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 _____	08/23/2023

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 citations represent the findings of a resurvey with a complaints #172938, 173090, 175448, 177033, 180105, 182149, 182308 and 182310 at the above named Home Plus conducted on 08/16/23, 08/17/23, 08/21/23, 08/22/23 and 08/23/23.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of six residents. The facility identified one resident at risk for elopement. Based on observation, interview and record review the operator failed to ensure resident (R)104 was not subjected to neglect by the failure to ensure the front entrance door had a working alarm in place to notify staff when a resident at risk for elopement exited the building without staff being aware. This resulted in cognitively impaired R104 exiting the facility and being unaccounted for by staff for approximately	S5026		

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 _____	08/23/2023

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
S5026	Continued From page 1 25 minutes during a rain shower untill local law enforcement located her approximately one and a half blocks from the facility. Findings included: - R104's medical record revealed the resident moved into the facility on 08/09/23 with a diagnosis of dementia. R104's "Functional Capacity Screen" (FCS) dated 08/09/23 revealed she was independent with transfers and mobility, had a cognitive score of four indicating she was severely cognitively impaired and triggered for wandering. R104's "Negotiated Service Agreement" (NSA) did not address what staff were to do about her wandering and was not amended to address her elopement on 08/13/23 and what services staff provided to prevent further elopements. Review of R104's medical record revealed the following: The 08/11/23 at 09:30 AM "Nurse's Note" documented, "...Resident is a high elopement risk...Has been wandering this morning and trying to elope. Staff 1:1 with resident at this time." The 08/11/23 at 03:00 PM "Nurses' Note" documented, "Around 10:45 (AM) resident tried to elope again...ending up outside in the front yard...Resident once again trying to get out of the gate..." The 08/13/23 at 10:00 PM "Nurses' Note"	S5026		

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 _____	08/23/2023

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
S5026	Continued From page 2	S5026		

documented; one Certified Nurse Aide (CNA) was feeding another resident while other staff were cleaning the kitchen. R104 left the facility around 12:50 PM as she walked out the front door. A Certified Medication Aide (CMA) on duty received a phone call a few minutes later from local law enforcement reporting they were on the way to return R104 and arrived at the facility at 01:04 PM.

An observation on 08/16/23 at 03:30 PM revealed the facility was in a residential neighborhood. The streets were paved and had a speed limit of 30 miles per hour with minimal traffic. There were no sidewalks. Weather conditions at the time of the elopement as verified on https://www.wunderground.com/ revealed it was daylight outside with heavy rainstorms and a temperature of 78 degrees Fahrenheit.

An observation on 08/16/23 at 04:15 PM revealed R104 walked around the living room and front foyer and went to the front door. Staff redirected R104 away from the front door.

An observation on 08/17/23 at 08:40 AM revealed the front walkway gate had no lock and there was not a working latch on the gate. The newly installed motion sensor was located on the ground instead of mounted on the wooden post as intended. Another wooden gate closer to the house near the driveway had a latch but was not locked.

An observation on 08/17 23 at 09:12 AM revealed that when the front door was opened there was no sound to alert staff when it was

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 _____	08/23/2023

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
S5026	Continued From page 3 opened. On 08/17/23 at 09:02 AM CNA C stated R104 frequently attempted to exit seek when she was agitated. On 08/22/23 at 11:08 AM CMA D stated they were assisting another resident with her meal when R104 walked out the front door of the facility. CMA D stated they did not hear the door open and close and was not aware that R104 had exited the facility until local law enforcement called to let staff know they were bringing R104 back to the facility. CMA D stated they were not aware that R104 was an elopement risk prior to the elopement incident. On 08/17/23 at 11:17 AM Licensed Nurse (LN) B stated R104 started wandering and exit seeking within approximately 24 hours of being admitted to the facility. The operator failed to ensure R104 was not subjected to neglect when the operator failed to ensure the front exit door had a working alarm and failed to ensure the gates in the front yard latched properly. This resulted in cognitively impaired R104 exiting the facility without staff knowledge and being unaccounted for approximately 25-minutes. On 08/17/23 at 01:15 PM Administrative Staff A was informed of the findings which resulted in immediate jeopardy for a cognitively impaired resident exiting the facility unaccompanied by staff, failure of staff to ensure the front exit door had a working alarm in place to notify staff when a resident at risk for elopement exited the	S5026		

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 _____	08/23/2023

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
S5026	Continued From page 4 building without staff being aware, and the failure to ensure the front yard gate latched properly when closed. Administrative Staff A submitted an abatement plan which included the following: R104's medication was reevaluated and changed on 08/14/23. Repaired the front gate latch on 08/17/23. Staff to check on R104 every 30 minutes starting 08/17/23. Provide a sitter for 1:1 care as available. Alarm system company onsite to repair door alarm on 08/17/23. Staff education on how to prevent elopement, 30-minute checks and one-on-one care when R104 was agitated, and pacing started on 08/17/23. The immediate jeopardy was abated on 08/17/23 at 04:30 PM based on the facility's plan of correction and approved by the department.	S5026		
S5105 SS=F	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	S5105		

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 _____	08/23/2023

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
S5105	Continued From page 5	S5105		

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.

This REQUIREMENT is not met as evidenced by:
KAR 26-42-202(a)(1)

The facility reported a census of six residents with three residents included in the sample and two abbreviated reviews. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) was fully developed on what triggered in the "Functional Capacity Screen" (FCS) for residents (R)101, R102, R103, R104 and R105.

Findings included:

- R101's medical record revealed the resident moved into the facility on 06/27/20 with a diagnosis dementia.

The 06/27/23 FCS identified R101 had difficulty with short-term memory, memory recall and decision-making. R101 rarely or never understood when spoken to and triggered for falls.

The 06/27/23 NSA did not address R101's

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 _____	08/23/2023

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
S5105	Continued From page 6	S5105		

difficulty with short-term memory, memory recall and decision-making, his inability to understand others or his trigger for falls, unsteadiness.

On 08/22/23 at 09:36 AM Licensed Nurse (LN) B acknowledged not all items that triggered on R101's FCS were addressed on the NSA.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered in the FCS.

- R102's medical record revealed the resident moved into the facility on 06/06/22 with a diagnosis of dementia.

The 06/06/23 FCS identified R102 was physically unable to manage her medications and treatments, had difficulty with short-term, memory recall and decision-making, and triggered for falls, unsteadiness and wandering.

The 06/06/23 NSA did not address R102's management of medications, treatments, impaired cognition, falls, unsteadiness and wandering.

On 08/22/23 at 09:36 AM Licensed Nurse (LN) B acknowledged not all items that triggered on R102's FCS were addressed on the NSA.

The operator failed to ensure R102's NSA was fully developed to include all items that triggered in the FCS.

-R103's medical record revealed the resident moved into the facility on 11/08/21 with a diagnosis of Parkinson's Disease.

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 _____	08/23/2023

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
S5105	Continued From page 7 The 11/08/22 FCS documented R103 required physical assist with transfers, was unable to manager her own medications and treatments, had severely impaired cognition, sometimes understood other and triggered for falls, unsteadiness and impaired decision-making. The 11/08/22 NSA did not address R103's need for physical assist with transfers, management of medications and treatments, impaired cognition and communication and triggers for falls, and impaired decision-making. On 08/22/23 at 09:36 AM Licensed Nurse (LN) B acknowledged not all items that triggered on R103's FCS were addressed on the NSA. The operator failed to ensure R103's NSA was fully developed to include all items that triggered in the FCS. -R104's medical record revealed the resident moved into the facility on 08/09/23 with a diagnosis of dementia. The 08/09/23 FCS documented R104 was unable to manage her medications or treatments, was occasionally incontinent, experienced short-term memory loss, had impaired memory/recall and decision-making, was sometimes understood when communicating with others, triggered for falls, unsteadiness, impaired vision and wandering. The 08/09/23 NSA did not address R104's medication and treatment management, incontinence, cognitive impairment,	S5105		

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 _____	08/23/2023

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
S5105	Continued From page 8 communication and triggers for falls, impaired vision and wandering. On 08/22/23 at 09:36 AM Licensed Nurse (LN) B acknowledged not all items that triggered on R104's FCS were addressed on the NSA. The operator failed to ensure R104's NSA was fully developed to include all items that triggered in the FCS. -R105's medical record revealed the resident moved into the facility on 12/14/18 with a diagnosis of dementia. The 12/14/22 FCS documented R105 was incontinent, had impaired cognition, was rarely or never understandable and sometimes understood others, and triggered for falls, unsteadiness. The 12/14/22 FCS did not address R105's incontinence, impaired cognition, communication and trigger for falls. On 08/22/23 at 09:36 AM Licensed Nurse (LN) B acknowledged not all items that triggered on R105's FCS were addressed on the NSA. The operator failed to ensure R105's NSA was fully developed to include all items that triggered in the FCS.	S5105		
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	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 _____	08/23/2023

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 9 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, 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 six residents. All six residents ate food prepared in the same kitchen. The operator failed to ensure food items were served at the proper temperature. Findings included: - On 08/16/23 at approximately 04:00 PM review of kitchen records revealed there was no documentation that food temperatures were monitored prior to serving to the facility residents after 08/02/23. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or	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 _____	08/23/2023

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 10 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		
S5230 SS=F	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; (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 facility reported a census of six residents. Based on interview and record review five new employee records, the operator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included:	S5230		

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 _____	08/23/2023

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
S5230	Continued From page 11 - Review of five newly hired staff records revealed the following: Certified Medication Aide (CMA) D's employee record revealed a hire date of 06/05/23. The facility failed to ensure a Tuberculosis Symptom Screening Questionnaire was completed within seven days of employment. CMA F's employee record revealed a hire date of 09/29/2022. The facility failed to ensure Tuberculosis Symptom Screening Questionnaire was completed and the first step of the two-step Tuberculosis skin test (TST) was administered within seven days of employment. CMA H's employee record revealed a hire date of 12/28/2022. The facility failed to ensure Tuberculosis Symptom Screening Questionnaire was completed and the first step of the two-step Tuberculosis skin test (TST) was administered within seven days of employment. On 08/23/23 at 09:50 AM Administrative Nurse A stated she was unable to locate the missing TB information for some newly hired staff. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new ... employee shall have an initial TB symptom screen that includes the components of the TB symptom questionnaire within seven days of ...employment ...Each new ...employee shall receive a two-step TST ...within 7 days of ...employment..." The operator failed to ensure the facility remained in compliance with the department's	S5230		

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 _____	08/23/2023

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
S5230	Continued From page 12 tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees.	S5230		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(2) The facility reported a census of six residents. Based on interview and record review, the	S5258		

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 _____	08/23/2023

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
S5258	Continued From page 13 operator failed to ensure three of five newly hired employee records included evidence of successful completion of certification was completed prior to employment and evidence a criminal background check was completed prior to staff employment. Findings included: - Review of employee files conducted on 08/22/23 revealed the following: Certified Medication Aide (CMA) G hired on 07/29/23. Documentation revealed a Nurse Aide Registry Confirmation Notice and documentation of a Kansas Bureau of Investigations (KBI) criminal background check were completed on 08/22/23 twenty-four days after the date of hire. CMA D hired on 06/05/23. The personnel records did not include a Nurse Aide Registry Confirmation and documentation of a Kansas Bureau of Investigations (KBI) criminal background check was completed on 08/22/23 seventy-eight days after the date of hire. CMA F hired on 09/29/2022. The personnel records did not include a Nurse Aide Registry Confirmation or documentation of a Kansas Bureau of Investigations (KBI) criminal background check completed upon rehire. The operator failed to ensure criminal background checks of newly hired staff were completed prior to staff employment.	S5258		
S5286 SS=D	26-42-205 (b) Administration of Selected Medications	S5286		

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 _____	08/23/2023

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
S5286	Continued From page 14 (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(b) The facility reported a census of six residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)103 identified the responsible person for administration and management of selected medications. Findings included: -R103's medical record revealed he moved into the facility on 11/08/21 with a diagnosis of Parkinson's Disease. The 11/08/22 "Functional Capacity Screen" (FCS) documented R103 unable to manage her medications. R103's 11/08/22 NSA failed to document that she self-administered her Rytary ER (medication used to treat Parkinson's Disease). Review of R103's medical records revealed:	S5286		

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 _____	08/23/2023

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
S5286	Continued From page 15 A physician's order dated 04/05/22 for Rytary ER 48.74 milligrams (mg.) - 195 mg., give three capsules by mouth at 07:00 AM and 12:00 Noon. A physician's order dated 04/05/22 for Rytary ER 48.74 milligrams (mg.) - 195 mg., give two capsules by mouth at 05:00 PM and 10:00 PM. On 08/22/23 at 10:20 AM R103 stated she self-administered her own Parkinson's medication that she kept at her bedside and took four times a day. On 08/22/23 at 09:36 AM Licensed Nurse (LN) B stated R103 self-administered her Rytary for Parkinson's Disease and acknowledged this medication was not identified on the self-administration of medications assessment or on the NSA. The operator failed to ensure the NSA identified the responsible person for administration and management of R103's Rytary which she self-administered.	S5286		
S5313 SS=D	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the	S5313		

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 _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARAWAY, LLC	1815 SW WESTWOOD CIRCLE TOPEKA, KS 66604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5313	Continued From page 16 original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of six residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over-the-counter medications. Findings included: - Observation on 08/16/23 at 04:50 PM revealed the medication storage cart contained the following over-the counter medications which were not labeled with a resident's full name: Resident (R)105: A bottle of Extra Strength Tylenol Rapid Release Gels A bottle of Bayer Low Dose Aspirin A bottle of Kaopectate Diarrhea & Upset Stomach R102: A bottle of Carlyle Kid's Melatonin 1 milligram gummies The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		

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 _____	08/23/2023

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