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	B089082	A. BUILDING: _____ B. WING _____	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE TOPEKA #2	618 SW OAKLEY AVE, SUITE B TOPEKA, KS 66606

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 196462, 196816, 196960, 197229, 197468, and 197595 at the above named home plus facility conducted on 02/17/26.	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 nine residents with three included in the sample and two closed record reviews. Based on interview and record review the operator failed to ensure the Negotiated Service Agreement (NSA) for Residents (R)1, R2, and R3 described the	S5105		

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

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S5105	Continued From page 1 services they received based on their Functional Capacity Screens (FCS). Findings included: - Record review for R1 revealed an admission date of 11/25/25 with a diagnosis of dementia. The 11/25/25 FCS identified R1 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was frequently incontinent of bladder; had short term memory, memory/recall, and decision-making difficulties; was usually understood or understandable with communication; had impaired vision, hearing, and decision making; and was at risk for falls. The 11/25/25 Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) documented staff provided one-person assistance with bathing, dressing, toileting, transfers, and walking/mobility; provided cueing, reorientation, and simple options for cognition; administered medications and treatments; and staff spoke directly in front of R1 for communication. The NSA/HSP failed to describe the services she received to prevent falls. Observation on 02/17/26 at 03:57 PM revealed R1 had a pull type alarm pinned to her shirt. On 02/17/26 at 10:35 AM Administrative Nurse B stated R1 had bed and chair alarms to assist with preventing falls. - Record review for R2 revealed an admission	S5105		

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S5105	Continued From page 2 date 02/02/26 with diagnoses of hypothyroidism, hypertension, and acute renal failure. The 02/02/26 FCS identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short term memory, long term memory, memory/recall, and decision-making difficulties; was usually understood or understandable with communication; had impaired hearing and decision making; and was at risk for falls. The 02/02/26 NSA/HSP documented staff or hospice agency provided one-person or moderate assistance to R2 with bathing, dressing, toileting, transfers, and walking/mobility; provided simple questions for cognition and decision-making; administered medications and treatments; and staff spoke slow and loud for communication. The NSA/HSP failed to describe the services she received to prevent falls. - Record review for R3 revealed an admission date 11/20/25 with diagnoses of hypothyroidism, hypertension, and acute respiratory failure. The 11/20/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; was incontinent of bladder; had short term memory, long term memory, memory/recall, and decision-making difficulties; was usually understood or	S5105		

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S5105	Continued From page 3 understandable with communication; had impaired hearing and decision making; and was at risk for falls. The 11/20/25 NSA/HSP documented staff or hospice agency provided one-person or moderate assistance to R3 with bathing, dressing, toileting, transfers, and walking/mobility; provided time to process for cognition and communication; and administered medications and treatments. The NSA/HSP failed to describe the services she received to prevent falls. Observation on 02/17/26 at 04:25 PM R2 was lying on a winged mattress. On 02/17/26 at 10:35 AM Administrative Nurse B confirmed the NSAs failed to include fall prevention interventions for all residents at risk of falls including R1, R2, and R3. The facility's undated "Negotiated Service Agreements" policy explained the agreement would include a range of services necessary to support the resident's safety and would describe the resident's needs and preferences in enough detail to be a guide for staff. The operator failed to ensure the NSA for R1, R2, and R3 described the services provided based on their FCS.	S5105		
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	S5195		

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S5195	Continued From page 4 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 nine 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. Findings included: - Observation on 02/17/26 at 09:12 AM revealed two refrigerator and freezer units in the facility's main kitchen which contained food items for the residents. The following food items were located in the south refrigerator space and were not labeled with date opened or past use date: One bag 40-ounce turkey breast opened with no opened date One 32-ounce container of strawberry yogurt without opened date One 32-ounce container of peach yogurt without opened date One 32 fluid ounce jar of mild banana pepper rings with best by date of 02/07/26 On 02/17/26 at 09:18 AM Certified Medication Aide (CMA) C confirmed the foods were opened and not dated upon opening or past use date.	S5195		

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S5195	Continued From page 5 The 2009 Food Code on page 85 and 86 instructed to date food when prepared or opened and commercially processed food should be marked with a use by date. The operator failed to ensure foods were stored under safe conditions.	S5195		
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 nine residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of the residents on the original packages of five over-the-counter (OTC) medications.	S5313		

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S5313	Continued From page 6 Findings included: - Observation on 02/17/26 at 09:22 AM revealed Certified Medication Aide (CMA) C unlocked and opened the medication closet where the medications for the residents were stored. The following over-the-counter medications were not labeled with residents' full names: One bottle ferrous sulfate 65 milligrams (mg), 100 tablets in a basket for R1 One bottle cranberry 4200 mg, 120 softgels in a basket for R6 One bottle vitamin D 25 micrograms, 450 softgels in a basket for R7 One bottle lutein 25mg/zeaxanthin 5mg, 150 softgels in a basket for R7 On 02/17/26 at approximately 09:27 AM Licensed Nurse D confirmed the OTC medications were not labeled with residents' full names. - Observation on 02/17/26 at 09:33 AM of the refrigerator in the medication room revealed one zippered bag of three bisacodyl 10 mg suppositories lacked a resident's name. On 02/17/26 at 09:35 AM Licensed Nurse D confirmed the medication was not labeled with a resident's name. The operator failed to ensure all OTC medications were labeled with the residents' full names.	S5313		
S5315 SS=E	26-42-205 (h) Medication Storage	S5315		

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S5315	Continued From page 7 (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)	S5315		

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S5315	Continued From page 8 The facility reported a census of nine residents. Based on observation and interview the operator failed to ensure that all medications and biologicals were stored safely and securely. Findings included: - Observation on 02/17/26 at 09:30 AM revealed the following controlled substance carded medications had tape applied to compromised medication spaces: One card oxycodone 5 milligrams, 26 tablets with tape on space number "5" One card lorazepam 0.5 milligram, 30 tablets with tape on spaces "7," "15," and "22" On 02/17/26 at approximately 09:32 AM Licensed Nurse D confirmed the medications in compromised spaces had been taped. She was unaware of facility policy but thought they should be destroyed. On 02/17/26 at 09:50 AM Administrative Nurse B stated it was acceptable for a Certified Medication Aide to place tape on a compromised medication space and confirmed the facility did not have a policy regarding taping medications into a card. The operator failed to ensure that all medications and biologicals are stored safely and securely.	S5315		
S9999	Final Observations KAR 26-42-103(c)	S9999		

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S9999	Continued From page 9 If the home plus admits residents with dementia, the administrator or operator shall ensure the provision of staff education, at orientation and at least annually thereafter, on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This requirement is not met as evidenced by: The facility reported a census of nine residents. Based on interview and record review the operator failed to ensure staff education at orientation for treatment and appropriate response to persons who exhibit behaviors associated with dementia. Scope/severity of E: Findings included: - Review of R1's record revealed admission date 11/25/25 with a diagnosis of dementia. Requested record of dementia training for five newly hired staff on 02/17/26 at 01:10 PM which the facility failed to provide. On 02/17/26 at 01:22 PM Administrative Nurse B confirmed dementia training was not completed on hire for all personnel hired since last survey. The operator failed to ensure staff education at orientation for treatment and appropriate response to persons who exhibit behaviors associated with dementia.	S9999		