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	175555	A. BUILDING _____ B. WING _____	02/13/2024

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THE HEALTHCARE RESORT OF TOPEKA	6300 SW 6TH AVENUE TOPEKA, KS 66615

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 02/27/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
- On 02/07/24 at 12:05 PM, observation of the West dining room revealed residents sat at the dining room tables and ate lunch. Continued observation revealed Dietary Staff BB asked the surveyor to relocate to a different table in the dining room because the staff needed the "feeders" to sit at that table so staff could assist them with their meals. Dietary Staff BB again stated the other table where the "feeders" normally sat was filled up, so staff needed to use the table.

On 02/13/24 at 09:30 AM, Administrative Nurse D verified staff were to not call residents "feeders," the term was unacceptable. Administrative Nurse D said she would speak with the staff regarding the issue.

The facility's undated "Resident Rights" policy, dated 10/04/23, documented the residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility. Residents have the right to be treated with respect and dignity.

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The facility failed to promote care in a manner that maintained and enhanced dignity and respect, when staff called the residents that required assistance with eating "feeders." This placed the residents at risk for an undignified dining and living experience.

The facility had a census of 70 residents. The sample included 19 residents, with one reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect when staff obtained Resident (R) 41's blood sugar (measures the glucose levels in the blood) and administered insulin (a hormone that lowers the level of glucose in the blood) by the dining room, with five other residents in full view. The facility further failed to address residents with respect and dignity when staff called residents who required meal assistance "feeders." This placed the residents at risk for undignified experiences and impaired psychosocial well-being.

Findings included:

- The Electronic Medical Record (EMR) for R41 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made. or the body cannot respond to the insulin) type 2, dysphagia (dysphagia (swallowing difficulty), hypertension (high blood pressure), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The "Quarterly Minimum Data Set" (MDS), dated

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01/04/24, documented R41 had moderately impaired cognition and was dependent upon staff for dressing, personal hygiene, and transfers. R41 received insulin daily.

R41's "Care Plan," dated 12/29/23, initiated on 02/13/23, directed staff to administer diabetic medication as ordered by the physician and monitor for side effects and effectiveness. The update dated 08/01/23 directed staff to obtain blood sugar checks as ordered; monitor, document, and report to the physician signs and symptoms of hypoglycemia (less than normal amount of sugar in the blood) and hyperglycemia (greater than normal amount of glucose in the blood).

The "Physician's Order," dated 05/11/23, directed staff to obtain a blood glucose check before meals and at bedtime, and if less than 70 milligrams per deciliter (mg/dl), hold the insulin and notify the physician. If the blood glucose was greater than 400 mg/dl, administer ordered insulin and notify the physician for diabetes mellitus.

The "Physician's Order," dated 12/18/23, directed staff to administer Novolog (rapid-acting insulin), four units with meals, and hold for blood glucose less than 120 mg/dl or if not eating.

On 02/12/24 at 12:15 PM, observation revealed R41, sat in her wheelchair by the dining room as Licensed Nurse (LN) G obtained her blood sugar. LN G then administered R41's insulin within view of the five residents present.

On 02/12/24 at 12:15 PM, LN G stated she always checked the resident's blood sugar and administered insulin by the dining room.

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F 550	Continued From page 4 On 02/13/24 at 11:10 PM, Administrative Nurse D stated blood sugar checks and insulin administration should be done in the resident's room unless it was an emergency. The facility's "Dignity and Respect" policy, dated 10/2015, documented it was the policy of the facility that all residents would be treated with kindness, dignity, and respect and treated in a manner that maintained the privacy of their bodies. The facility failed to promote care in a manner to maintain and enhance dignity and respect when staff obtained R41's blood sugar and administered insulin in the dining room, with five other residents in full view. This placed the resident at risk for undignified care and services.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		

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facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents, with two reviewed for choices. Based on observation, record review, and interview, the facility failed to offer Resident (R) 163 a choice of showers instead of sponge baths. This placed R163 at risk for decreased self-determination and impaired psychosocial well-being.

Findings included:

- The Electronic Medical Record (EMR) for R163 documented diagnoses of fracture around the internal prosthetic right knee joint (a break in the bone around the knee implant), need for assistance with personal care, weakness, heart failure, and hypertension (high blood pressure).

The "Admission Medicare 5-Day Minimum Data Set" (MDS), dated 02/06/24, documented R163 had severely impaired cognition and was dependent upon staff for lower body dressing, and substantial to maximum assistance with toileting, upper body dressing, mobility, and bathing. The MDS further documented it was very

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important for R163 to choose between a tub bath, shower, bed bath, or sponge bath.

R163's "Care Plan," dated 01/31/24, documented R163 required assistance with bathing and/or showering and all hygiene.

The facility's "Bathing Record," for January and February 2024, documented R163 received two baths per week, on dayshift Wednesday and Sunday.

On 02/07/24 at 10:23 AM, R163's family member stated R163 preferred showers and did not understand why she had only received sponge baths since her admission.

On 02/12/24 at 10:45 AM R163 stated staff brought in a bucket with water so she could wash herself off and further said she would like to have a shower next time.

On 02/12/24 at 12:56 PM, Licensed Nurse (LN) H stated that R163 required the use of a full mechanical lift and that it was hard to get the lift into the shower room, so staff decided to give R163 sponge baths. LN H further stated R163 no longer used the full lift, but R163 continued to receive sponge baths.

On 02/13/24 at 09:40 AM, Certified Nurse Aide (CNA) M verified she had never offered a shower to R163.

On 02/13/24 at 09:00 AM, Administrative Nurse D stated that R163 should be asked what her preference was with bathing. Administrative Nurse D said the facility had other means to provide showers to residents who required full

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F 561	Continued From page 7 lifts for transfers. The facility's "Bath, Shower" policy, dated 05/23, documented it was the policy of the facility that residents would be able to choose when they wanted to bathe and what style of bathing the resident preferred. The facility failed to offer a choice of bathing to R163. This placed R163 at risk for decreased self-determination and impaired psychosocial well-being.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		

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facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents. Based on record review and interview, the facility failed to provide Resident (R)16 and R12 or their representative, the completed Centers for Medicare and Medicaid (CMS) Skilled Nursing Facility Advanced Beneficiary Notices (ABN) Form 10055. This placed the resident at risk of uninformed decisions and costs about their skilled services.

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Findings included:

- The "Medicare ABN form 10055" informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) "I understand if Medicare does not pay, I will be responsible for payment but can make an appeal to Medicare," (2) "receive therapy listed, but do not bill Medicare, I am responsible for payment for services," (3) "I do not want the listed services."

A review of the ABN provided to R16 revealed the form lacked the estimated cost of continued service and R16 received the wrong form. R16 received the CMS-R-131 instead of CMS Form 10055. The resident's skilled services ended on 12/06/23.

A review of the provided to R12 revealed the form lacked the estimated cost of continued service and R12 received the wrong form. R12 received CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 11/27/23.

On 02/13/24 at 09:30 AM, Social Services X verified she provided R16 and R12, and/or their representative, the CMS-R-131 form and failed to provide the 10055 form. Social Service X verified the form provided to the residents lacked the estimated amount of money it would cost the residents for continued services.

On 02/13/24 at 09:45 AM, Administrative Nurse D verified the facility provided the CMS-R-131 form

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F 582	Continued From page 10 to R16 or R12, and/or their representative, and failed to provide the 10055 with the estimated amount it would cost the resident if they wished to continue services. The facility's "Advance Beneficiary Notices" policy, dated September 2020, recorded the facility would ensure a liability notice to Medicare beneficiaries before the Skilled Nursing Facility provides an item or service that is usually paid by Medicare, but may not be paid for in this instance because it is not medically reasonable and necessary, or custodial care. Failure to provide the ABN may result in the facility being unable to bill the beneficiary directly for the subject services. The ABN of noncoverage is used for beneficiaries in original Medicare when the facility believes that Medicare is not likely to cover the services described in the ABN. The Form CMS 10055 is used to satisfy the SNF Part A, ABN requirement. The facility failed to provide R16 and R12 or their representatives, the correct 10055 form which included an estimated cost of continued services when discharged from skilled care. This placed the residents at risk of uninformed decisions and costs about their services and the continuation of their skilled services.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		

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mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents. Based on record review and interview, the facility staff failed to identify an unwitnessed fall that resulted in serious injury as a potential allegation of neglect or abuse and report immediately to the State Survey Agency (SA), when Resident (R) 172, a cognitively impaired resident, had an unwitnessed fall with injuries. This placed the resident at risk for further injury and unidentified abuse or neglect.

Findings included:

- R172's Electronic Medical Record (EMR)

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documented R 172 had diagnoses of displaced posterior arch fracture of the first cervical vertebra (broken neck), fracture of part of the neck of the left femur (thigh bone) just below the ball of the joint (at the hip), reduced mobility, and weakness,

R172's "Admission Minimum Data Set" (MDS), dated 12/10/23, documented the resident had a Brief Interview of Mental Status (BIMS) of eight which indicated moderate cognitive impairment. The MDS documented R172 required substantial/maximal staff assistance with most activities of daily living (ADLs)

The "Care Area Assessment" (CAA) dated 12/10/23 documented R172 had a reduction in ADLS and needed minimal assistance from one staff and occasionally two staff. The CAA documented R172 had an increased risk for falls but had no reported falls as of that assessment. R172 reported falls before admission while at home.

R172's "Care Plan," revised 12/04/23, documented R172 had a fracture of her left femur and cervical spine (neck). The care plan instructed staff to anticipate and meet R172's needs, make sure her call light was within her reach, and respond promptly when it was activated. The plan directed staff to encourage the use of supportive devices (neck collar) and follow physician orders for weight-bearing status and the therapy treatment plan. The care plan instructed staff to monitor R172 for fatigue and educate her family and caregivers on the safety measures necessary to reduce the risk of falls. The care plan instructed staff to keep R172's routine consistent and try to provide consistent

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caregivers as much as possible to decrease confusion and report to the nurse any changes in R172's cognitive function.

The facility's "Incident Note," dated 12/27/23 at 01:15 PM, documented that staff heard R172 yelling. Upon entering the room staff observed R172 lying on the floor of her bathroom on her left side with the top half of her body on the floor of the shower and her lower body on the floor of the bathroom. Her back was against the wall of the shower. The note documented R172 had a shirt on and had thrown away her pants. R172 did not have her wheelchair or walker in the bathroom. The note documented R172 complained of extreme pain in her bilateral lower legs and rated the pain the highest rating using the cognitively impaired scale. The note documented R172 had swelling of her left lower leg and bruising of her left chest and left ankle. The note documented staff stabilized R172's head and neck.

The facility investigation related to the fall included "Fall Witness Statements" from staff which documented R172 was toileted at 11:00 AM on the day of the fall and then last observed in the Dining room at 12:40 PM. The investigation did not include a resident statement or root cause analysis. The investigation lacked documentation regarding how the facility ruled out abuse and/or neglect.

The "Hospital Note, dated 12/27/23, documented R172 arrived at the hospital after she sustained a fall, apparently unwitnessed, when she was tried to the bathroom. R172 immediately complained of left hip pain and pelvic pain, and R172 was unable to provide a specific history due to her cognition. The note documented that R172 had

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F 609	Continued From page 14 an acute left femoral neck fracture. On 02/12/24 at 01:50 PM, Administrative Staff A verified the facility had not reported R172's unwitnessed fall with injuries to the SA due to the fact he interviewed the three certified nurse aides present at the time of the fall, and no staff were in the room when R172 fell. Administrative Staff A stated R172 was alert and oriented and was able to tell staff what happened. The facility's "Abuse Prevention Policy," revised 06/23, documented that all alleged violations, including injuries of unknown sources and misappropriation of resident property, would be reported immediately to the administrator of the facility and to the officials in accordance with state law through established procedures. The policy documented all alleged violations would be reported to the administrator/designee immediately and thoroughly investigated. all alleged incidents of abuse, mistreatment, or neglect would be reported to the state licensing agency immediately or within 24 hours. once the incident is fully investigated the administrator or designee would notify the person making the report of the conclusions and any corrective actions implemented based on investigative findings. The facility staff failed to report R172's unwitnessed fall with injuries to the SA as required, placing her at risk for further injury and unidentified abuse or neglect.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		

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neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents. Based on record review, and interview, the facility failed to identify an unwitnessed fall that resulted in serious injury as a potential allegation of neglect or abuse and conduct a thorough investigation, when Resident (R) 172, a cognitively impaired resident, had an unwitnessed fall with serious injuries. This placed the resident at risk for further injury and unidentified abuse or neglect.

Findings included:

- R172's Electronic Medical Record (EMR) documented R 172 had diagnoses of displaced posterior arch fracture of the first cervical vertebra (broken neck), fracture of part of the neck of the left femur (thigh bone) just below the ball of the joint (at the hip), reduced mobility, and weakness,

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R172's "Admission Minimum Data Set" (MDS), dated 12/10/23, documented the resident had a Brief Interview of Mental Status (BIMS) of eight which indicated moderate cognitive impairment. The MDS documented R172 required substantial/maximal staff assistance with most activities of daily living (ADLs)

The "Care Area Assessment" (CAA) dated 12/10/23 documented R172 had a reduction in ADLS and needed minimal assistance from one staff and occasionally two staff. The CAA documented R172 had an increased risk for falls but had no reported falls as of that assessment. R172 reported falls before admission while at home.

R172's "Care Plan," revised 12/04/23, documented R172 had a fracture of her left femur and cervical spine (neck). The care plan instructed staff to anticipate and meet R172's needs, make sure her call light was within her reach, and respond promptly when it was activated. The plan directed staff to encourage the use of supportive devices (neck collar) and follow physician orders for weight-bearing status and the therapy treatment plan. The care plan instructed staff to monitor R172 for fatigue and educate her family and caregivers on the safety measures necessary to reduce the risk of falls. The care plan instructed staff to keep R172's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion and report to the nurse any changes in R172's cognitive function.

The facility's "Incident Note," dated 12/27/23 at 01:15 PM, documented that staff heard R172

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yelling. Upon entering the room staff observed R172 lying on the floor of her bathroom on her left side with the top half of her body on the floor of the shower and her lower body on the floor of the bathroom. Her back was against the wall of the shower. The note documented R172 had a shirt on and had thrown away her pants. R172 did not have her wheelchair or walker in the bathroom. The note documented R172 complained of extreme pain in her bilateral lower legs and rated the pain the highest rating using the cognitively impaired scale. The note documented R172 had swelling of her left lower leg and bruising of her left chest and left ankle. The note documented staff stabilized R172's head and neck.

The facility investigation related to the fall included "Fall Witness Statements" from staff which documented R172 was toileted at 11:00 AM on the day of the fall and then last observed in the Dining room at 12:40 PM. The investigation did not include a resident statement or root cause analysis. The investigation lacked documentation regarding how the facility ruled out abuse and/or neglect.

The "Hospital Note, dated 12/27/23, documented R172 arrived at the hospital after she sustained a fall, apparently unwitnessed, when she was tried to the bathroom. R172 immediately complained of left hip pain and pelvic pain, and R172 was unable to provide a specific history due to her cognition. The note documented that R172 had an acute left femoral neck fracture.

On 02/12/24 at 01:50 PM, Administrative Staff A verified the facility had not reported R172's unwitnessed fall with injuries to the SA due to the fact he interviewed the three certified nurse aides

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F 610	Continued From page 18 present at the time of the fall, and no staff were in the room when R172 fell. Administrative Staff A stated R172 was alert and oriented and was able to tell staff what happened. The facility's "Abuse Prevention Policy," revised 06/23, documented all alleged violations, including injuries of unknown sources and misappropriation of resident property would be reported immediately to the administrator of the facility and to the officials in accordance with state law through established procedures. The policy documented all alleged violations would be reported to the administrator/designee immediately and thoroughly investigated. all alleged incidents of abuse, mistreatment, or neglect would be reported to the state licensing agency immediately or within 24 hours. once the incident is fully investigated the administrator or designee would notify the person making the report of the conclusions and any corrective actions implemented based on investigative findings. The facility failed to thoroughly investigate potential abuse or neglect when R172, a cognitively impaired resident, had an unwitnessed fall with serious injuries placing her at risk for further injury and unidentified abuse or mistreatment.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents, with one reviewed for catheters (a tube inserted into the bladder to drain urine into a collection bag). Based on observation, record review, and interview, the facility failed to notify the physician when Resident (R) 10's urine output was less than 360 milliliters (ml) in 12 hours as ordered. This placed the resident at risk for physical decline.

Findings included:

- The Electronic Medical Record (EMR) R10 documented diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 12/20/23, documented R10 had intact cognition and was dependent upon staff for toileting, showers, dressing, transfers, and personal hygiene. The MDS further documented R10 had a catheter.

R10's "Care Plan," dated 11/21/23, initiated on

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09/24/20, directed staff to irrigate (flush) the catheter with acetic acid (vinegar) and sterile water per orders. The update, dated 04/30/21, directed staff to change the suprapubic (surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) catheter as ordered. The update, dated 06/15/21, directed staff to monitor, record, and report to the physician any signs of infections; and check the catheter anchor (secures and stabilizes a catheter to keep it in place). The plan directed to monitor and document intake and output per facility policy. An update, dated 03/26/23, directed staff to monitor R10's urine output and report any concerns to the physician.

The "Physician's Order," dated 03/28/23, directed staff to detach the catheter bag and irrigate R10's catheter every morning with five milliliters (ml) of acetic acid 0.25%, and 60 ml of sterile water. Instill into the catheter and allow to drain freely, reattach the catheter bag, and the procedure was to be done by the nurse. The physician further directed staff to clean around the catheter, apply a drainage sponge, secure it with tape, change it daily, and report any changes to the physician. The order directed staff to document urine output every shift and notify the physician if the urine output was less than 360 ml in 12 hours.

R10's "Treatment Administration Record" (TAR), dated February 2024, documented the following outputs.
02/09/24 dayshift-70 ml
02/09/24 nightshift-70 ml

The EMR lacked evidence the physician was notified of less than 360 ml of urine output that was outside of the ordered parameters.

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F 684	Continued From page 21 On 02/12/24 at 11:30 AM, observation revealed R10 sat in his room watching television. Further observation revealed R10 declined any survey observations of his catheter care. On 02/12/24 at 11:15 AM, Licensed Nurse (LN) G verified the urine output below 360 ml and stated the physician should have been notified as ordered. On 02/13/24 at 09:00 AM, Administrative Nurse D stated the 70 ml urine output was very low for the resident and staff should have contacted the physician. The facility's "Notification, Physician or Responsible Party," policy, dated 09/18, directed staff to promptly notify the resident's physician, and//or responsible party of changes in the resident's condition and/or status. The policy further directed staff to notify the physician when there was a need to alter the resident's treatment significantly and he/she would be notified when deemed necessary or appropriate. The facility failed to notify the physician as ordered when R10's urine was out of the parameters as set by the physician. This placed the resident at risk for physical decline.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		

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instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to date Resident(R)20's insulin (a hormone which allows cells throughout the body to uptake glucose) flex pen when opened and failed to discard R11 and R12 insulin flex pen when outdated. This deficient practice placed the affected resident at risk for ineffective medications.

Findings included:

- On 02/07/24 at 08:40 AM, observation of the facility's West Hall treatment cart revealed the following:
R20's Humulin aspart (rapid-acting insulin) flex

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F 761	Continued From page 23 pen lacked an open date and discard date. R11 Lantus (long-acting insulin) date opened 01/09/24 (expired on 02/05/24, 28 days.) R12 Humalog (fast-acting insulin) date opened 01/10/24 (expired on 02/06/24, 28 days) On 02/07/24 at 08:45 AM, Licensed Nurse (LN) I verified the nurses were to date the insulin pens when opened and discard the expired insulin. On 02/13/24 at 09:30 AM, Administrative Nurse D verified the nurses should label and date the insulin pens with the resident's name and discard expired pens. Medlineplus.gov directs open, unrefrigerated Lantus, insulin lispro (Humalog) and Humulin aspart pens can be used within 28 days; after that time, they must be discarded. The facility lacked a "Storage of Medication" policy, dated 10/2023, documented it is the policy of the facility to store all drugs and biologicals in locked compartments under proper temperature control. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy documented insulin pens are labeled with name and date opened and stored in the cart. The facility failed to label, and date the resident's flex pen, with the date opened and expiration date placing the residents at risk for ineffective medication.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 24 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to measure and record food temperatures for pureed food items at mealtimes, placing the two residents who received a pureed diet at risk for foodborne illness. Findings included: - On 02/08/24 at 11:40 AM, during the preparation of the two pureed diets, observation revealed Dietary Staff (DS) CC prepared the pureed diet food items. DS CC placed the servings of each food item into bowls and then placed the uncovered bowls on the lid of a compartment on the steam table. At 12:20 PM, DS CC served the pureed diets to the residents	F 812		

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without checking the food items' temperatures before serving them.

The "Weekly Steam Table Temperature Logs" lacked documentation staff obtained pureed diet (meat, starch, and vegetables) food temperatures at mealtimes for the following days:
2023
10/01-10/17 - the East and West kitchenette pureed meal temperatures were not taken for all three meals.
10/08-10/14-the East kitchenette pureed meal temperatures were not taken for all three meals. The West Hall kitchenette was not taken one day for breakfast and five days for supper.
10/15-10/21- the East kitchenette pureed meal temperatures were not taken every day for all three meals.
10/22-10/28-the East kitchenette pureed meal temperatures were not taken for all three meals.
10/29-11/04-the East kitchenette pureed meal temperatures were not taken for all three meals.
11/5-11-the East kitchenette pureed meal temperatures were not taken for all three meals.
11/12-11/18- the East kitchenette pureed meal temperatures were not taken for all three meals. The West kitchenette was not taken for supper every day.
11/19-11/25- The East kitchenette pureed meal temperature was not taken for all three meals. The West kitchenette was not taken on one day for lunch and supper.
11/19-25-the East kitchenette pureed meal temperatures were not taken for all three meals. The West kitchenette was not taken for two days for breakfast and lunch and one day for supper.
11/26-12/2- the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette was not taken

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on one day for lunch and supper.
12/3-12/09- the East kitchenette pureed meal temperatures were not taken every day for all three meals. The East kitchenette was not taken one day for breakfast and two days for lunch and supper.
12/10-12/16-the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette was not taken for two days for lunch and every day for supper.
12/17-12/23-the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette temperatures were not taken for one day for lunch and four days for supper.
12/24-12/30- the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette temperatures were not taken six days for supper.
2024
01/01- 01/06- In the East kitchenette the pureed meal temperature was not taken every day for all three meals.
01/07-01/13-the East kitchenette pureed meal temperature was not taken every day for all three meals. The West kitchenette was not taken one day for breakfast, one day for lunch, and every day for supper.
01/14-01/20- the East kitchenette pureed meal temperature was not taken every day for all three meals. The West kitchenette temperatures were not taken two days for breakfast and lunch, and every day for supper.
01/21-01/27-the East kitchenette pureed meal temperature was not taken every day for all three meals. The West kitchenette temperatures were not taken two days for breakfast and lunch and every day for supper.
01/21-01/27- the East kitchenette pureed meal

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	175555	A. BUILDING _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF TOPEKA	6300 SW 6TH AVENUE TOPEKA, KS 66615

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F 812	Continued From page 27	F 812		

temperature was not taken every day for all three meals.
01/28-2/03- the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette meal temperatures were not taken five days for breakfast, six days for lunch and supper.
02/04-02/10-the East kitchenette pureed meal temperatures were not taken every day for all three meals. The West kitchenette pureed meal temperatures were not taken for two days for lunch.

On 02/08/24 at 12:30 PM DS CC verified he had not checked the pureed diet food items before serving to the residents and stated he should have.

On 02/08/24 at 12:45 PM, DS BB verified the lack of pureed food temperatures on the above dates and stated staff should check them before serving them to the residents.

On 02/12/24 at 01:52 PM, Registered Dietician (RD) GG stated staff should measure the pureed food item temperatures before they served them to the residents.

The facility's " Guidelines for Food Temperatures Policy," revised 10/23, documented that food temperatures would be taken and recorded before each meal service. Food would be reheated/cooled to ensure proper serving temperatures before meal service. If there were two meal services, food temperatures would be taken before each meal service.

The facility failed to obtain meal temperatures for pureed food items before meal service. This

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F 812	Continued From page 28 placed the residents who received pureed diets at risk for food-borne illness.	F 812		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the	F 883		

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F 883	Continued From page 29	F 883		

benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 70 residents. The sample included 19 residents with five residents reviewed for immunizations to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interview, the facility failed to follow the latest guidance from the Centers for Disease Control and Prevention (CDC) when they failed to offer, obtain an informed declination, or a physician-documented contraindication for pneumococcal PCV20 vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from the pneumococcal disease.

Findings included:

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F 883	Continued From page 30	F 883		

- Review of Resident (R) 20, R17, R33, R42, and R51's clinical medical records lacked evidence of consent, informed declination, or physician-documented contraindication for the current pneumococcal vaccine PCV20.

On 02/08/24 at 08:42 AM, Administrative Nurse E stated she had offered the flu and Prevnar 13 and 23 vaccines but not the PCV20. Administrative Nurse E stated the facility had not discussed the vaccine with the physician and was told by the pharmacy it was unavailable

On 02/08/24 at 02:24 PM, Administration Staff A stated he discussed the PCV20 with the Medical Director and that the facility would start talking with residents and providing consent forms to families about the new vaccine. Administration Staff A further stated the vaccine would be available within the next two weeks.

The facility's "Prevention of infection, Immunization, Influenza, and Pneumococcal" policy, dated 1/2024, documented the immunizations are to minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumonia by assuring that each resident was informed about the benefits and risks of immunizations, had the opportunity to receive, unless medically contraindicated or refused or already immunized, influenza and pneumococcal vaccine. The policy further documented, that each resident was offered a pneumococcal immunization unless the immunization was medically contraindicated, or the resident had already been immunized. Before vaccination, the resident and/or resident representative would be provided information and education regarding the benefits and potential

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F 883	Continued From page 31 side effects of influenza and/or pneumococcal immunization, the resident and/or resident representative would be allowed to refuse immunizations, if the resident and/or resident representative consented to the vaccine the facility obtained a physician order for the resident. For residents who receive vaccination, the following information will be documented in the resident's electronic health record. if declined document the reason why the resident did not receive the influenza and/or pneumococcal immunization, administration of the influenza and/or pneumococcal vaccination would be made in accordance with current CDC recommendations at the time of vaccination. The facility failed to offer the pneumococcal PCV20 vaccinations per CDC recommendations. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.	F 883		