STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE I	2111 SW RANDOLPH AVENUE TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 05/04/22 and 05/05/22.	S 000		
S5020 SS=D	26-42-101 (d) Resident Rights (d) Resident rights. Each administrator or operator shall ensure the development and implementation of written policies and procedures that incorporate the principles of individuality, autonomy, dignity, choice, privacy, and a home environment for each resident. The following provisions shall be included in the policies and procedures: (1) The recognition of each resident's rights, responsibilities, needs, and preferences; (2) the freedom of each resident or the resident's legal representative to select or refuse a service and to accept responsibility for the consequences; (3) the development and maintenance of social ties for each resident by providing opportunities for meaningful interaction and involvement within the home and the community; (4) furnishing and decorating each resident's personal space; (5) the recognition of each resident ' s personal space as private and the sharing of a bedroom only when agreed to by the resident; (6) the maintenance of each resident's lifestyle if there are not adverse effects on the rights and safety of other residents; and (7) the resolution of grievances through a specific process that includes a written response to each written grievance within 30 days. This REQUIREMENT is not met as evidenced by:	S5020		

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

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S5020	Continued From page 1 K.A.R 26-42-101 (d) The facility reported a census of 10 residents. Based on observation, interview and record review the operator failed to ensure the resident rights of dignity and privacy for Resident (R) 112, when during the initial survey tour a baby monitor with a picture of the head of the resident's bed sat on the ledge between the facility kitchen and the common dining room observable by all in the area. Findings included: - Observation on 05/04/22 at 09:58 AM during the initial facility tour revealed a "Baby Sense" video monitor, which sat on the ledge between the dining room and the facility kitchen with the monitor facing the dining room and showed the resident's headboard, pillow, and striped comforter of a resident's bed. Interview on 05/04/22 at 12:10 PM with Certified Medication Aide (CMA) C confirmed the video monitoring system was placed in the facility by the resident's family. She stated the monitor was always on and never unplugged. She stated when it was placed she did have a concern about R112's privacy. CMA C confirmed the resident used the toilet on the other side of the room and CMA C did not touch the equipment. Interview on 05/04/22 at 12:10 PM with Certified Nurse Aide (CNA) E confirmed the video monitoring system was always on, even if the residnet was in the room. Interview on 05/04/22 at 02:45 PM with Operator A stated the resident had bad dreams and was incontinent at night. She stated the family placed	S5020		

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S5020	Continued From page 2 the video monitoring system so resident 112 would be heard in the night. She continued to state the monitor was not used during the day and stated it was unplugged, although the video monitoring system remained on/plugged in during daytime ovservations on 05/04/22. Interview 05/04/22 at 11:45 PM with CMA F stated she understood the family placed the monitoring system in the facility. Interview 05/04/22 at 11:45 PM with CNA G stated she would occasionally carry the monitor with her if she attended to other residents, that way if the resident called out she would hear R112 and she could speak to her through the monitor. She continued to state that to her "understanding the monitor is to be always left on". The operator failed to ensure the resident rights of dignity and privacy for Resident (R) 112, when during the initial survey tour a baby monitor with a picture of the head of a resident's bed sat on the ledge between the facility kitchen and the common dining room observable by all in the area, and staff further reported they carried the monitor into other residents rooms.	S5020		
S5026 SS=D	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;	S5026		

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S5026	Continued From page 3 (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-101 (f) (B) The facility reported a censes of 10 residents. The sample included 3 residents (R). Based on observation, interview, and record review the operator failed to ensure R112 was not subjected to neglect on the following days; 03/27/22, 03/28/22, 3/29/22, 03/30/22 and 04/02/22. Review of the video footage provided to the State Agency by R112's family, revealed staff responding to the resident request for toileting assistance. Facility staff asked R112 to soil herself and the facility staff stated to R112 they would return to "change her". Per the resident signed negotiated service agreement staff were instructed to assist R112 to the bedside commode at night. The facility staff neglected R112 on the following dates: 03/27/22, 03/28/22, 03/29/22, 03/30/22 and 04/02/22, by not providing the service as defined in the signed negotiated service agreement of assisting the resident to the bedside commode. Findings Included: Record review for R1 revealed and admission date of 02/15/22 with diagnoses of Alzheimer's disease with late onset, Anxiety, hypertension, diabetes mellitus, chronic atrial fibrillation, acute embolism and thrombosis of deep veins of lower extremity, major depressive disorder, weakness and dementia.	S5026		

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S5026	Continued From page 4 The admission "Functional Capacity Screen" (FCS) dated 2/15/2022 identified the resident with impaired short-term memory and decision making. She required physical assistance with bathing, dressing, toileting and. She lacked the ability to manage her own medications and a fall risk and used a wheelchair assistive device. The combined "Negotiated Service Agreement (NSA)/"Health Service Plan" (HSP) dated 02/15/22 included the following services/directions to be provided to the resident by the facility. Staff would provide physical assistance with bathing, dressing, and toileting. The facility staff were required to have two staff and a gait belt to assist with transfers, and staff were to assist with transfers to the toilet. Observation of the video footage (provided by R112's representative) dated stamped 03/27/22 at 04:32AM revealed the following; facility staff responded to resident and identified the need for the resident to go to the toilet, staff responded "ok ...can you just go in your pants and I will just change you in bed". Observation of the video footage (provided by R112's representative) dated stamped 03/28/22 at 08:48 PM revealed the following: R112 stated "you want me to do it now?", facility staff responded, "go ahead and go, do your thing hon". Observation of the video footage (provided by R112's representative) dated stamped 03/28/22 at 08:49 PM revealed the following: facility staff raised the bed, uncovered the patient, and stated, "check you for a minute and let you do your thing". Observation of the video footage (provided by	S5026		

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S5026	Continued From page 5	S5026		

R112's representative) date stamped 03/28/22 at 08:50 PM revealed a facility staff member instructing the other staff member that the commode goes by the bed at night time, the facility staff member repeats the instructions of the bed side commode at night time and states "I understand".

Observation of the video footage (provided by R112's representative) date stamped 03/29/22 at 06:55 AM revealed 2 facility staff entered the room and announced to R112 "we're gonna change your brief".

Observation of the video footage (provided by R112's representative) date stamped 03/29/22 at 06:56 AM revealed R112 in the bed and facility staff G and an 1 other facility staff at the bedside. Facility staff G stated to R112 while she is lying in bed, "you go and tell me when you're done".

Observation of the video footage (provided by R112's representative) date stamped 03/30/22 at 06:43 AM revealed one facility staff G at the bedside who checked R112 incontinent brief and facility staff G stated, "your dry hon", the staff did not ask R112 if she needed to use the bedside commode.

Observation of the video footage (provided by R112's representative) date stamped 04/2/22 at 06:27 AM revealed facility staff responding to resident request to go the bathroom, facility staff responded "can you go to the bathroom in your brief for me because I am the only one here".

Record review of the "Nursing Progress Notes"/"Progress Notes" between 03/25/22 and 04/08/22 revealed the following entries:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	C 05/05/2022

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S5026	Continued From page 6	S5026		

On 03/25/22 at 09:56 AM urinalysis was obtained on 3/22, cue to resident complaining when she urinates it burns. Per staff R112 has not complained about burning past couple of days. No new orders per primary care physician regarding lab. "Staff educated to provided good peri care and apply barrier creams".

On 3/29/2022 at 10:42AM Late entry: resident ...Urinalysis obtained today, R112 is continuing to complain of burning when she urinates, and urine is cloudy.

On 4/8/2022 at 12:53PM ...Urine analysis results received and noted, with the culture pending.

Record review of the facility provided email dated 04/13/22 at 12:49 PM from R112representative revealed the following concern: family stated that R112 care plan instructs facility staff to be transferred for toileting.

Record review of the facility provided email dated 04/24/22 at 04:57 PM from Regional Nurse H revealed the following: "I want to assure you that we have been working with the staff and the leadership team on the concerns and issues". "I addressed the situation with the transfers for toileting with the leadership team and we have re-educated staff regarding her care plan, and I am following up to ensure that it does not occur again".

Record review of facility staff in-service materials dated 4/13/22 provided by Operator A revealed the following information included in the Inservice training; Inservice sign in sheet for employees dated 04/13/22 with topics of abuse, neglect, exploitation, resident rights and quarterly disaster training. With a separate page with the following

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S5026	Continued From page 7 statement, "We are never allowed to tell a resident "they can go in their brief". Changing someone in bed is one thing, asking them to [urinate in their brief] is never acceptable". Interview on 05/04/22 at 11:28 PM Facility Staff G denied asking residents to go in their brief and further stated she would change them later. Interview on 05/04/22 at 11:28 PM with facility Certified Medication Aide F revealed R112's toileting process required two staff, and staff were instructed to assist the resident to the bedside commode at night, and during the day time hours she uses the private toilet in her room. The operator failed to ensure R112 was not subjected to neglect on the following days; 03/27/22, 03/28/22, 03/29/22, 03/30/22, and 04/02/22. Review of the video footage provided to the State Agency by R112's family, revealed staff responding to the resident request for toileting assistance. Facility staff asked R112 to soil herself and the facility staff stated to R112 they would return to "change her". Per the resident signed negotiated service agreement staff were instructed to assist R112 to the bedside commode at night. The facility staff neglected R112 on the following dates: 03/27/22, 03/28/22, 03/29/22, 03/30/22 and 04/02/22 by not providing the service as defined in the signed negotiated service agreement of assisting the resident to the bedside commode.	S5026		
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		

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	N089033	A. BUILDING: _____ B. WING _____	C 05/05/2022

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S5192	Continued From page 8 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: K.A.R. 26-42-206 (e) The facility reported a census of 10 residents. Based on observation, interview, and record review the operator failed to ensure staff prepared food using safe methods and failed to ensure food was served at the proper temperature having the potential to affect all residents. Findings included: - Observation on 05/04/22 at 10:10 AM during the initial tour of the kitchen revealed a clear zip lock bag with an opened chub of hamburger sitting in a bowel in the kitchen sink. Record review on 05/04/22 at 11:00 AM of the facility food temperature log revealed a page from the Kansas Department of Agriculture Focus on Food Safety. The page showed four ways to thaw food safely.	S5192		

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S5192	Continued From page 9 Interview with on 05/04/22 at 10:10 AM with Operator B confirmed the meat was on the menu for the noon meal and should have been in the refrigerator to thaw. - Record review on 05/04/2022 at 11:00 AM of the facility food temperature log provided by Certified Medication Aide D for the month of April and May 2020, revealed gaps in recording food temperatures prior to serving the residents. The log provided 7 columns for days of the week and 3 sections down the side of the page, one section for each meal. The sections included lines for meats, vegetables, starches and desserts. The log lacked clear and precise information on food temperatures, which meal/foods temperature were checked, and consistency in days/meals checked. The April 2022 log revealed the following: Friday 4/1- The supper sections lacked any entries. Saturday 4/2 -. The supper sections lacked any entries. Sunday 4/3 - The supper sections lacked any entries. Monday 4/4 - The supper sections lacked any entries. Tuesday 4/5 - The supper sections lacked any entries. Wednesday 4/6- The supper sections lacked any entries. Friday 4/8 - No data/columns were blank. Sunday 4/10 - The supper sections lacked any entries. Monday 4/11- The breakfast and lunch section lacked any entries. Tuesday 4/12- No data/columns were blank.	S5192		

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S5192	Continued From page 10 Wednesday 4/13- No data/columns were blank. Thursday 4/14- No data/columns were blank. Saturday 4/16 - No data/columns were blank. The operator failed to ensure staff prepared food using safe methods and failed to ensure food was served at the proper temperature having the potential to affect all residents.	S5192		
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(b)(3) The facility reported a census of 10 residents. Based on observation and interview the operator failed to ensure the laundering and handling of soiled and clean laundry items met professional health care standards.	S5225		

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S5225	Continued From page 11 Findings included: - Observation on 05/04/22 at 09:29 AM revealed Administrative Nurse B unlocked and opened the laundry room. A washer and dryer were provided, but there was not a one-way flow from a soiled area to a clean area. The washer and dryer sat directly opposite each other facing toward the center of the room. There was a large metal trash can between the door and the dryer on the dryer side of the room. A laundry basket of clothing was on the floor next to the dryer and a laundry basket of clothing was on top of the dryer. On 05/04/22 at 09:30 AM Administrative Nurse B stated she did not know if the laundry baskets contained clean or dirty items. She would have to ask an aid. On 05/04/22 at 12:26 PM Certified Medication Aide (CMA) D stated the laundry basket on top of the dryer was clean unclaimed clothes, such as socks. The laundry basket on the floor beside the dryer was a resident's personal clothing that was waiting to be washed in the washer. The operator failed to ensure the laundering and handling of soiled and clean laundry items met professional health care standards.	S5225		
S5313 SS=F	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	S5313		

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S5313	Continued From page 12	S5313		

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 26-41-205 (g)(3)

The facility reported a census of 10 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package and the container, bottle, or tube if it could be removed from the original package of over-the-counter medications.

Findings included:

- 05/04/22 at 09:56 AM revealed Certified Medication Aid (CMA) C opened the locked medication cart where the medications were stored. The cart contained the following over-the-counter medications that were not labeled with a resident's name:

Three boxes of lubricant eye drops.
One bottle of acetaminophen 500 milligrams (mg), 24 gel caps.
One bottle of omeprazole 20 mg, 24 tablets.
One 30 milliliter (ml) bottle of Systane eye drops.

At 10:03 AM Dana Rainey, LPN stated she expected all over-the-counter medications to be labeled with the resident's full name.

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S5313	Continued From page 13 The operator failed to ensure all over-the-counter medications were labeled with the resident's full name.	S5313		
S5335 SS=D	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, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (a) The facility reported a census of 10 residents. Licensed Nurse (LN) B identified 3 of the 10 residents with cognitive impairment and independently mobile. Based on observation and interview the operator failed to ensure the facility was maintained to protect the health and safety of the residents, personnel and the public regarding unlocked chemicals. Findings included: - Observation on 05/04/22 at 09:32 AM during initial tour of the facility revealed an unlocked closet in the bathroom, which had the following chemicals on sitting on the floor; a spray bottle of 409 cleaner, an opened can of Comet cleaner, a container of P and G Proline Micro Kill, and 3 containers of Pro Spray Wipes.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE I	2111 SW RANDOLPH AVENUE TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5335	Continued From page 14 Interview on 5/4/2022 at 9:32 AM with LN B confirmed the closet door with the chemicals in the bathroom should be locked. Observation on 5/4/2022 at 10:10 AM, initial tour of the kitchen revealed the absence of facility staff, both 1/2 doors into the kitchen were standing open, a note tapped to the door frame at eye level stated, "no residents beyond this point". The cabinet doors under the kitchen sink freely opened and revealed the following chemicals; a container of Lysol, a bottle of cascade, 2 disinfectant spray cans of BA167, an unlabeled spray bottle with 900 milliliters of blue liquid, and 3 containers of disinfectant wipes. On the counter next to the sink was an unlabeled spray bottle with an off-white liquid. The counter next to the kitchen door and directly under the kitchen/dining room window type opening sat a container of Perk disinfectant wipes. Interview on 5/5/2022 at 3:15 PM with operator A confirmed the kitchen doors should be closed and the cabinets storing the chemicals should be locked. The operator failed to ensure the facility was maintained to protect the health and safety of 3 cognitively impaired and independently mobile residents, personnel and the public regarding unlocked chemicals.	S5335		