Section III. Current or Recent Problems and Risks marked "none"; and Section IV. Mobility Appliance/Devices not included on resident's form. The 12/03/15 NSA (negotiated service agreement) documented facility to manage medications. The 12/2015 MAR (medication administration record) documented facility staff administered medications. The medical record contained 12/06/15, 12/07/15, and 12/08/15 documentation of socially disruptive behaviors, and examples of impaired decision making. The FCS failed to reflect these identified as "current problems or risks" Review determined; Section II.B. Medication and Treatment management inaccurate/missing; Section III. 5. 6. Socially inappropriate disruptive behavior, Impaired decision making inaccurate; and, Section IV. Mobility Appliances/Devices inaccurate/missing. The Operator failed for #182 to ensure designated staff completed the FCS accurately. - Review of record revealed #180 admitted to facility with diagnoses of Hypertension, Sleep apnea, Gastroesophageal reflux disease, PTSD (post traumatic stress disorder), Bipolar, Insomnia, Anxiety, Dermatitis, Depression, and Allergies. The current 12/09/15 FCS assessed #180	S5095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5095	Continued From page 7 independent with bathing, dressing, toileting, transfers, mobility, eating; with decision making impairment. The "Medication and Treatment management absent from FCS. The 12/09/15 NSA (negotiated service agreement) documented facility to manage medications. The 12/2015 MAR (medication administration record) documented facility staff administered medications. Review determined; Section II.B. Medication and Treatment management inaccurate/missing; The Operator failed for #180 to ensure designated staff completed the FCS accurately.	S5095		
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.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5105	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-42-202 The census equalled four the sample included three Residents and two focused reviews completed. Based on interview and reviews of records, for one of three sampled (#185), and for one focused review (#180), the Operator failed to ensure the negotiated service agreement (NSA) contained: A description of the services the Resident to receive, Identification of the provider of each service, and Identification of each party responsible for payment if outside resources provide a service. Findings included: - Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's, Schizophrenia, Hypothyroidism, Hypoparathyroid, Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia. The current 12/23/15 FCS assessed #185 in need of supervision (1) with bathing, dressing, mobility, and eating; in need of physical assistance (2) with medications; long term memory and memory recall impairment; speech sometimes understandable; Falls, unsteadiness; The current 12/23/15 negotiated service agreement (NSA) documented #185 to receive medication management. On 01/04/16 at 4:15pm during evening meal, observed speech difficult to understand.	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5105	Continued From page 9 On 01/04/16 at 5:09pm and 5:20pm, Medication aide #F physically assisted #185 to a standing position from the TV room couch... physically assisted #185 to walk to stairs, to ascend the stairs, and assisted into the bathroom... #F obtained a walker while #185 used the bathroom... #F then prompted and assisted #185 to side of bed with walker, prompted to turn and sit, then covered Resident with blanket, handed him/her remote control and filled water glass for #185's bedside table. On 01/05/16 at 10:45am, when asked how often #185 physically assisted, Medication aide #F stated "#185 not usually like that... usually isn't shaky... gets nervous when State or Police here... probably once a month have to physically help upstairs, help get to bed, help with whatever is going on at the time... has a walker... bathroom close to bed... has cell phone to call me if needs help to bathroom... bed time meds kinda knock him/her out... has not called in middle of night for help... The NSA lacked a description of services to include physical assistance and communication interventions. By interview on 01/05/16 at 10:45am, Medication aide #F stated #185 admitted to hospital because #185 hit #182... to hospital to make sure medications OK... The NSA lacked interventions to address 185's inappropriate behaviors and impaired decision making needs. The Operator failed to ensure the NSA for #185	S5105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5105	Continued From page 10 contained a description of the services the Resident to receive. - Record review revealed #180 admitted to facility 3/13/15 with diagnoses of Hypertension, Sleep apnea, Gastroesophageal reflux disease, PTSD (post traumatic stress disorder), Bipolar, Insomnia, Anxiety, Dermatitis, Depression, and Allergies. The current 12/09/15 FCS assessed #180 independent with bathing, dressing, toileting, transfers, mobility, eating; with decision making impairment; Limit Sodium intake. The medical record contained a 12/09/15 order for Low Salt diet, and a 12/19/15 order for Low Salt, Low Cholesterol, Low Fat diet. The 12/09/15 NSA lacked therapeutic diet orders or interventions. On 01/15/16 at 3:00pm, Medication aide #F stated I don't cook with salt... just let them adjust it at the table... The Operator failed to ensure the NSA for #180 contained a description of services the Resident to receive.	S5105		
S5185 SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5185	Continued From page 11 services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The census equalled four the sample included three Residents with two focused reviews completed. All Residents received meal service. Based on interview and record review, for one of two focused reviews (#180) with a therapeutic diet ordered, the Operator failed to ensure the diet prepared according to written instructions from a medical care provider or licensed dietician in accordance with the NSA. Findings included: - Record review revealed #180 admitted to facility 3/13/15 with diagnoses of Hypertension, Sleep apnea, Gastroesophageal reflux disease, PTSD (post traumatic stress disorder), Bipolar, Insomnia, Anxiety, Dermatitis, Depression, and Allergies. The current 12/09/15 FCS assessed #180 independent with eating; with decision making impairment; Limit Sodium intake.	S5185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5185	Continued From page 12 The medical record contained a 12/09/15 order for Low Salt diet, and a 12/19/15 order for Low Salt, Low Cholesterol, Low Fat diet. The 12/09/15 NSA lacked therapeutic diet orders or interventions. On 01/15/16 at 3:00pm, Medication aide #F stated I don't cook with salt... just let them adjust it at the table... On 01/11/16 requested written directions by physician or dietitian for therapeutic diet orders, written directions not available. The Operator failed to ensure the diet for #180 prepared according to written instructions from a medical care provider or licensed dietician.	S5185		
S5215 SS=E	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 (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.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5215	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The census equalled four the sample included three Residents, with two focused reviews completed. The facility identified four employee hired since the last resurvey. Based on review of record and interview, for all Residents and all employees, the Operator failed to ensure a quarterly review of the home's emergency management plan with employees and residents. Findings included: - On 01/04/16 at 4:45pm, reviewed the requirement for quarterly reviews with Operator #G... Operator #G stated "I did not do that"... Operator #G provided monthly fire drills completed by staff with staff signatures... stated we do fire drills monthly and do a full evacuation each time, but not the quarterly reviews of entire emergency plan. Dates of last two fire drills documented as 11/13/15 and 12/15/15. The Operator failed to ensure quarterly reviews of the facility emergency management plan completed with Residents and Employees.	S5215		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5230	Continued From page 14 (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The census equalled four the sample included three Residents and two focused reviews included. The facility identified four employees hired since the last Resurvey. Based on interviews and reviews of records, for three of four employee reviewed, (#B, #C, and #D), and for two of three sampled (#185 and #189), the Operator failed to ensure the home's compliance with the department's TB (tuberculosis) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of records on 01/04/16 and 01/05/16 revealed the following: #B - Registered Nurse - hired 6/09/15 - record contained one TB skin test administered 6/05/15; record lacked a second step TB test; record contained a TB symptom questionnaire also completed 6/09/15. #C - Registered Nurse - hired 09/15/15 - record	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5230	Continued From page 15	S5230		

contained one TB skin test administered 9/24/15 (more than 7 days after hire); record lacked a second step TB test; did contain a TB symptom questionnaire completed 9/26/15 (also more than 7 days after hire).

#D - Certified Nurse Aide - hired 3/20/15 - record contained one TB skin test administered 3/20/15; record lacked a second step TB; record contained a TB symptom questionnaire also completed 3/22/15.

Resident #185 - admitted 4/08/13 - record contained a CD (compact disc) labeled with Resident's name, and notation "2 view chest X Ray of 6/16/14. Facility CMA (certified medication aide) #F stated he/she did not have means of showing what was on the CD and did not have a report of results. Surveyor's computer unsuccessful at opening file to look at results included. At time of this visit, unable to review information for compliance. Record contained a 6/18/14 TB questionnaire, but lacked an annual updated questionnaire since 6/18/14. This Resident documented with history of hospital admission and outings from facility since 6/18/14.

Resident #189 - admitted 6/30/13 - record contained a two step TB test of 7/03/13 and 7/26/13; the record lacked an annual TB questionnaire since one completed on 6/18/14.

On 01/04/16 at 5:00pm Facility CMA #F confirmed no second step testing available on #B, #C, #D... confirmed no annual TB questionnaires available for #189 and #185.

The Operator failed to ensure for #B, #C, #D, #189, and #185, the home's compliance with the department's TB guidelines for adult care homes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The census equalled four the sample included three Residents, with two focused reviews completed. Based on interviews and reviews of records, for one of three sampled (#185), and for two of two focused reviews completed (#180 and #182), the Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence,a action taken, and results of the action. Findings included: - Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's, Schizophrenia, Hypothyroidism, Hypoparathyroid, Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia. The current 12/23/15 FCS assessed #185 in need of supervision with bathing, dressing, mobility, and eating; in need of physical assistance with medications; treatment management left empty; with memory impairment, with communication impairment; with	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5251	Continued From page 17 Falls, unsteadiness. FCS contained note of "hospital stay 12/--/15 - 12/23/15." Medical record lacked documentation of reason for hospitalization. By interview on 01/05/16 at 10:45am, Medication aide #F stated #185 admitted to hospital because #185 hit #182 on 12/19/15... #185 sent to hospital to make sure medications OK... #F stated this occurred in facility in the TV living room... - Review of record revealed #182 admitted to facility with diagnoses of Respiratory Sarcoidosis, Depression, Anxiety, and PTSD (post traumatic stress disorder). The current 12/03/15 FCS assessed #182 independent with transfers, mobility; Current or Recent Problems and Risks marked "none". The 12/03/15 NSA (negotiated service agreement) documented facility to manage medications. The medical record contained 12/06/15, 12/07/15, and 12/08/15 documentation of multiple socially disruptive behaviors, and multiple examples of impaired decision making. By review, each medical record (for #185 and #182) lacked any documentation of the 12/19/15 Resident to Resident altercation. The medical records lacked the date and the time, location, and whether anyone witnessed the incident. The medical records lacked a licensed nurse assessment of each Resident's condition on 12/19/15 following the incident.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5251	Continued From page 18 The medical records lacked documentation of family, physician, or law enforcement notifications. The medical record lacked the actions taken to address the altercation, and lacked documentation of the results of the actions. The medical record lacked an assessment of #185's condition upon return from the hospital. The medical record lacked documentation of any changees in services as a result of this altercation and hospitalization. On 01/05/16 at 10:45am, Medication aide #F confirmed no documentation available in the facility records... stated the Facility nurse #E may have some notes in his/her notebook. The Operator failed to ensure for #185 and #182, the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. - Review of record revealed #180 admitted to facility 3/13/15 with diagnoses of Hypertension, Sleep apnea, Gastroesophageal reflux disease, PTSD (post traumatic stress disorder), Bipolar, Insomnia, Anxiety, Dermatitis, Depression, and Allergies. The current 12/09/15 FCS assessed #180 independent with bathing, dressing, toileting, transfers, mobility, eating; with decision making impairment. The 12/09/15 NSA (negotiated service agreement) documented facility to manage medications.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5251	Continued From page 19 Medical record documentation of 12/03/15 to 12/09/15 described behaviors and outing from facility that resulted in #180 requesting hospital admission for amphetamine detox on 12/06/15. The last entry of medical record docuemented hospital release, Walmart visit, and return to facility on 12/09/15. The medical record failed to document #180's departure from facility, the date, the time, and failed to document Resident's current status or where abouts. On 01/04/16 at 5:20pm, Facility nurse #E confirmed #180 absent from facility, out of town in a Rehabilitation unit, and confirmed no documentation available in medical record. The Operator failed to ensure for #180 the documentation of all incidents, symptoms, the date, time of occurrence, action taken, and results of the action.	S5251		
S5255 SS=F	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The census equalled four the sample included	S5255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5255	Continued From page 20	S5255		

three Residents and two focused reviews completed. All Residents identified on Resident roster as receiving medication management. Based on observation, interviews, and reviews of records, for three of three sampled with medication management (#189, #187, and #185), the Operator failed to ensure the provision of a sufficient number of qualified personnel to provide each Resident with medication management in accordance with FCS (functional capacity screens), NSA (negotiated service agreements), and HSP (health service plans).

Findings included:

- Record review revealed #189 admitted to facility 6/30/13 with diagnoses of Bipolar I, PTSD (post traumatic stress disorder), Gastroesophageal reflux disease, Anxiety, Hypothyroid, Chronic obstructive pulmonary disease, Post-op thyroid cancer, History of alcohol and cannabis abuse, and Hepatitis C. The current 6/20/15 FCS assessed #189 in need of (1) supervision with medications. The 6/20/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications.

- Record review revealed #187 admitted to facility 10/05/15 with diagnosis of Schizoaffective disorder. The current FCS assessed #187 (0) independent with medications. The 10/05/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications.

- Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5255	Continued From page 21	S5255		

Schizophrenia, Hypothyroidism, Hypoparathyroid, Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia. The current 12/23/15 FCS assessed #185 in need of physical assistance (2) with medications. The 12/23/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications.

- On 01/04/16 at 2:30pm in medication storage room of facility, Medication aide #F accessed medication room and individual drawers of medication storage... #F stated I am basically the only one who gives medications to Residents... Facility Nurse #E does occasionally, but usually it is me...

On 01/04/16 at 4:35pm, Medication aide #F initialed a PRN (as needed) medication administered to #185.

On 01/05/16 at 4:05pm, review of Nurse Aide Registry information revealed Medication aide #F's certification expired on 12/30/15... Medication aide #F not certified/qualified to administer medications since 12/30/15.

The Operator failed to ensure the provision of a sufficient number of qualified personnel to provide each Resident with medication management in accordance with FCS, NSA/HSP.

- By confidential interview an Individual stated Medication aide #F does administer medications at both locations and goes to appointments and to pick up medications, supplies... when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5255	Continued From page 22 Medication aide #F is absent from facility, Operator #G is at house with Residents... Certified Nurse Aide (CNA) #H does not go to facility every evening when #F goes to pass medications at the other location... Residents are left there with Operator #G... By interview on 01/04/16 at 12:45pm Operator #G stated "I am not a CNA (certified nurse aide) or a CMA (certified medication aide). On 01/04/16 at 2:30pm in medication storage room of facility, Medication aide #F accessed medication room... stated I am basically the only one who gives medications to Residents... here and at second location of another facility with same owners... Facility Nurse #E does occasionally pass medications, but usually it is me... On 01/05/16 at 3:59pm requested from Medication aide #F how often CNA #H worked in facility. Medication aide #F stated "As Needed"... "no schedule no time card no"... Requested documentation of timecards and payroll records; not available. Unable to determine presence of qualified, Certified staff when Medication aide #F absent from facility almost daily for medication passes at other location or other out of facility obligations. The Operator failed to ensure the provision of a sufficient number of qualified (certified) personnel to provide each Resident with certified staff at all times in accordance with FCS, NSA/HSP.	S5255		
S5265 SS=E	26-42-205 (a) (1) Medication Self Administration Assessment	S5265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5265	Continued From page 23 (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(a) The census equalled four the sample included three Residents and two focused reviews completed. The Resident roster identified all Residents as receiving medication management. Based on record reviews, for one of one sampled with a self administered medication (#187), and for one of one focused review Resident with a self administered medication (#182), the Operator failed to ensure a licensed nurse performed an assessment to determine the Resident could safely and accurately administer a medication without staff assistance. Findings included:	S5265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5265	Continued From page 24 - Record review revealed #187 admitted to facility 10/05/15 with diagnosis of Schizoaffective disorder. The current FCS assessed #187 (0) independent with medications. The 10/05/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications in January. The January 2016 MAR included an order for Epi Pen to be carried by Resident... "inject IM (intramuscularly) as needed in event of a bee sting." The medical record lacked a self administration assessment. The Operator failed to ensure a licensed nurse performed an assessment of #187's ability to safely self administer medication. - Review of record revealed #182 admitted to facility with diagnoses of Respiratory Sarcoidosis, Depression, Anxiety, and PTSD (post traumatic stress disorder). The current 12/03/15 functional capacity screen (FCS) assessed #182 independent (0) with bathing, dressing, toileting, transfers, mobility, eating; Medication and Treatment management cut off and not included in the FCS. The 12/03/15 NSA (negotiated service agreement) documented facility to manage medications. The 12/2015 MAR (medication administration record) documented facility staff administered medications.	S5265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5265	Continued From page 25 The 12/03/15 FCS documented #182 self administered a Nebulizer breathing treatment. The medication record lacked a self administration assessment. The Operator failed to ensure a licensed nurse performed an assessment of #182's ability to safely self administer medication.	S5265		
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: KAR 26-42-205(d) The census equalled four the sample included three Residents, with two focused reviews completed. The Resident roster identified all	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 26	S5300		

Residents as receiving medication management. Based on interview and record review, for three of three sampled with medication management (#189, #187, and #185), the Operator failed to ensure all medications and biologicals administered to Residents in accordance with written medical care provider orders, and in accordance with professional standards of practice.

Findings included:

- Record review revealed #185 admitted to facility 4/08/13 with diagnoses of Parkinson's, Schizophrenia, Hypothyroidism, Hypoparathyroid, Benign prostatic hypertrophy, Chronic obstructive pulmonary disease, Rhabdomyolysis, and Thrombocytopenia.

The current 12/23/15 FCS assessed #185 in need of physical assistance (2) with medications; treatment management left empty. The 12/23/15 negotiated service agreement documented #185 to receive medication management.

Comparison of the January 2016 MAR (medication administration record) with signed medical care provider orders revealed discrepancy:
Order documented "Levothyroxine 0.05mg one tablet po (by mouth) every morning AC (before meal) take on empty stomach"
According to MAR Levothyroxine scheduled and documented at 0745.

Levothyroxine documented given with all other meds scheduled at 0745 and not on empty stomach:
Aspirin, Amantadine, Benzotropine Mesylate, Carbidopa/Levadopa, Cholecalciferol,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 27 Diphenhydramine, Finasteride, Lorazepam, and Sertraline. On 01/05/16 at 12:20pm Medication aide #F stated I am the only one to give medications to #185 in January... gets all meds in the morning... used to get one at 6:00am (Ropinerole)... doesn't get that anymore so gets all meds at the same time... I go up and see if #185 is awake... if up I give by 7:00am... if sleeping I let sleep until 7:45am and then I give them... Levothyroxine not administered in accordance with written order and in accordance with professional standards as recommended on empty stomach. The Operator failed to ensure #185 received all medications in accordance with written order and in accordance with professional standards of practice. - Record review revealed #189 admitted to facility 6/30/13 with diagnoses of Bipolar I, PTSD (post traumatic stress disorder), Gastroesophageal reflux disease, Anxiety, Hypothyroid, Chronic obstructive pulmonary disease, Post-op thyroid cancer, History of alcohol and cannabis abuse, and Hepatitis C. The current 6/20/15 FCS assessed #189 in need of (1) supervision with medications. The 6/20/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications to #189 in January.	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 28 Comparison of written orders with the January 2016 MAR revealed discrepancies: Levothyroxine 0.175mg (milligrams) one tab every morning AC (before meal). Omeprazole 20mg 2 caps every morning 30 minutes AC. Levothyroxine and Omeprazole scheduled and documented as given at the same time as all other oral morning medications: Folic acid (recommended with food if upsets stomach), Lithium Carbonate (recommended with food), Multivitamin (typically recommended with food), Oxybutinin chloride (with or without food), Propanolol (recommended with food if upsets stomach), and Thiamine (recommended on empty stomach). Levothyroxine and Omeprazole not administered in accordance with written orders and in accordance with professional standards as recommended. The Operator failed to ensure #189 received all medications in accordance with written order and in accordance with professional standards of practice. - Record review revealed #187 admitted to facility 10/05/15 with diagnosis of Schizoaffective disorder. The current FCS assessed #187 (0) independent with medications. The 10/05/15 NSA documented facility to manage medications. The current January 2016 MAR (medication administration record) documented Medication aide #F administered all medications in January. Comparison of written orders with the January	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 29 2016 MAR revealed discrepancies: 10/02/15 order for Cetirizine HCL 10mg once a day; not on MAR and not given 10/02/15 order for Multivitamin daily; not on MAR and not given MAR contained order for Epi-Pen injection 0.3mg/0.3ml IM (intramuscularly) as needed in event of bee sting; no written order found for this medication. The Operator failed to ensure #187 received all medications in accordance with written order and in accordance with professional standards of practice. - Review of record revealed #182 admitted to facility with diagnoses of Respiratory Sarcoidosis, Depression, Anxiety, and PTSD (post traumatic stress disorder). The current 12/03/15 FCS assessed #182 independent (0) with bathing, dressing, toileting, transfers, mobility, eating; Medication and Treatment management cut off and not included in the FCS. The 12/03/15 NSA (negotiated service agreement) documented facility to manage medications. The 12/2015 MAR (medication administration record) documented facility staff administered medications. Comparison of written orders with the December 2105 MAR (medication administration record) revealed discrepancies: Alprazolam 0.5mg (milligram) one tab po (by mouth) TID (three times daily) a day as needed for anxiety for seven days; this medication on the	S5300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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 30 MAR, written medical care provider order not located. Hydroxyzine Pamoate 25mg one tab po every HS (bed time); this medication on the MAR, written medical care provider order not located. Doxycycline Hydrate 100mg one cap po BID (twice daily) for 10 days; this medication on the MAR, written medical care provider order not located. Amlodipine Besylate 10mg one tab po every morning; this medication on the MAR, written medical care provider order not located. The Operator failed to ensure #187 received all medications in accordance with written order and in accordance with professional standards of practice.	S5300		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5315	Continued From page 31 self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The census equalled four the sample included three Residents and two focused reviews completed. Based on observations, interviews, and reviews of record; For one of three sampled Residents (#189), for one of two focused review Residents (#182), and for two employees (Operator #G and Medication aide #F), Licensed nurses and Medication aides failed to develop in facility policy and practice TB (tuberculosis) solution properly stored in accordance with manufacturer's recommendation and not administered beyond the manufacturer's recommended date of discard. For two of three sampled Residents (#189 and #185), Licensed nurses and Medication aides failed to develop facility policy and practice that separated expired medications from active medications to ensure expired medications not administered to Residents.	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5315	Continued From page 32 Findings included: - On 01/04/16 at 3:25pm, by observation the current facility supply of TB test solution lacked a documented "opened date." By interview on 01/04/16 at 3:25pm, Facility Medication aide #F stated not sure of date this vial opened... #F added "that stuff lasts how long... about two years?" At 3:25pm Facility Medication aide #F phoned Facility Nurse #E. After discussion, Facility Nurse #E and Medication aide #F determined the current vial most likely opened 6/09/15. By review of available employee and Resident TB testing documentation the following determined: TB vial Lot #757135 administered to employee #D on 3/20/15. TB vial Lot #757135 administered to sampled Resident #189 on 6/09/15, and to Medication aide #F and Operator #G on 6/09/15. This date span demonstrated the opened vial of TB solution not discarded 30 days after first opened, in accordance with manufacturer's instructions printed on solution packaging. TB vial Lot #762017 administered to employees #E and #C on 9/24/15. TB vial Lot #762017 administered to focus review Resident #182 on 12/03/15 and 12/07/15. This date span demonstrated the opened vial of TB solution not discarded 30 days after first opened, in accordance with manufacturer's instructions printed on solution packaging. On 01/06/16 at 9:10am, Facility Nurse #E stated I was not aware of the need to discard TB solution 30 days after opening... we have never done	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5315	Continued From page 33	S5315		

that... I have worked at facility since September of 2014.

Licensed nurses and Medication aides failed for #182, for #189, and failed to develop for facility policy and practice, a method to ensure TB solution properly stored in accordance with manufacturer's recommendation and not administered beyond the manufacturer's recommended date of discard.

- On 01/04/16 at 2:30pm, observed medication storage area of facility. Drawers of medications for individual Residents contained a mixture of active/current medications with expired/discontinued medications.
Sampled Resident #189's drawer:
Albuterol expired 02/2015
Saline nasal spray expired 7/15/14
Docusate sodium expired 7/01/15
Trazadone expired 6/27/13
Venlafaxine expired 8/13/13
Diclofenac expired 07/2014
Hydroxizine expired 9/12/13
Refresh tears expired 03/2015
Levothyroxine expired 3/05/15
Cyclobenzaprine expired 7/20/13

Sampled Resident #185's drawer:
Trazadone expired 03/2014
Zoloft expired 7/29/2011
Symbicort expired 11/2013
Triamcinolone expired 03/2015
Simvastin expired 12/09/14
Cholecalciferol 11/06/15

On 01/04/16 at 2:30pm, Medication aide #F confirmed expired medications in same drawer as current, active medications... stated we just don't give those... have not had opportunity to destroy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089080	A. BUILDING: _____ B. WING _____	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BOGART HOUSE LLC-II	3535 SW 6TH ST 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
S5315	Continued From page 34 them. On 01/06/16 at 9:10am, Facility Nurse #E confirmed the need to go through medications and destroy expired medications stored in the drawers of current/active Resident medications. For #189 and #185, Licensed nurses and Medication aides failed to develop facility policy and practice that separated expired medications from active medications to ensure expired medications not administered to Residents.	S5315		