STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPEKA PRESBYTERIAN MANOR	**4712 SW 6TH AVE , TOPEKA, Kansas, 66606**

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations 4429476 ,3785881, 3751465, 3769055, and 3723034. The census was 58 residents. The sample included 15 residents.	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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: Based on observations and interviews, the facility failed to follow sanitary dietary standards related to food storage and sanitation. Findings included: - During the initial tour on 11/16/2026 at 07:36 AM,	F0812		

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 reverse for further 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.

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

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F0812 SS = F	Continued from page 1 observation revealed the following: A long steam table pan with orange Jello in the walk-in cooler, unlabeled and undated. Two long steam table pans of green Jello were uncovered, unlabeled, and undated. On 11/16/2026 at 12:02 PM, Certified Medication Aide (CMA)R asked R2 if she was going to eat her lunch. CMA R lifted the sandwich, touching the bread on R2's sandwich with her bare hands and stated, "You should eat, you like cheese sandwiches." CMA R did not perform hand hygiene or apply gloves before handling R2's sandwich. On 11/16/2026 at 12:40 PM, the kitchenette had a trash can overflowing with trash. The lid for the trash would not go down; the trash container was next to the steam table. On 11/17/2026 at 11:30 AM, Dietary Staff laid all the ladles and scoops for serving the food for lunch on top of the food transport cart. The food transport cart did not have a clean barrier. On 11/18/2026 at 10:25 AM, Dietary Staff BB stated the steam table pans of Jello should be covered and dated. He stated the trash in the kitchenette would be taken care of, and staff would find something for the serving utensils to ensure they were not placed on the hot food carts. On 11/18/2026 at 11:57 AM, Administrative Nurse D stated no staff should ever touch a resident's food without gloves. The facility's "Food Storage Sanitation and Infection Control" dated 02/2026 documented food was stored immediately after receipt and maintained in a manner that prevents damage, spoilage, infestation, and bacterial contamination. All products were labeled and dated with the receiving date. Move old supplies to the front of the shelf to ensure rotation of products and place new supplies to the rear of the shelf. Once opened, products are covered to prevent contamination and dated with an open date.	F0812		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide	F0880		

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F0880 SS = F	Continued from page 2 a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880		

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F0880 SS = F	Continued from page 3 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to provide adequate infection control practices when staff failed to ensure respiratory equipment was stored in a sanitary manner for Residents (R)2, R42, R59, R51, and R32. The facility also failed to ensure the ice scoops on “Cedar View”, “Sunflower” and “Cotton Wood” were stored in a container. The facility further failed to perform hand hygiene after each medication pass and failed to ensure clean laundry was transported in a sanitary manner. Findings Included: - On 11/16/2026 at 08:18 AM, during the facility walk through. R2’s nasal oxygen cannula laid across her chair; R2’s oxygen canula was not in a container. R48’s nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask laid the wall next to her reclining chair; the mask was not in a container. R32’s clear and green oxygen nasal cannulas laid on the floor beside R32’s oxygen concentrator; the nasal cannulas were not in a container. On “Cedar View” hall, the ice scoop laid on a towel beside the ice chest on a black cart; the ice scoop was not in a container or covered. On “Sunflower” hall, the ice scoop laid on a towel beside the ice chest; the ice scoop was not in a	F0880		

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F0880 SS = F	Continued from page 4 container or covered. On “Cotton Wood” hall, a small ice scoop laid directly on a black cart, a larger ice scoop was placed in a container. The small ice scoop was not in a container or covered. On 11/17/2026 at 08:21 AM, Certified Medication Aide (CMA) R administered medications to R5. CMA R donned gloves without performing hand hygiene CMA R administered R58’s eye drops. CMA R Removed the gloves and did not perform hand hygiene after doing so. On 11/17/2026 at 11:42 AM, laundry staff pushed an uncovered cart with clean clothes down the Sunflower hallway. On 11/18/2026 at 08:07 AM, R51’s continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) laid directly on the floor was not in a container between his recliner and bedside table. On 11/18/ 2026 at 11:25 AM, Certified Medication Aide (CMA) S stated ice scoops should be stored in a container with a cover. She stated respiratory equipment should be stored in a bag or container with a cover. CMA S stated hand hygiene should be performed between each resident, between medication administration, and glove changes. On 11/17/2026 at 11:40 AM, Licensed Nurse (LN) G stated ice scoops should be kept in a covered container not on a towel. She stated hand hygiene should be performed between each resident when administrating medication and glove changes. LN G stated respiratory equipment should be stored either in a bag or container. She stated it was the charge nurse’s responsibility to ensure was stored correctly. On 11/18/2026 at 11:52 AM, Administrative Nurse D stated she expected hand hygiene to be performed between resident cares, glove changes, and medication administration. She stated she expected all respiratory equipment to be bagged or stored in a container. She stated it was everyone’s responsibility to ensure items are stored correctly. Administrative Nurse D stated clean laundry should be covered during transportation. The facility’s “Infection Control” policy dated 10/06/2025 documented the community would facilitate safe care of all residents and staff with	F0880		

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F0880 SS = F	Continued from page 5 known or suspected communicable disease by establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This policy applies to all staff members from all departments of this community, residents residing in the community, visitors of community, volunteers of community, contracted and vendors of community. The Infection Prevention and Control Program would follow accepted national standards and was based on community assessment and includes prevention, identification, reporting, investigation, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. The Infection Control Program includes identifying, investigation, controlling, reporting, and preventing infections and communicable diseases in the community including appropriate immunizations; appropriate reporting of infectious incidents; standard and transmission-based precautions to prevent spread of infections; development of procedures such as isolation to be applied to an individual resident; circumstances to prohibit employees with communicable disease or other infectious state from direct contact with residents or food; hand hygiene for staff involved in direct resident contact; and maintaining a record of incidents and corrective actions related to infections.	F0880		
F0761 SS = E	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 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	F0761		

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F0761 SS = E	Continued from page 6 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: Based on observation, record review, and interview, the facility failed to ensure medication carts remained locked while unattended. The facility failed to ensure staff securely stored insulin (a hormone that lowers the level of glucose in the blood) pens safely. Findings included: - On 11/16/2026 at 07:34 AM, upon entry to the facility and walking passed an unattended and unlocked medication cart near the Prairie Point dining room area. The top of the medication cart contained an unidentified residents dated insulin pen. On 11/16/2026 at 07:51 AM, a medication cart was near the Prairie Point dining room and was unlocked, and there were no staff nearby. A few minutes later Licensed Nurse (LN) H walked up to the medication cart and stated, “Is there something you need?” When asked if the cart should be left unlocked and unattended, LN H responded “No”. On 11/16/2026 at 03:45 PM, the treatment cart near the Prairie Point nurse’s station was unlocked, and there were no staff nearby. On 11/16/2026 at 07:36 AM, LN H stated she thought as long as the insulin pens were in the individual resident container it was ok for them to be on top of the medication cart. LN H further stated she was not far from her medication cart as she was just in the dining room. On 11/18/2026 at 11:57 AM, Administrative Nurse D stated that the medication carts should never be unlocked and left unattended. Administrative Nurse D stated that at no time should an insulin pen be left unattended on top of the medication cart. The facility’s “Medication Storage” policy dated 02/02/2025 documented Medications and biologicals are stored safely, securely, and properly following	F0761		

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F0761 SS = E	Continued from page 7 manufacturers' recommendations or those of the supplier. Medications are accessible only to licensed nursing, pharmacy personnel, or staff members lawfully authorized to administer medications. Only licensed nurses, consultant pharmacists, and those lawfully authorized to administer medications (such as medication aids) are allowed access to medications. Medication rooms, carts and supplies are locked or attended only by people with authorized access.	F0761		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review, the facility failed to ensure reasonable accommodations were provided for Resident (R) 23 and R50 when staff propelled the residents in their wheelchairs without providing foot pedals. Findings included: - On 11/17/2026 at 7:50 AM, Certified Nurse Aide (CNA)N pushed R23 without foot pedals to the dining room for breakfast. CNA N asked R23 to hold her feet up and asked her not to drag her feet. On 11/17/2026 at 07:55, CNA M pushed R50 without foot pedals into the dining room area with her feet only one to two inches off the floor. On 11/18/ 2026 at 11:25 AM, Certified Medication Aide (CMA) S stated staff should always have wheelchair pedals on when transporting a resident. On 11/17/2026 at 11:40 AM, Licensed Nurse (LN) G stated there should always have pedals on the resident's wheelchairs when staff pushed them in the hallways. On 11/18/2026 at 11:52 AM, Administrative Nurse D stated she expected the staff to put pedals on the resident's wheelchair when staff pushed them to the dining room.The facility's "Lifting and Transferring Residents" policy dated 02/03/2025 documented the facility would provide a safe work environment for	F0558		

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F0558 SS = D	Continued from page 8 resident care areas by providing and requiring the use of safety materials, equipment, and training designed to prevent injury.	F0558		
F0684 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 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: Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 8 received care and treatment in accordance with professional standards of practice when staff failed to notify the physician of R8's two pound weight gain in a 24 hour period. Findings Included: - R8's EMR from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hypertension (HTN-elevated blood pressure). The "Quarterly Minimum Data Set" (MDS) dated 09/23/2026 recorded a Brief Interview for Mental Status (BIMS) five which indicated severely impaired cognition. The MDS documented R8 received diuretics (a medication to promote the formation and excretion of urine) during the observation period. R8's " Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 06/28/2026 documented R8 was occasional continent of bowel and bladder, R8 received cardiovascular (pertaining to the heart and blood vessels), and diuretic medications daily. R8's speech was clear and she was able to make her needs known and understand. R8 ambulated with a walker with the assist of one	F0684		

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F0684 SS = D	Continued from page 9 staff and required limited assistance with toileting. R8 had poor memory and decision making R8's "Care Plan" documented the following: 01/22/2026-R8 had fluid overload or a potential fluid volume overload related to her disease process of volume overload. Nursing was to administer medication as ordered by physicians. Staff were to obtain vital signs as ordered by physician and record them. Nursing was to report to physicians any significant abnormalities or changes. Staff were to weigh at the same time every day and record weight. R8 was weighed daily in the morning. Nursing was to notify physicians of sudden changes of two pounds in 24 hours or five pounds in one week. R8's EMR under the "Orders" tab revealed the following physician orders: Daily weight, call cardiology if patient gains more than two pounds in 24 hours or more than five pounds in one week, weigh in the mornings, dated 01/21/2026. Furosemide (diuretic medication) 20 milligrams (mg) give one tablet by mouth one time a day related to CHF date 08/13/2026. R8's EMR under "Weights and Vitals" documented a weight: 08/25/2026-121.2 pounds (lbs.) 08/26/2026-123.2 lbs. 09/12/2026-116 lbs. 09/13/2026-120 lbs. 09/24/2026-117.4 lbs. 09/25/2026-123. Lbs. R8's EMR lacked documentation that the physician was notified of the two pounds gain in 24 hours on 08/26/2026 and 09/25/2026. On 11/16/2026 at 09:10 AM, R8 sat in her chair in her room. R8 waited for staff to take her to breakfast. On 11/18/2026 at 11:25 AM, Certified Medication Aide (CMA) S stated weights were delegated to the	F0684		

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F0684 SS = D	Continued from page 10 Certified Nurse's Aides (CNA). She stated after weights were obtained, they were given to the nurse to chart in the medical record. CMA S stated it would be the nurse's duty to check weights and call the physician if applicable. On 11/18/2026 at 11:42 AM, Licensed Nurse (LN) G stated weights were delegated to the CNA. She stated the CNA report to the nurse, and the nurse would call the physician if needed. LN G stated if the nurse had called the physician there should be a note in the resident's progress notes, either an order or no concern. On 11/18/2026 at 11:57 AM, Administrative Nurse D stated that weights could be delegated to the CNA and then reported to the nurse in charge of the hall. She stated the nurse would call the physician if the weights were out of parameters. Administrative Nurse D stated the nurse should document in the progress note that the physician was notified. She stated she would expect the nurse to notify the physician if there was a physician order to do so. The facility's "Weight Nutritional Status" dated 10/31/2021 documented based on a resident's comprehensive assessment, the manor would ensure that the resident maintains usual body weight or desirable body weight range and electrolyte balance unless the resident's clinical condition demonstrates this is not possible.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview the facility failed to ensure care planned interventions were in place for Resident (R) 31 who had a history of falls. Findings included: - R31's Electronic Medical Record (EMR) from the	F0689		

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F0689 SS = D	Continued from page 11 "Diagnoses" tab documented diagnoses of. dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following 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) affecting the right dominant side. R31's "Quarterly Minimum Data Set" (MDS) dated 09/10/2026 documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R31 had an impairment on one side of his upper body and was dependent on staff for toileting. R31's MDS documented R31 had falls since admission or re-entry. The MDS documented R31 had one fall without injury in the observation period. R31's "Fall Care Area Assessment (CAA)" dated 12/23/2025 documentedR31 was at risk for falls. R31 had a history of falls, R31 had no falls since the last review. The CAA documented R31 required extensive assistance with his activities of daily living (ADLs), transfer, and mobility. R31's "Care Plan" documented the following fall interventions: 03/20/2026-R31 was at risk for falls. 02/09/2026-Staff were to place a sign on R31's TV to remind him to use his "Reacher" to get things off the floor. 07/29/2026-Staff were to ensure all R31's items were with his reach at his bedside, and while he was up in his wheelchair to prevent falling while he was reaching. On 11/16/2026 at 08:55 AM, R31's TV lacked a sign for R31 to use his "Reacher." On 11/17/2026 at 12:10 PM, R31's TV lacked a sign stating R31 to use his "Reacher". On 11/17/2026 at 02:12 PM, R31 sat in his wheelchair next to the dining room bent over in his wheelchair, grabbing on to the wall to move his	F0689		

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F0689 SS = D	Continued from page 12 wheelchair closer to the dining room. On 11/18/2026 at 11:25 AM, Certified Medication Aide (CMA)S stated the Quality Assurance staff would place the sign in the R31's room. She stated the Certified Nurse's Aides (CNAs) had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA S stated there were a lot of agency staff, and they would need to read the Kardex for the residents they were caring for to see that R31 was to have a sign in his room, for his "Reacher". On 11/18/2026 at 11:42 AM, Licensed Nurse (LN) G stated the Quality Assurance staff would place the sign in the resident's room. She stated it was then the nurses and the CNAs responsibility to ensure the sign was still in place. On 11/18/2026 at 11:57 AM, Administrative Nurse D stated it was the Quality Assurance staff's responsibility to ensure the sign was placed in R31's room. She stated there were times that the residents had removed the sign, or the residents' family. She stated the nurses have access to the care plan and CNAs have access to the Kardex. She stated the staff should have hung the sign back up or let someone know that the sign was no longer in R31's room.	F0689		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate,	F0756		

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F0756 SS = D	Continued from page 13 written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities related to Resident(R) 45's hypertensive medication (class of medication used to treat high blood pressure) and R3's insulin (a hormone that lowers the level of glucose in the blood). Findings included: - 1. R45's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN-elevated blood pressure) and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Quarterly Minimum Data Set (MDS)" dated 10/05/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. R45's "Psychotropic Drug Use Care Area Assessment (CAA)", dated 01/16/2026, documented she had no adverse reaction or side effects from medications given.	F0756		

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F0756 SS = D	Continued from page 14 R45's "Care Plan," documented the following interventions: 09/20/2026 – Staff would administer medications as ordered and monitor for side effects. R45's EMR under the "Orders" tab revealed the following physician orders: Amlodipine besylate (a class of medication used to treat high blood pressure) oral tablet five milligrams (mg); give one tablet by mouth daily for HTN. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters of mercury (mmHg) dated 07/27/2026. Lisinopril (medications used to treat high blood pressure) oral tablet 30mg, give 30 mg by mouth daily for HTN. Hold for SBP <100 mmHg dated 07/27/2026. Review of the EMR under the "Reports" tab for "Medication Administration Record" (MAR) reviewed from 09/01/2026 to 11/18/2026 (79 days) lacked evidence of blood pressure monitoring prior to administration of amlodipine and lisinopril. The CP's "Monthly Medication Review" (MMR), reviewed from October 2025 through October 2026 revealed the CP did not identify and report the lack of blood pressure monitoring for R45's physician ordered parameters for her antihypertensive medications. On 11/17/2026 at 07:51 AM, R45 walked with a walker from her room to the dining room. R45's hair was neatly combed. R45 sat down in a chair and pushed herself up to the table. On 11/17/2026 at 11:40 AM, Licensed Nurse (LN) G stated she did not review the facility's MMR. On 11/18/2026 at 11:52 AM, Administrative Nurse D stated she expected the CP to identify and report any irregularities related to each resident's medication. She stated the facility was in the process of changing pharmacies.	F0756		

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F0756 SS = D	Continued from page 15 - 2. R3's Electronic Medical Record (EMR) documented diagnoses of type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R3's "Significant Change Minimum Data Set" (MDS) dated 03/17/2026 documented she had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R3 had impairment on one side of her upper extremity and was needed partial to maximal assistance from staff for her activities of daily living (ADL). R3 received insulin injection. R3's "Functional Abilities Care Area Assessment" (CAA) dated 03/20/2026 documented she had a recent hospital stay and was working with skilled therapy. Her speech was clear and had difficulty finding words or finishing thoughts. She had a history of diabetes. R3's Care Plan revised on 04/21/2026 directed staff to give DM medications as ordered by the physician, monitor and document for side effects and effectiveness. R3's "Orders" tab of the EMR documented a physician's order dated 10/02/2026 for Lantus glargine (a long-acting insulin) subcutaneous injector pen to inject 22 units twice daily. Hold if blood glucose (BG) is less than 140 milligrams per deciliter (mg/dl). This order was discontinued on 10/12/2026 R3's "Orders" tab of the EMR documented a physician's order dated 10/12/2026 for Lantus glargine pen injector 100units/milliliter (ml) Inject 15 units subcutaneously two times a day related to Type 2 DM. Hold for BG less than 140 mg/dl. R3's "Orders" tab of the EMR documented a physician's order dated 10/12/2026 for insulin Aspart (rapid-acting) pen-injector 100unit/ml. Inject 10 units before meals for Type 2 DM. Hold if not eating or BG is less than 100. Review of R3's October 2026 "Medication Administration Record" (MAR) and Treatment Administration Record" (TAR) reports it was noted that her Lantus glargine was given when her BG level was below 140 on four of 19 opportunities. With one administration resulting in a medication error on 10/06/2026. Review of CP Monthly Regimen Review (MRR) for	F0756		

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F0756 SS = D	Continued from page 16 October 2026 revealed that the CP report lacked identification and reporting of R3 being administered insulin outside of physician ordered hold parameters. On 10/17/2026 at 08:12 AM, R3 sat in her wheelchair at the dining table. On 11/17/2026 at 11:40 AM, Licensed Nurse (LN) G stated she did not review the facility's MMR. On 11/18/2026 at 11:52 AM, Administrative Nurse D stated she expected the CP to identify and report any irregularities related to each resident's medication. She stated the facility was in the process of changing pharmacies. The facility's "Drug Regimen Review" policy dated 08/2024 documented a resident's medication regimen would be reviewed monthly and as needed by a licensed pharmacist. Drug Regimen Review (DRR) was completed at admission by clinical staff. DRR was a thorough evaluation of resident medications in order to improve outcomes and minimize adverse outcomes or risks.	F0756		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0757		

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F0757 SS = D	Continued from page 17 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to monitor blood pressure (BP) per physician parameters for Resident(R) 45's hypertensive medication (class of medication used to treat high blood pressure). Findings included: - R45's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (HTN-elevated blood pressure) and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The "Quarterly Minimum Data Set (MDS)" dated 10/05/2026 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. R45's "Psychotropic Drug Use Care Area Assessment (CAA)", dated 01/16/2026 documented she had no adverse reaction or side effects from medications given. R45's "Care Plan," documented the following interventions: 09/20/2026 – Staff would administer medications as ordered and monitor for side effects. R45's EMR under the "Orders" tab revealed the following physician orders: Amlodipine besylate (a class of medication used to treat high blood pressure) oral tablet five milligrams (mg); give one tablet by mouth daily for HTN. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters of mercury (mmHg) dated 07/27/2026. Lisinopril (class of medications used to treat high blood pressure) oral tablet 30mg, give 30 mg by	F0757		

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F0757 SS = D	Continued from page 18 mouth daily for HTN. Hold for SBP <100 mmHg dated 07/27/2026. Review of the EMR under the “Reports” tab for “Medication Administration Record” (MAR) tab reviewed from 09/01/2026 to 11/18/2026 (79 days) lacked evidence of blood pressure monitoring prior to administration of amlodipine and lisinopril. On 11/17/2026 at 07:51 AM, R45 walked with a walker from her room to the dining room. R45’s hair was neatly combed. R45 sat down in a chair and pushed herself up to the table. On 11/18/ 2026 at 11:25 AM, Certified Medication Aide (CMA) S stated she would notify the charge nurse of any vital sign or blood sugar was outside the physician ordered parameters or outside the normal range. On 11/17/2026 at 11:40 AM, Licensed Nurse (LN) G stated medications should be administered as ordered. She stated blood pressure should be obtained with every administration when a parameter was ordered by the physician. On 11/18/2026 at 11:52 AM, Administrative Nurse D stated she expected the blood pressure monitoring would be included the physician ordered parameters on the MAR. She stated the BP to be monitored every time the medication was administered. The facility was unable to provide a policy as requested on 11/18/2026 for unnecessary medications.	F0757		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure nursing staff followed physician ordered parameters for insulin (a hormone	F0760		

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F0760 SS = D	Continued from page 19 that lowers the level of glucose in the blood) administration, which resulted in Resident (R) 3 receiving insulin when it should have been held, resulting in a significant medication error. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R3's "Significant Change Minimum Data Set" (MDS) dated 03/17/2026 documented she had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R3 had impairment on one side of her upper extremity and was needed partial to maximal assistance from staff for her activities of daily living (ADL). R3 received insulin injection. R3's "Functional Abilities Care Area Assessment" (CAA) dated 03/20/2026 documented she had a recent hospital stay and was working with skilled therapy. Her speech was clear and had difficulty finding words or finishing thoughts. She had a history of diabetes. R3's Care Plan, revised on 04/21/2026, directed staff to give DM medications as ordered by the physician, monitor and document for side effects and effectiveness. R3's "Orders" tab of the EMR documented a physician's order dated 10/02/2026 for Lantus glargine (a long-acting insulin) subcutaneous injector pen to inject 22 units twice daily. Hold if blood sugar is less than 140 milligrams per deciliter (mg/dl). This order was discontinued on 10/12/2026 R3's "Orders" tab of the EMR documented a completed physician's order dated 10/06/2026 to check blood sugars at 01:00 AM, 03:00 AM, and 05:00 AM and call if blood sugar was low. R3's October 2026 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) documented for the bedtime administration of Lantus glargine 22 units in the AM and at bedtime (HS) was given on 10/05/2026 at HS for a blood sugar of 115 mg/dl; on 10/06/2026 AM for a blood sugar of 108mg/dl; and 10/06/2026 for a blood sugar of 69mg/dl. The administration on 10/06/2026 at HS resulted in a significant medication error by nursing staff.	F0760		

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F0760 SS = D	Continued from page 20 Review of R3's November 202 MAR/TAR it was noted that her insulin Aspart was given on two occasions when her BG was below 100 (11/08/2026 at 05:00 PM and 11/12/2026 at 05:00 PM). R3's "Nursing Progress Note" dated 10/07/2026 at 01:48 AM in the EMR from Licensed Nurse (LN) I documented the residents HS blood sugar taken with result of 69 mg/dl at 10:22 PM. Glucerna was given after pulling the resident up in bed to help with raising head of bed (HOB) up, then she was given her scheduled Lantus 22 units. As the Nurse was preparing to give the night shift nurse report the Nurse noticed the extended order (when clicking on the "more") read to hold Lantus if blood sugar was less than 140 mg/dl. Before the Nurse had a chance to recheck the blood sugar after giving a few minutes for Glucerna to absorb, a phone call was received from daughter-in-law requesting to know what residents blood sugar was. The nurse let the daughter in-law know it was 69 mg/dl. The daughter-in-law became upset and somewhat rude with the nurse on the phone demanding that the resident be given a snack from baskets in her room, and was upset that she was given the Glucerna. The nurse explained that Glucerna had 10 grams of protein to help carry her blood sugar through the night. The daughter -in-law also voiced being upset that the Lantus was given. It was explained to the daughter-in-law that the doctor would be called to report the incident and ask for further orders. The Nurse went back to resident's room at 10:53 PM and rechecked blood sugar with result of 77mg/dl after only drinking half of the Glucerna. The resident did drink the rest of the Glucerna while the Nurse was in the room. The resident then was given a snack out of snack basket. The nurse let the resident know she would be back in a few minutes to recheck her blood sugar again. Before the nurse had a chance to make call to the on-call provider service, the daughter in law had arrived at the facility and was at desk asking what the last blood sugar check was and provided the 77mg/dl reading info. A phone call placed to the on-call provider service at 10:56 PM. The nurse requested a call back from the provider on call. The nurse spoke with the provider at 11:17 PM, and the situation was explained, and asked if she had any new orders. A phone order from the provider was received to check the blood sugar every two hours throughout the night. The daughter-in-law was notified of new order. The resident's blood sugar was checked again at 11:37 PM with 107mg/dl result. The order was put in for the blood sugar to be checked at 01:00 AM, 03:00 AM, and 05:00. The	F0760		

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F0760 SS = D	Continued from page 21 daughter-in-law asked to be called after each blood sugar was taken throughout the night. This nurse explained that information would be passed on to the night nurse. The daughter-in-law stated she would be having a talk with the Administrator in the morning. The order to hold Lantus if blood sugar was below 140 mg/dl was new as of 10/02/2026 after having an appointment with the endocrinologist. A separate order (in BOLD) was put on the MAR to hold the Lantus if blood sugar was less than 140 mg/dl, so it stood out more for other Nurses. A “Health Status Note” in the EMR for R3 dated 10/07/2026 at 02:35 AM documented the resident blood glucose reading at 01:00 AM was 83 mg/dl. The resident was given a snack of orange juice, peanut butter, and pudding. The resident’s blood sugar was checked again in 30 minutes and was 111 mg/dl. Family was notified. R3’s October 2026 MAR/TAR documented her blood sugar reading at 03:00 AM on 10/07/2026 was 167 mg/dl; the 10/07/2026 at 05:00 AM blood sugar reading was 160mg/dl. On 10/17/2026 at 08:12 AM, R3 sat in her wheelchair at the dining table. On 11/17/2026 at 10:23 AM, Administrative Nurse D stated after she was notified of the incident on 10/06/2026 by LN I, she re-educated, wrote up the staff member, and a medication error report was completed. Administrative Nurse D stated R3 was seen the next morning by the facility physician. Administrative Nurse D stated that nurse was no longer employed at the facility. Administrative Nurse D stated she had a stand-up meeting with nurses to re-educate them to read the full orders for hold parameters. The facility’s “Medication Errors” policy reviewed on 02/03/2025 documented “Significant medication error” means one that causes the resident discomfort or jeopardizes his/her health and safety. Medication errors result because of failure to follow manufacturer’s specifications or accepted professional standards. Medication errors shall be immediately reported to the PCP and director of nursing or designee. Medication errors shall be documented on an Incident Tracking Report. Notify the resident’s responsible party. Medication errors should be tracked for quality assurance purposes on the Incident Log.	F0760		