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	B089091	A. BUILDING: _____ B. WING _____	09/05/2024

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KARAWAY, LLC	1815 SW WESTWOOD CIRCLE TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 190167, 189389, 189022, 189008, 188621, 188448, and 184035 at the above named home plus facility conducted on 09/03/24-09/05/24.	S 000		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of six residents with three included in the sample and two abbreviated record reviews. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R)2 and R3 described the services they received based on their "Functional Capacity Screens" (FCS).	S5105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5105	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 11/24/23 with diagnoses of failure to thrive, psychosis, post-traumatic stress disorder, and traumatic brain injury. The 11/24/23 FCS identified R2 was independent with bathing, dressing, transferring and had impaired hearing. The 11/24/23 NSA described R2 needed both setup and supervision for bathing as well as setup and one person assistance with bathing. Dressing assistance for R2 was documented that he needed both setup and supervision as well as setup and one person assistance. Transfer assistance was marked that R2 needed assistance of one certified staff to transfer from one area to another. The FCS failed to describe services provided for impaired hearing. - Record review for R3 revealed an admission date of 06/24/24 with a diagnosis of quadriplegia. The 06/24/24 FCS identified R3 required assistance with mobility and was unable to perform management of medications or treatments. The 06/24/24 NSA failed to describe the services he received for mobility assistance. The NSA/HSP documented that the facility staff would order medications and treatments, but the resident would self-administer. Interview on 09/04/24 at 11:02 AM with R3 stated the staff completed wound measurements, took pictures, then completed dressing changes.	S5105		

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S5105	Continued From page 2 Interview on 09/04/24 at 11:20 AM of Administrative Nurse B confirmed the staff completed dressing changes with and without a wound vac to R3's coccyx wound. Interview on 09/04/24 at 12:24 PM of R3 revealed the resident had no medications in his room. He stated the staff brought him the medications he needed and that he did not self-administer any medications. On 09/04/24 at approximately 01:32 PM Administrative Staff A confirmed R2 and R3's NSA failed to describe the services provided based on their FCS. The operator failed to ensure the NSA for R2 and R3 described the services provided based on their FCS.	S5105		
S5161 SS=E	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of six residents with three residents included in the sample and two abbreviated chart reviews. Based on interview and record review the operator failed to ensure the resident's "Negotiated Service Agreements"	S5161		

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S5161	Continued From page 3 (NSA) named the Licensed Nurse (LN) responsible for implementing and supervising the plan for Resident (R) 1, 2, 4, and 5. Findings included: - Review of R1's record revealed an admission date of 04/11/24. The 04/11/24 NSA for R1 identified one facility staff would assist in dressing, take to bathroom, assist to transfer, and assist with walking and mobility. Staff was to administer medications and treatments and offer choices to aide in cognition. R1's NSA failed to name the LN responsible for implementing and supervising her service plan. On 09/04/24 at 01:32 PM Administrative Staff A confirmed R1's NSA failed to name the nurse responsible for implementing and supervising the service plan. - Record review for R2 revealed an admission date of 11/24/23. The 11/24/23 NSA documented LN H as the nurse responsible for implementation and supervision of the service plan. An addendum was not completed for R2's NSA when LN B was hired and became responsible for implementing and supervising his service plan. On 09/04/24 at 01:32 PM Administrative Staff A confirmed R2's NSA failed to include an addendum for change in nurse responsible for implementing and supervising the service plan. - Review of R4's medical record revealed she	S5161		

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S5161	Continued From page 4 moved into the facility on 02/01/19. R4's most recent NSA was completed on 02/01/24 and identified LN H as the nurse responsible for implementation and supervision of the health care service plan. LN B was hired on 05/28/24 but no addendum to R4's NSA was completed when LN B assumed responsibility. On 09/04/24 at 01:32 PM Administrative Staff A confirmed R4's NSA failed to include an addendum for change in nurse responsible for implementing and supervising the service plan. The operator failed to ensure the NSA was updated to identify the licensed nurse responsible for the implementation and supervision of the health care services plan for R4. - Review of R5's medical record revealed he moved into the facility on 09/19/23. R5's most recent NSA was completed on 09/19/23 and identified LN H as the nurse responsible for the implementation and supervision of the health care service plan. LN B was hired on 05/28/24 but no addendum to R5's NSA was completed when LN B assumed responsibility. On 09/04/24 at 01:32 PM Administrative Staff A confirmed R5's NSA failed to include an addendum for change in nurse responsible for implementing and supervising the service plan. The operator failed to ensure the NSA was updated to identify the licensed nurse responsible	S5161		

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S5161	Continued From page 5 for the implementation and supervision of the health care services plan for R5.	S5161		
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 reported a census of six residents. The facility had a main kitchen where food was stored and prepared. Based on observation and interview the operator failed to ensure foods were stored under safe conditions for ten unsealed items and five undated items. Findings included: - Observation on 09/03/24 at 02:14 PM in upper cabinet to the right of the refrigerator revealed three bags of chips unsealed. The cabinet above refrigerator had two boxes of raisin bran and one bag of mini spoons cereal unsealed. The cabinet to left of kitchen stove included a bag of walnuts and a bag of cinnamon topping unsealed. On 09/03/24 at 02:17 PM Certified Nurse Aide (CNA) D confirmed these items were unsealed.	S5195		

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S5195	Continued From page 6 - Observation on 09/03/24 at 02:14 PM revealed a refrigerator was in the facility's main kitchen which contained food items for the residents. The following items one bag oven roasted turkey undated, one bag of shredded cheese undated, and two dishes of yellow pudding thick substance unsealed and undated. On 09/03/24 at 02:19 PM Certified Nurse Aide (CNA) D confirmed these items were unsealed and/or undated. - Observation on 09/03/24 at 02:45 PM revealed a refrigerator in the facility's garage which contained food items for the residents. A gallon of milk located in refrigerator was undated when opened. On 09/03/24 at 02:45 PM Certified Nurse Aide (CNA) B confirmed the gallon of milk was undated. Observation on 09/05/24 at 09:50 AM revealed the undated gallon of milk was still in the refrigerator. On 09/05/24 at 12:59 PM Administrative Staff A stated the milk "was disposed of". The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet page 19 documented cold foods must be date marked appropriately and covered to maintain cold holding temperature. The day of preparation or day commercially processed food is opened counts as "day one." Foods can be held for seven days before they need to be consumed or discarded. The operator failed to ensure foods were stored	S5195		

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S5195	Continued From page 7 under safe conditions.	S5195		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of six residents. Based on interview and record review the operator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan with all residents was completed. Findings included: - Review of the facility's quarterly reviews of the "Emergency Management Plan" (EMP) revealed the 10/17/23 review was completed with staff but	S5215		

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S5215	Continued From page 8 not with residents. The 01/01/24 and 04/01/24 reviews failed to include Resident (R)2. The 07/10/24 review failed to include R1, R2, and R3. On 09/05/24 at 01:12 PM Administrative Staff A confirmed quarterly reviews of the facility's EMP was not conducted with all residents. A policy regarding quarterly reviews was requested on 09/05/24 but operator did not provide one. The operator failed to ensure quarterly reviews of the facility's emergency management plan completed with all residents.	S5215		
S5225 SS=F	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(a)	S5225		

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S5225	Continued From page 9 The facility had a census of six residents. Based on observation and interview, the operator failed to ensure the provision of a sanitary environment for resident, staff and visitors by not providing disposable towels for use to dry off hands after washing them. Findings included: - On 09/05/24 at 12:50 PM observation of the downstairs restroom did not have any means to dry hands after a person washed them at the sink. There were no disposable towels available and there were a couple of regular towel holders, but no reusable towels were in place. On 09/05/24 at 01:05 PM Certified Nurse Aide (CNA) D stated there was usually a regular hand towel available in the downstairs restroom and a roll of paper towels stored on the shelf. On 09/05/24 at 01:40 PM observation of the upstairs hallway bathroom revealed there were no disposable towels available for people to dry their hands. There was a dark gray cloth hand towel situated on the vanity top. The operator failed to ensure the provision of a sanitary environment for all individuals who used the public restrooms.	S5225		
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	S5230		

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S5230	Continued From page 10 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 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: - Resident (R)3 was admitted to the facility on 06/24/24. Review of R3's medical record revealed a TB Screening Questionnaire was not completed on admission. The first step of the two-step "TB skin test" (TST) was administered on 06/24/24 and read as not positive on 06/26/24. A second step of the TST was not completed. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire	S5230		

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S5230	Continued From page 11 within 7 days of residency ...If the first TST is read as not positive, a second TST shall be administered within 1 to 3 weeks." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly admitted residents. - R1 was admitted to the facility on 04/11/24. Review of R1's medical records revealed a TB Symptom Screening Questionnaire was completed but not dated. The records lacked evidence that a two-step TST was completed. On 09/04/24 at 01:21 PM Administrative Staff A stated R1's two-step TST was not completed because the tuberculin had expired and was on order from the pharmacy. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire within 7 days of residency ...Each new resident ...shall receive a two-step TST or an IGRA for Mycobacterium tuberculosis within 7 days of residency ..." The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105. - Certified Nurse Aide (CNA) G was hired on 07/08/24. Review of personnel records failed to locate documentation of a TB Symptom	S5230		

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S5230	Continued From page 12 Screening Questionnaire completed. Administrative Nurse B was hired on 05/28/24. The first step of the two-step TST was read as not positive on 06/03/24. The second step TST was administered on 06/08/24 two days early. The June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented, "Each new resident ...shall have an annual TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire within 7 days of ...employment ...If the first TST is read as not positive, a second TST shall be administered within 1-3 weeks." A policy was requested from the operator on 09/05/24 but none was provided. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S5230		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an	S5250		

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S5250	Continued From page 13 emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(10) The facility reported a census of six residents with three included in the sample and two abbreviated record reviews. Based on interview and record review the operator failed to ensure the resident's record contained records of medications, biologicals, and treatments administered for Resident (R) 3. Findings included: - Review of R3's record revealed an admission date of 06/24/24 with a diagnosis of quadraplegia. The 06/24/24 "Functional Capacity Screen" (FCS) for R3 identified the resident required assistance with management of medications and treatments. The 06/24/24 "Negotiated Service Agreement" (NSA) for R3 described the staff would order medications and treatments but R3 "is able to self-administer them." R3's record lacked evidence of the medication	S5250		

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S5250	Continued From page 14 administration record for July 2024. Interview on 09/04/24 at 12:24 PM R3 stated he had no medications in his room. He stated the staff brought him the medications he needed and that he did not self-administer any medications. Interview on 09/05/24 at 10:04 AM Certified Medication Aide (CMA) C stated she administers all of R3's needed medications. On 09/05/24 at approximately 01:28 PM Administrative Staff A failed to provide R3's record of medication and treatment administration for July 2024. The facility's "Medication Policy" dated 11/2017 under "Maintaining Medication Administration Records (MARs)" documented "The MAR becomes a permanent part of the resident's record." The operator failed to ensure the resident's record contained records of medications, biologicals, and treatments administered for R3.	S5250		
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	S5258		

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S5258	Continued From page 15 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 operator failed to ensure two of four newly hired employees records included evidence of verification of licensing or certification was completed prior to staff employment, and the operator failed to ensure one of four newly hired employee records included evidence a criminal background check was completed in a timely manner. Findings included: - Review of employee files conducted on 09/04/24 revealed the following: Licensed Nurse (LN) B was hired on 05/28/24. Documentation revealed a criminal background check, license verification was completed on 07/22/24, approximately two months after the date of hire.	S5258		

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S5258	Continued From page 16 Certified Nurse Aide (CNA) F was hired on 10/07/23. Documentation revealed a verification with the nurse aide registry was completed on 07/08/24, nine months after being hired. The operator failed to ensure verifications of licenses and certifications were completed prior to staff employment and criminal background checks of newly hired staff were completed in a timely manner.	S5258		
S5301 SS=F	26-42-205 (d) (3) Facility Administration of Medications (d) (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d)(3)(C)	S5301		

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S5301	Continued From page 17 The facility reported a census of six residents. Based on observation, record review and interview, the operator failed to ensure that all medications were administered within professional standards of practice. The Certified Medication Aide (CMA) and Licensed Nurse (LN) staff pre-popped medications into medication cups for administration to residents at a future time and failed to follow professional standards of practice designed to safeguard each resident. The operator also failed to ensure staff remained with residents until the medication was ingested or applied and could not be sure that residents took all the medications that were given to them. Findings included: - Review of Resident (R) 4's medical record revealed she was admitted to the facility on 02/01/19. The 02/01/24 "Functional Capacity Screen" (FCS) identified R4 required physical assistance with management of her medications. The 02/01/24 "Negotiated Service Agreement" (NSA) documented staff administered all of R4's medications with exception to some antacids which R4 self-administered. On 09/05/24 at 01:13 PM R4 stated that at times staff left her medications with her to take and other times they stayed until she took her medications. The February 2011 Kansas Certified Medication Curriculum page 169 documented, "Take the medication to the resident and administer as ordered. The medication aide must observe the resident swallow the medication or apply the	S5301		

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S5301	Continued From page 18	S5301		

medication as ordered. Never, under any circumstances, leave a medication cup with a resident without observing the resident taking or applying the medication."

The operator failed to ensure designated staff administered medications within professional standards of practice by remaining with residents until their medications were ingested or applied.

- Review of R2's medical record revealed he was admitted to the facility on 11/24/23.

The 11/24/23 FCS identified R2 required physical assistance with management of his medications.

The 11/24/23 NSA documented staff administered all R2's medications.

On 09/05/24 at 01:18 PM CMA C stated it was normal for R2 to take his medications somewhere else to take at his leisure. CMA C could not tell how she made sure that R2 took all his medications.

On 09/05/24 at 01:04 PM R2 went to Administrative Staff A and asked for his medications. Administrative Staff A gave R2 his medications then he walked away from the medication room carrying his medications with him.

The February 2011 Kansas Certified Medication Curriculum page 169 documented, "Take the medication to the resident and administer as ordered. The medication aide must observe the resident swallow the medication or apply the medication as ordered. Never, under any circumstances, leave a medication cup with a resident without observing the resident taking or

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S5301	Continued From page 19 applying the medication." The operator failed to ensure designated staff administered medications within professional standards of practice by remaining with residents until their medications were ingested or applied. - On 09/03/24 at 02:51 PM Administrative Nurse B stated medications were popped into medication cups labeled with resident names and stated multiple resident medication cups could be taken at the same time to be administered to residents. On 09/05/24 at 11:47 AM an observation of the medication cart revealed five medication cups filled with resident medications in them. On 09/05/24 at 11:47 AM CMA C stated she pre-popped the resident medications into medication cups and then stacked them without any cover/lids and took the medication cups to administer them to the residents. On 09/05/24 at 01:18 PM CMA C stated she believed she received online training to prepare medications for residents one at a time. CMA C stated sometimes there was not enough time to prepare medications individually and she felt rushed. The February 2011 Kansas Certified Medication Curriculum page 165 documented, "All medications must be identified to point of administration. For medications removed from a package or container with the prescription label, a medication card must be used which contains the resident's name, the name of the medication, the route of administration, special instructions for administration and time of administration. This	S5301		

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S5301	Continued From page 20 card must be checked against the MAR before administering the medication to a resident." The operator failed to ensure staff followed professional standards of practice designed to safeguard each resident when administering medications.	S5301		
S5312 SS=D	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (g)(2) The facility reported a census of six residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 08/03/23 at 03:03 PM revealed the facility's medication file cabinet contained the following prescription medications which were not labeled with a resident's full name: Resident 1: One Lantus insulin pen, 3 milliliters One lispro insulin pens, 3 milliliters The facility's "Medication Policy" dated 11/2017	S5312		

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S5312	Continued From page 21 documented that "Insulin will be put in a container with resident's name." On 08/03/24 at approximately 03:05 PM Administrative Nurse B confirmed the insulin pens in the file cabinet were not labeled with residents' full names. The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S5312		
S5313 SS=E	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 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, record review and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages	S5313		

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S5313	Continued From page 22 of eleven over-the-counter (OTC) medications. Findings included: - Observation on 08/03/24 at 02:55 PM revealed Administrative Nurse B unlocked and opened the medication cart where some medications used for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One tube bacitracin ointment, 1 ounce Two boxes Allegra 180mg, 5 tablets One bottle acetaminophen 500 milligram, 500 tablets One tube anti-itch plus hydrocortisone 1%, 1ounce One tub medseptic skin protectant lanolin 50%, 4 ounce On 08/03/24 at approximately 02:56 PM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names. - Observation on 08/03/24 at 02:58 PM revealed Administrative Nurse B unlocked and opened the medication file cabinet where medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One brown bag of Salonpas pain relieving patches, 4 packs One tube clotrimazole 1%, 1 ounce One tube bacitracin, 1 ounce One bottle acetaminophen 650mg, 24 tablets One bottle melatonin 10mg, 120 tablets On 08/03/24 at approximately 02:59 PM	S5313		

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S5313	Continued From page 23 Administrative Nurse B confirmed the OTC medications in the file cabinet were not labeled with residents' full names. The facility's "Medication Policy" dated 11/2017 failed to address labeling of over-the-counter medications with residents' full names. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist.	S5316		

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S5316	Continued From page 24	S5316		

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

The facility reported a census of six residents. Based on observation, interview and record review the operator failed to ensure licensed nurses and medication aides maintained records of medications managed by the home for an accurate reconciliation when controlled medication counts were not correct for four cards of controlled substances.

Findings included:

- Observations and record review of facility's controlled medications count reconciliation book on 09/03/24 at approximately 03:58 PM revealed the following:

1) A punch card of pregabalin 150 milligram (mg) capsules in a separately locked box in the medication cart contained eight capsules. The count reconciliation sheet documented five remaining.
2) A punch card of oxycodone 10 mg tablets in a separately locked compartment within the locked medication cart contained 15 tablets. The count reconciliation sheet documented 25 tablets remaining.
3) A punch card of hydrocodone/acetaminophen 10/325 tablets in a separately locked compartment within the locked medication cart had 27 tablets left. The count reconciliation book failed to include a sheet for the medication. The medication sheet was found in the medication

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S5316	Continued From page 25	S5316		

box attached to other cards with no doses documented.
4) A punch card of hydrocodone/acetaminophen 10/325 tablets in a separately locked compartment within the locked medication cart had eight tablets left. The count reconciliation sheet documented eight remaining with two doses unsigned for. The date, time and signature columns were blank for dose 23 and 24.

On 09/03/24 at approximately 04:02 PM Administrative Nurse B confirmed the count for tablets and capsules of four controlled medications were different than what was documented in the reconciliation book.

On 09/04/24 at 10:27 AM Certified Medication Aide C stated she completed the shift change controlled substance count with Certified Nurse Aide (CNA) F.

On 09/05/24 at 11:35 AM Administrative Staff A stated facility staff had not reported the medication amount discrepancy as she would expect.

On 09/05/24 at 11:47 AM Administrative Staff A stated her expectation is that two sets of eyes, even if one is a CNA, completes the controlled substances count at each beginning and end of shift. She would expect the off going staff member to sign in "OFF" column and on coming staff to sign in "ON" column.

The facility's "Medication Policy" dated 11/2017 failed to describe documentation and reconciliation of controlled substances.

According to the May 10, 2013 Kanas Certified Nurse Aide Curriculum Guidelines, page 13

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S5316	Continued From page 26 describes actions not within the CNA's responsibilities including administering medications. It is beyond the professional standards of a Certified Nurse Aide's scope of practice to count medications including controlled substances. The operator failed to ensure licensed nurses and medication aides maintained records of medications managed by the home for an accurate reconciliation when four controlled medications counts were not correct between medications in the cards and what was documented in the medication count book.	S5316		
S5325 SS=F	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure quarterly medication regimen reviews were conducted for all residents.	S5325		

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S5325	Continued From page 27 Findings included: - Review of R1's record revealed an admission date of 04/11/24 with diagnoses of stroke with left sided weakness, hypertension, hypothyroidism and depression. The 04/11/24 "Functional Capacity Screen" (FCS) identified R1 was unable to perform management of medications or management of treatments. The 04/11/24 "Negotiated Service Agreement" (NSA) for R1 identified facility staff would administer medications and treatments. R1's record lacked evidence of documentation of quarterly medication regimen reviews. - Review of R2's record revealed an admission date of 11/24/23 with diagnoses of failure to thrive, psychosis, post-traumatic stress disorder, and traumatic brain injury. The 11/24/23 FCS identified R2 was unable to perform management of medications or management of treatments. The 11/24/23 NSA for R2 identified facility staff would order and administer medications and treatments. R2's record lacked evidence of documentation of quarterly medication regimen reviews. - Review of R3's record revealed an admission date of 06/24/24 with a diagnosis of quadriplegia. The 06/24/24 FCS identified R3 was unable to perform management of medications or management of treatments.	S5325		

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S5325	Continued From page 28 The 06/24/24 NSA for R3 identified facility staff would order and administer medications and treatments. R3's record lacked evidence of documentation of quarterly medication regimen reviews. On 09/04/24 at 10:50 AM Certified Medication Aide C confirmed quarterly medication regimen reviews were not completed for any residents. She stated the last review was completed 08/07/23. Interview 09/04/24 at 10:31 AM Administrative Nurse B stated she had never completed a pharmacy review, sent, or received documents from pharmacist for review. Interview 09/04/24 at 01:14 PM Administrative Staff A stated her expectation is for Administrative Nurse B to have completed pharmacy review process by sending medication records to pharmacy and complete follow up as necessary. The operator failed to ensure quarterly medication regimen reviews were conducted for all residents.	S5325		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes,	S5335		

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S5335	Continued From page 29 ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of six residents. Based on observation and interview the operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 08/20/24 at approximately 02:14 PM revealed an unlocked, lockable cabinet below kitchen sink. The following chemicals were in the cabinet with labels that read "Keep out of reach of children:" One container Clorox disinfecting wipes, 85 wipes One spray bottle Windex, 32 oz One aerosol can of flying insect spray, 20 oz One jug Bug Stop spray, one gallon One container dishwashing pacs, 105 count One aerosol can of ant and roach spray, 20 oz Two containers of stainless steel cleaner wipes, 40 wipes On 08/03/24 at approximately 02:16 PM Certified Nurse Aide D confirmed chemicals were not in a locked area. The operator failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		

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 _____	09/05/2024

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

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S5370	Continued From page 30	S5370		
S5370 SS=F	28-39-437 Construction (f) Sanitation and maintenance. Each facility shall provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. (g) Public telephone. There shall be a public telephone locally accessible to individuals with disabilities in a private area that allows a resident or another individual to conduct a private conversation. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(f) The facility reported a census of six residents. There were two dogs that also inhabited the home. Based on observation and interview the operator failed to ensure the facility provided a safe and comfortable environment for the public. Findings included: - Observations on 09/03/24 at 01:20 PM revealed the two dogs at the front door and surveyors were let into home by staff prior to dogs being taken to porch. No sign posted at front door for dogs at large or notice to ring door and wait for staff to open. On 09/03/24 at 02:45 PM Certified Nurse Aide (CNA) D escorted surveyor through porch where dogs were located. Dogs not told to go or get away until dog saliva was spread on surveyor's pant leg. On 09/04/24 at 12:55 PM dogs ran, jumped, and	S5370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5370	Continued From page 31 barked at plumber in yard. On 09/05/24 at 09:50 AM both dogs were at the front door barking with no staff when doorbell rang. No sign on door for dogs at large. On 09/05/24 at 01:01 PM Administrative Staff A confirmed that no sign was hung at door for dogs. On 09/05/24 at 01:01 PM an animal policy was requested which the facility failed to provide. The 11/15/23 entity reported incident for a bite to an outside provider, stated the facility interventions were to post a sign for dog at large on front door, create an animal policy, and dogs would be put up or outside when providers and visitors are in facility. The operator failed to ensure the facility provided a safe and comfortable environment for the public.	S5370		