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 _____	08/17/2022

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 represent the findings of a resurvey for the above named Home Plus facility conducted on 08/18/2022.	S 000		
S5126 SS=D	26-42-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(h) The facility had a census of seven residents. Three residents were included in the sample. Based on record review and interview for one of three residents sampled (Resident (R)817) the facility failed to ensure each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement. Findings included: - Record for R817 revealed an admission date of 12/14/18 with a diagnosis of dementia. The 12/14/21 NSA revealed R817 was cognitively impaired and did not include the signature of R817's legal representative.	S5126		

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 _____	08/17/2022

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
S5126	Continued From page 1 On 08/17/22 at 02:52 PM Licensed Nurse A stated R817's sister was her legal representative and only came to the facility infrequently. On 08/17/22 at 10:14 AM Administrative Staff C stated R817's legal representative has been asked to sign the NSA but she has not done so. The operator failed to ensure the NSA was signed by the resident's legal representative when the resident was cognitively impaired.	S5126		
S5156 SS=E	26-42-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(b) The facility reported a census of seven residents. Three residents were included in the sample. Based on record review and interview the facility failed to develop a Health Care Service Plan (HCSP) that included the use of a mechanical lift for transfers for Resident (R)817 and failed to identify R818 as a fall risk due to having seizures.	S5156		

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 _____	08/17/2022

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
S5156	Continued From page 2 Findings included: - Record for R817 revealed an admission date of 12/14/18 with a diagnosis of dementia. The 12/14/21 "Functional Capacity Screen" (FCS) documented R817 was not able to transfer on her own. The 12/14/21 "Negotiated Service Agreement" (NSA) documented staff provided 1:1 physical assistance with transfers. The 12/14/21 "Client Personal Care Service Plan" did not address R817's need for a mechanical lift for transfers. On 08/17/22 at 12:46 PM Certified Medication Aide B stated R817 was not able to get out of bed by herself and was a two-person transfer requiring the use of a mechanical lift. On 08/17/22 at 02:52 PM Licensed Nurse (LN) A stated R817 was a two-person transfer using a mechanical lift. LN A stated the use of a mechanical lift should be included on the NSA/HCSP and stated she was not able to find anything in the NSA or the care plan concerning the use of a mechanical lift for R817. The facility failed to develop a care plan that included the use of a mechanical lift for transfers for R817. - Record for R818 revealed admission date of 06/06/22 with a diagnosis of unspecified convulsions.	S5156		

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 _____	08/17/2022

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
S5156	Continued From page 3 The 06/06/22 "Functional Capacity Screen" (FCS) identified R818 required physical assistance with walking and triggered for falls. The 06/06/22 "Negotiated Service Agreement" (NSA) documented R818 ambulated independently and was a fall risk. The 06/06/22 "Client Personal Care Service Plan" documented R818 ambulated independently and was a fall risk but did not address her as having had falls due to seizures. On 08/17/22 at 02:44 PM Licensed Nurse (LN) A stated R818 had a fall within the first few days of being admitted to the facility due to having a seizure. LN A stated she was told by R818's family member that R818 was more at risk of having a seizure if she was anxious. LN A stated the care plan should include that R818 was at risk of falls due to seizures. The facility failed to develop a care plan that identified R818 as a fall risk due to having seizures.	S5156		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures,	S5192		

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 _____	08/17/2022

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
S5192	Continued From page 4 holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (e) The facility had a census of seven residents. All seven residents ate food prepared in the same kitchen. Based on record review and interview the operator failed to ensure food items were served at the proper temperature. Findings included: - Review of the faclity's "Kitchen Guidance and Menus" notebook, the record lacked documentation of food temperatures for resident food being completed for 2022. On 08/18/22 at approximately 03:30 PM Licensed Nurse A stated she did not always document food temperatures prior to serving food to the residents. A policy concerning food serving temperatures was requested from the facility on 08/18/22 at 07:58 AM but no policy was provided. According to the Kansas Department of	S5192		

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 _____	08/17/2022

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
S5192	Continued From page 5 Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The operator failed to ensure food items were served at the proper temperature.	S5192		
S5195 SS=F	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (f) The facility had a census of seven residents. All seven residents ate food prepared in the same kitchen. The operator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - Review of the "Karaway Temperature Log" for	S5195		

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 _____	08/17/2022

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
S5195	Continued From page 6 refrigerator and freezer temperatures revealed the temperature logs for May and June 2022 lacked numerous entries and no logs were completed for July and August 2022. On 08/18/22 at approximately 03:30 PM Licensed Nurse A confirmed there were no refrigerator and freezer temperatures documented for the months of July and August 2022. A policy concerning food storage temperatures was requested from the facility on 08/18/22 at 07:58 AM but no policy was provided. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature." The operator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S5195		
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.	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 _____	08/17/2022

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 7	S5325		

This REQUIREMENT is not met as evidenced by:
KAR 26-42-205(l)

The facility reported a census of seven residents. Three residents were included in the sample. Based on record review and interview the facility failed to ensure a medication regimen review was completed at least quarterly for Resident (R)817 and R819.

Findings included:

- Records revealed R817 admitted to the facility on 12/14/18 with a diagnosis of dementia.

The 12/14/21 Negotiated Service Agreement (NSA) documented staff managed R817's medications.

R817's medical records revealed pharmacy reviews were completed on 02/09/21, 09/02/21, 03/29/22 and 07/12/22.

On 08/17/22 at 02:52 PM Licensed Nurse (LN) A stated the pharmacist usually came quarterly to review the resident medications but after she reviewed R817's medical records she acknowledged the pharmacist did not review medications for her on a quarterly basis.

The facility failed to ensure the pharmacist completed a medication regimen review for R817

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 _____	08/17/2022

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 8 at least on a quarterly basis. - Records revealed R819 admitted to the facility on 02/01/19 with diagnoses of Type 2 Diabetes Mellitus and cerebral infarction. The 02/01/22 Negotiated Service Agreement (NSA) documented staff managed R819's medications. R819's medical records documented pharmacy reviews were completed on 02/09/21, 09/02/21, 03/29/22 and 07/12/22. On 08/17/22 at 02:52 PM Licensed Nurse (LN) A stated the pharmacist usually came quarterly to review the resident medications but after she reviewed R819's medical records acknowledged the pharmacist did not review medications for her on a quarterly basis. . The facility failed to ensure the pharmacist completed a medication regimen review for R819 at least on a quarterly basis.	S5325		