Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089081	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #1	618 SW OAKLEY AVENUE TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represent the findings of an abbreviated survey with review of complaint #194124, 191837, 191782, 191584, 181588, and 190027 at the above home plus conducted on 03/17/25.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

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

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S5028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3) The facility reported a census of 11 residents with three residents included in the sample. Based on interview and record review the operator failed to report an allegation of possible abuse to the department within 24 hours when Resident (R) 1 sustained a broken bone to his left wrist with unknown cause which has caused loss of function of limb. Findings included: - Record review for R1 revealed an admission date of 09/13/23 with diagnoses of cerebral vascular accident affecting left side and Parkinson's disease. The 07/13/24 Functional Capacity Screen (FCS) identified R1 required physical assistance with bathing, dressing, transfers, walking/mobility, and eating; was unable to perform toileting, management of medications and treatments; had short-term and long-term memory, memory/recall, and decision-making difficulties; was sometimes able to understand and was understood during communications; was incontinent of bladder; and was at risk of falls, impaired hearing and impaired decision-making. The 07/13/24 facility's combined "Negotiated Service/Health Care Service Plan" (NSA/HSP) identified facility staff would provide assistance for bathing, dressing, transfers, walking/mobility,	S5028		

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S5028	Continued From page 2	S5028		

incontinence, and eating; facility licensed nurse managed medications; staff spoke slowly and clearly with communication; staff explained processes and allowed time to process; and a Hoyer lift was used for transfers.

The 03/10/25 at 03:55 PM AM "Nursing Notes" documented R1 had facial grimacing with movement of left arm.

The 03/10/25 "Outside Agency Form" signed by licensed nurse from local hospice company documented R1 had acute pain in left arm.

The "Patient Report" dated 03/11/25 at 07:38 PM documented a broken bone within R1's left wrist.

Review of R1's record revealed lack of evidence of documentation the incident was reported to the department within 24 hours.

On 03/17/25 at approximately 12:44 PM R1 winced, groaned, and withdrew arm when left wrist lifted from lap. Wrist brace was in place.

On 03/17/25 at 02:37 PM Certified Nurse Aide D stated R1 used left arm to grab side rail prior to injury but no longer is able.

On 03/17/25 at 02:58 PM Administrative Staff B confirmed an initial report was not filed to the department but would have been day of survey due to findings of unknown cause of injury.

The department's "Adverse Incidents Protocol" explained each incident including a serious injury, which specifically includes loss of limb function, shall be reported within 24 hours of the

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S5028	Continued From page 3 provider becoming aware of the occurrence of the adverse incident. The operator failed to report an allegation of possible abuse when R1 sustained a broken bone to his left wrist with unknown cause.	S5028		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 11 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure staff provided adequate documentation of all incidents including date, time, and results of the actions when Resident (R) 3 eloped from the facility. Findings included: - Record review for R3 revealed an admission date of 11/16/22 with diagnosis of Alzheimer's dementia. The 06/24/24 Functional Capacity Screen (FCS) identified R3 required physical assistance with	S5251		

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S5251	Continued From page 4	S5251		

bathing, dressing, toileting, and eating; was unable to perform management of medications and treatments; required supervision with transfers and walking/mobility; was frequently incontinent of bladder; had short-term and long-term memory loss, memory/recall, and decision-making impairments; and had or was at risk for falls, impaired vision, impaired hearing, wandering, socially disruptive behaviors, and impaired decision-making.

The 06/24/24 facility's combined "Negotiated Service/Health Care Service Plan" (NSA/HSP) identified facility would visually check R3 often, cue occasionally for transfers, ensure unattended doors were never left open, provide de-escalation location, increase supervision if R3 was agitated and resistant. Staff of one assist was provided for bathing, dressing, toileting as needed, and facility licensed nurse managed medications. Staff directed R3 to his room or took for a walk if wandering.

The 08/19/24 Incident Report sent to the department documented R3 completed an elopement on 08/18/24 by setting off front door alarm, staff reset alarm without securing door. R3 subsequently approached same door 13 minutes later and was able to walk through without activating alarm.

Review of R3's "Nursing Notes" revealed a note on 08/14/24 regarding R3's finger. The next note dated 09/09/24 at 01:00 PM documented installation of wanderguard system and wrist band applied to R3's left wrist.

R3's record lacked documentation of elopement

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S5251	Continued From page 5 incident including incident details, assessment of resident, and any results or actions taken. On 03/17/25 at 11:31 AM Administrative Staff B confirmed lack of documentation in R3's record of elopement incident including incident details, assessment of resident, and any results or actions taken. The operator failed to ensure staff provided adequate documentation of all incidents including date, time, and results of the actions when R3 eloped from the facility.	S5251		