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 _____	01/26/2021

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 are the result of a survey for re-licensure conducted on 1/21/21, 1/25/21 and 1/26/21 at the above named residential care facility in Topeka, KS.	S 000		
S3215 SS=F	26-41-205 (h) Medication Storage (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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 facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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
	N089033	A. BUILDING: _____ B. WING _____	01/26/2021

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
S3215	Continued From page 1	S3215		

This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-205(h)

The facility reported a census of 7 residents. The sample included 3 residents. Based on observation and interview, the licensed nurses and medication aides failed to ensure all medications and biologicals were 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.

Findings included:

- Observation on 1/21/21 at 9:36am in the locked facility medication cart with certified medication aide #C revealed 17 bottles/ boxes of over the counter medications (OTC) that lacked the full name of the resident on the container:

Including:
Wa-itin Loratadine (sinus congestion) 10mg (milligrams) 70 count tablets;
Multivitamin 100 tablets; Nature made melatonin (sleep) 3mg, 120 tablets;
Solaray Valerian (anxiety) 470mg ("staff" written on the bottle)
Kroger Vitamin D3 (supplement) 50mg, 400 soft gels;
Nature's Bounty Elderberry (immune support) gummies 100mg 70 count;
Kroger Vitamin C (supplement) 500mg 150 tablets.
Spring Valley B12 (supplement) 1000mcg

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 _____	01/26/2021

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
S3215	Continued From page 2 (micrograms) 150 tablets. Interview on 1/21/21 at 9:36am with certified medication aide #C confirmed some of the OTC medications are for staff use and some belong to residents. She confirmed the bottles lacked full names for the residents. Observed in the locked medication refrigerator an open bottle of Tubersol TB (tuberculin test) solution. Open date written on package: 10/29 with discard date of 11/29, Lot number C5735AA. Solution open passed discard date of 30 days. Facility policy titled Medication storage, recorded: The community will not supply over the counter medications and medications will be labeled and maintained in accordance with state and federal laws. For all residents of the facility the operator failed to ensure all medications and biologicals were 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.	S3215		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency	S3280		

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 _____	01/26/2021

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
S3280	Continued From page 3 procedures; (3) quarterly review of the facility ' 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 26-4-104(d)(3) The census equaled 7 the sample included 3 residents. For all residents, the operator failed to ensure quarterly review of the facility's emergency management plan (EMP) with employees and residents and failed to conduct an annual evacuation as evidenced by interviews and review of records. Findings included: - On 1/21/21 at 12:30pm reviewed facility documentation of EMP reviews completed with staff and residents. Records revealed the following staff in-services for the facility EMP: January 2019, March 2019, May 2019 and day shift only on 8/2/19. Resident reviews of the facility EMP were conducted on 2/13/19 and 3/6/19.	S3280		

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 _____	01/26/2021

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
S3280	Continued From page 4 Records lacked reviews of the EMP for the 2nd and 3rd quarters of 2019 with all staff, 2nd, 3rd and 4th quarters of 2019 with residents, and lacked all reviews of the EMP with staff and residents for all quarters of 2020 and lacked evacuation drills for 2019 and 2020. Interview on 1/21/21 with administrative staff #D confirmed disaster reviews and evacuations were not performed according to regulations. Email on 1/25/21 from Licensed nurse #B confirmed facility cannot locate any 2020 disaster reviews with staff or residents. For all residents, the operator failed to ensure quarterly review of the facility's emergency management plan (EMP) with employees and residents and failed to conduct an annual evacuation as evidenced by interviews and review of records.	S3280		
S3310 SS=D	26-41-207 (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; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

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 _____	01/26/2021

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
S3310	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, and interview, for sampled resident #121, the operator failed to ensure compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Record review for resident #121 recorded an admission date of 12/16/20 with diagnoses of Insomnia, hypertension, Gastro-esophageal reflux disease, benign prostatic hypertrophy and psychosis. Resident record lacked documentation of a 2 step TB test upon admission and lacked a TB symptom screen. Email on 1/26/21 from licensed nurse #B confirmed resident TB test was not completed. TB guidelines required a 2 step TB test be conducted on new admissions within 7 days of admission.	S3310		

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 _____	01/26/2021

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
S3310	Continued From page 6 For resident #121 the operator failed to ensure compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		