STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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 represent the findings of a resurvey with a complaint (#176146) at the above named facility conducted on 03/20/23 and 03/21/23.	S 000		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (1) The census equaled 32 residents. The sample included 3 residents. Based on record review and interview for 1 resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure the review, and if necessary, revision of the Negotiated Service Agreement (NSA) at least once every 365 days.	S3092		

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
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3092	Continued From page 1 Findings included: - R1's "Medical Record" revealed he admitted to the facility on 02/04/20 with diagnoses of hypertension, major depressive disorder, mixed hyperlipidemia, coronary artery disease, chronic kidney disease and diabetes mellitus type II. The "Resident Functional Capacity Screen" (FCS) dated 02/22/22 recorded the resident as independent with eating, required supervision with transfer and walk/ mobility, required physical assistance with dressing, toileting and management of medications and treatments and was unable to complete bathing. R1 had a catheter, impaired memory/ recall, understandable/ usually understood and had impaired vision. R1 used a walker to ambulate. The "Negotiated Service Agreement/ Health Service Plan" dated 02/01/22 recorded facility staff physically assisted R1 with bathing, dressing and toileting and administered medications. R1 was independent with transfer, walk/mobility and eating, was frequently incontinent, had a catheter, was understandable/ understood, and wore glasses. Record lacked completion of an annual Negotiated Service Agreement since 02/01/22. Interview on 03/21/23 at 11:02 AM with Certified Medication Aide (CMA) D stated facility staff assisted R1 with bathing, dressing, toileting and transferring, administered all medications. CMA D further stated R1 did not walk on own, used a wheelchair for mobility.	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3092	Continued From page 2 Interview on 03/21/23 at 02:40 PM with LN B confirmed unable to locate an annual Negotiated Service Agreement for R1 since 02/01/22. Facility's "Negotiated Service Agreements (NSA) and Health Care Service Plan (HCSP)" (no dated) recorded, "This agreement will be completed upon admit and reviewed annually and with any significant change in condition." Operator/LN A failed to ensure the review, and if necessary, revision of the negotiated service agreement at least once every 365 days.	S3092		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The census equaled 32 residents. The sample included 3 residents. Based on record review and interview for 1 resident (R)1, Operator/Licensed Nurse (LN) A failed to ensure a licensed nurse provided and coordinates the	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3155	Continued From page 3	S3155		

provision of necessary health care services (HCS) that meet the needs of each resident and are in accordance with the functional capacity screening (FCS) and the negotiated service agreement (NSA).

Findings included:

- R1's "Medical Record" revealed he admitted to the facility on 02/04/20 with diagnoses of hypertension, major depressive disorder, mixed hyperlipidemia, coronary artery disease, chronic kidney disease and diabetes mellitus type II.

The "Resident Functional Capacity Screen" (FCS) dated 02/22/22 recorded the resident as independent with eating, required supervision with transfer and walk/ mobility, required physical assistance with dressing, toileting and management of medications and treatments and was unable to complete bathing. R1 had a catheter, impaired memory/ recall, understandable/ usually understood and had impaired vision. R1 used a walker to ambulate.

The "Negotiated Service Agreement/ Health Service Plan" dated 02/01/22 recorded facility staff physically assisted R1 with bathing, dressing and toileting and administered medications. R1 was independent with transfer, walk/mobility and eating, was frequently incontinent, had a catheter, was understandable/ understood, and wore glasses.

The "Negotiated Service Agreement/ Health Service Plan" lacked an entry for the following related to R1's catheter: who and how often the catheter would be changed, cleansed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3155	Continued From page 4 emptied. Record lacked completion of an annual Negotiated Service Agreement since 02/01/22. Interview on 03/21/23 at 02:40 PM with LN B confirmed the current "Negotiated Service Agreement/ Health Service Plan" dated 02/01/22 did not include who and how often the catheter would be changed, cleansed and emptied. Facility's "Negotiated Service Agreements (NSA) and Health Care Service Plan (HCSP)" (no dated) recorded, "Information included in the agreement should include: Any nurse service, supervised nursing care or personal care ... A description of health care services and the provider of each service ...Other items to be included in the NSA/HCSP: Bathroom management and incontinence ...This agreement needs to describe the resident's needs and preferences in enough detail to act as a care plan guide for staff." Operator/Licensed Nurse (LN) A failed to ensure a licensed nurse provided and coordinates the provision of necessary health care services (HCS) that meet the needs of each resident and are in accordance with the functional capacity screening (FCS) and the negotiated service agreement (NSA).	S3155		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3171	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-41 204 (i) The census totaled 32 residents. The sample included 3 residents. Based on observation, interview and record review, Operator/ Licensed Nurse (LN) A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R)3. Findings included: - The "Resident Roster" obtained on 03/20/23 identified nine residents as having a bed assist device. R3's "Medical Record" revealed she admitted to the facility on 01/20/22 with diagnoses of anxiety disorder, hypertension, hyperlipidemia, major depressive disorder and hypothyroidism. The "Resident Functional Capacity Screen" (FCS) dated 01/20/23 recorded the resident as independent with toileting, transfer, walk/mobility, and eating, physical assistance required for bathing, dressing and management of treatments and unable to perform management of medications. R3 was at risk for falls and unsteadiness and had impaired vision and hearing. R3 used a walker.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3171	Continued From page 6 The "Negotiated Service Agreement/ Health Service Plan" dated 01/20/22 recorded staff assisted with bathing, dressing and management of medications and treatments. transfers, medication management and treatment management. The NSA recorded R1 used a wheelchair for ambulation and self-propelled. R1 was at risk for falling due to knee pain. The "Negotiated Service Agreement/ Health Service Plan" identified a bed assistive device used for safe transfers. Record review revealed an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. The assessment was dated 01/20/23. Observation on 03/21/23 at 02:11 PM in R3's room revealed a bed assist device to the right side of her bed. Bed assist device was not secured to the bed. R3 stated she used the bed device to get out of bed and confirmed it was not secured to bed. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3171	Continued From page 7 Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Facility's "Restraints/ Bed Assist Device" policy (no date) recorded, "Bed assist devices are assessed quarterly to ensure device is without gaps, is not loose, has the proper cover is applies and for broken or malfunctioning parts." Operator/LN A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of R3 regarding use of a bed assistive device.	S3171		
S3211 SS=D	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3211	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g) (3) The census totaled 32 residents. The sample included 3 residents. Based on observation and interview for 1 resident (R)3 and 3 non-sampled resident (R)4, R5 and R6, Operator/ Licensed Nurse (LN) A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the resident's over the counter medication. Findings included: - Observation on 03/20/23 with Operator/LN A revealed a locked medication cart at the nurse's station in the facility. The following over the counter medications were noted without full names: For R2 the cart contained one bottle of Aspirin (non-steroidal anti-inflammatory drug) and one bottle of Complete Women 50+ multivitamin, For R4, the cart contained one bottle of Tylenol Arthritis (joint pain reliever), For R5, the cart contained one bottle of Vitamin B12 (supplement). Observation on 03/20/23 with Operator/LN A revealed a second locked medication cart at the nurse's station in the facility. The following over the counter medications were noted without full names: For R6, the cart contained one bottle of Melatonin (supplement) and one bottle of Wal	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3211	Continued From page 9 Dryl Allergy Relief. Interview on 03/20/23 at 12:30 PM with Operator/ LN A confirmed the above listed medications were without full first and last names for R3, R4, R5 and R6. Facility's "Policy for labeling insulin pens and OTC [over the counter] bottles" (no date) recorded, "For OTC bottles the bottle not lid must be labeled with resident's full name by RN/LPN." Operator/LN A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the resident's over the counter medication.	S3211		
S3310 SS=D	26-41-207 (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; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' 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	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089002	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK SENIOR LIVING	3224 SW 29TH STREET TOPEKA, KS 66614

(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
S3310	Continued From page 10 by: K.A.R 26-41-207 (c) The census totaled 32 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 1 staff (Certified Medication Aide (CMA) C, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - Review of CMA C's employee record revealed they hired onto the facility on 12/16/22. CMA C's record lacked evidence of completion TB testing upon hire. CMA C's first step of TB testing was completed on 01/05/23, approximately 3 weeks after being hired by the facility. Interview on 03/21/23 at 10:50 AM with Operator/ Licensed Nurse (LN) A confirmed TB testing was not completed within seven days of hire for CMA C. Facility's "TB Basic Facts" policy (no date) recorded, "A two-step TB skin test is done within 7 days of hire or admission." The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		