STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175165	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Health Center	2400 SW Urish Road Topeka, KS 66614

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 27's care plan was revised with new interventions after having falls. This placed R27 at risk for delayed care and possible injuries.Findings included:- R27's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance (a range of problematic or disruptive behaviors that deviate from what is considered typical or expected for a given age, situation, or individual), and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).R27's Significant Change Minimum Data Set (MDS) dated 08/28/24 documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R27 required the use of a wheelchair to assist with mobility. R27 required substantial to being dependent on staff for assistance with her activities of daily living (ADL).R27's Falls Care Area Assessment (CAA) dated 09/03/24 documented R27 was at risk for falls related to the medications she received, poor cognition, incontinence, and her need for assistance with transfers and bed mobility. R27 also had poor trunk strength and required a high back wheelchair. R27 had not had any falls since the prior assessment.R27's Care Plan last revised on 06/04/25 directed staff that she required one-on-one extensive assistance for transfers. The Care Plan directed staff that R27 needed staff to reposition her when her bottom got close to the front of the wheelchair cushion or if I am leaning back in my chair for fall prevention. The Care Plan directed staff that R27 did not have wheelchair pedals on her wheelchair because she self-propelled her wheelchair. R27's Care Plan lacked new fall interventions post fall on 03/14/25 and 07/18/25.R27's Quarterly Assessment dated 03/16/25 documented R27 was at risk for falls. R27's Quarterly Assessment dated 06/09/25 documented she was at risk for falls related to her impaired mobility, incontinence, the medications she received, and her impaired cognition. Review of R27's Un-witnessed Fall or Fall with Head Injury #1644 report dated 03/14/25 documented R27 had an unwitnessed fall near the nurse's station around 02:50 PM. R27 was heard yelling for help. Staff immediately responded. R27 had been wheeling herself around the nursing station before the incident. R27 was observed to be on the floor at the head of Hall 1, in front of her wheelchair, with her buttocks on a leg rest and the underside of her right arm on the other leg rest. R27 has severe dementia and was unable to communicate what happened. Review of the facility video revealed that she removed her shoe and then leaned forward to replace the shoe without locking her wheelchair brakes. The wheelchair moved backwards while she leaned forward, causing her to fall. R27 was noted to have bruising to her right hand post-fall. R27 was oriented to person only but was confused with impaired gait balance and impaired memory. No new intervention was put in place post-fall.R27's Witnessed Fall (no head injury) #1685 report dated 07/18/25 documented the resident was found lying on the floor, in a fetal position, in the main dining room. R27 stated she was just lying on the floor and did not fall. On 07/22/25 after investigation and review of video, it was noted that the resident had a fall in the dining room. R27 was seen in her wheelchair, then she stood up, using the table as a support. R27 turned slightly to see where to sit, and while attempting to sit down, R27 missed the wheelchair and fell to the floor. No new fall intervention was put in place post-fall.On 07/27/25 at 10:15 AM, R27 sat in her wheelchair, telling staff that she was not going to go back to her room and to leave her alone. R27's wheelchair was noted to have Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in the seat and no foot pedals on the wheelchair.On 07/29/25 at 11:32 AM, Licensed Nurse (LN) G stated that after a resident had a fall an assessment was completed, and then an investigation was done. LN G stated that management staff worked together after the fall to implement a new intervention to avoid further falls. On 07/29/25 at 11:42 AM, Administrative Nurse D stated that after each fall, the staff would complete an assessment of the resident and then complete witness statements. The management team would then review the fall information and implement a new intervention to avoid future falls. The care plan should be revised with the new intervention upon completion of the fall investigation. The facility's Care Plan policy dated 03/21/24 documented the care plan should be designed to address the resident's preferences and needs to enable discharge. The care plan should be updated on an ongoing basis as the resident achieved goals and progressed towards discharge.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to provide direct, interactive activities based on resident preferences on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings included:- A review of the facility's Activity Calendars for May 2024, June 2025, and July 2025 was completed. The activities calendar for each month noted the same scheduled activities for Saturdays and Sundays. The calendar noted movies, games, social hour, puzzles, and a [NAME] game. On 07/28/25 at 11:00 AM, the facility's Resident Council reported weekend activities were often non-existent. The council stated that the activities coordinator sometimes came in and completed activities, but not every weekend. The council reported that the facility's nursing care staff did not complete the scheduled activities when the activity coordinator was not in the facility on the weekend. The council reported staff would put on movies and television shows, but did not complete staff-led activities. The council reported that the residents were often bored on weekends. On 07/29/25 at 11:30 AM, Certified Nurse Aide (CNA) M stated that scheduled weekend activities often did not get completed on weekends. She stated the activities staff were not in the facility on weekends, and staff often were too busy completing resident care. She stated the facility did provide puzzles and games for the residents to complete on their own. On 07/29/25 at 11:55 AM, Licensed Nurse (LN) G stated that weekend activities were not completed. She stated staff would try to provide movies and television for the residents, but direct care staff were not available to provide staff-led activities due to the resident care needs in the building. On 07/29/25 at 12:05 PM, Activities Staff Z stated she worked Monday through Friday but would sometimes come in on weekends to provide weekend activities. She stated that direct care staff were expected to complete the activities on the day she could not come to the facility. She stated the facility also provided coloring pages, puzzles, and games for the residents to complete individually when staff were not available to provide group activities. The facility's Activities Programming policy, revised 04/2018, indicated the facility would provide activities that meet the residents' needs and interests to support their physical, mental, and psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 44 residents. The sample included 12 residents, with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 2's pressure-reducing interventions were implemented correctly when R2's low air-loss mattress (a specialized adjustable air mattress that reduces pressure applied to the body) was not set within her current weight range. This deficient practice placed R2 at risk for complications related to skin breakdown and pressure ulcers.Findings included:- The Medical Diagnosis section within R2's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic kidney disease, and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). R2's Significant Change Minimum Data Set (MDS) completed 06/30/25 noted a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS noted she required substantial to maximal assistance with bathing, toileting, dressing, transfers, and bed mobility. The MDS noted she had a suprapubic urinary catheter (urinary bladder catheter inserted through the abdomen into the bladder). The MDS noted R2 had a stage-one pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open). The MDS noted she had pressure-reducing devices for her bed and chair. R2's Pressure Ulcer Care Area Assessment (CAA) completed 06/18/25 indicated she had a suprapubic urinary catheter and instructed staff to monitor her catheter for infections and skin breakdown. The CAA noted she had a history of pressure-related wounds. The CAA noted that interventions were care planned to minimize the risks and complications. The CAA noted she had a potential skin break on her coccyx (area at the base of the spine). The CAA noted she had a low-air-loss mattress and bilateral heel boots to float her feet. R2's Care Plan initiated 02/18/25 indicated she was at risk of skin breakdown, pressure ulcers, falls, and infections related to her suprapubic urinary catheter. The Plan noted she required staff assistance for toileting, dressing, bathing, footwear, transfers, and bed mobility. The plan noted she had a suprapubic urinary catheter. The plan instructed staff to ensure the catheter drainage bag and tubing were secured in a privacy bag and did not to touch the floor. The plan instructed staff to provide catheter care as needed. The plan instructed staff to ensure she was repositioned every two hours, but required staff assistance to shift her weight. The plan noted she had a pressure-reducing cushion for her wheelchair and a low-air-loss mattress for her bed. The plan lacked instructions related to the required weight and comfort settings for R2's low-air-loss mattress. R2's EMR under Physicians Orders revealed an order dated 07/23/25. The order indicated she had a low air-loss mattress and instructed staff to ensure proper functioning every shift. The order lacked an indication of weight or comfort settings related to R2's needs. R2's EMR under Vitals indicated she weighed 117 pounds (lbs.) on 07/09/25. A review of the manual of low air-loss mattress manufacturers' operation (Drive Model) indicated that the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated that an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. On 07/27/25 at 07:23 AM, R2 sat in her bed. R2 stated her bed was uncomfortable, and staff did not adjust the control panel for comfort. R2's low air-loss mattress control panel was set to 250 lbs. The mattress pump had fixed weight settings of 80lbs, 120lbs, 150lbs, 180lbs, 210lbs, 250lbs, 280lbs, 320lbs, and 350lbs. On 07/29/25 at 10:08 AM, R2 slept in her bed. Her low air-loss mattress pump remained set at 250lbs. On 07/29/25 at 10:10 AM, Licensed Nurse G stated the bed was to be set by weight and verified the mattress was set to 250lbs. She stated staff sometimes increased the weight to ensure it was inflated properly, but normally the mattresses were to be set by the resident's actual weight. On 07/29/25 at 11:45 AM, Certified Nurse's Aide (CNA) M stated the mattresses were set by weight, but the nurses usually checked them every shift. She stated that direct care staff just made sure the mattress was inflated and not flat. On 07/29/25 at 11:50 AM, Administrative Nurse D stated the low air-loss mattresses were to be set by the resident's current weight, and staff were expected to check the setting each shift. The facility's Wound Management policy (revised 11/2017) indicated that the facility would assess each resident's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a safe environment when cleaning chemicals and Sani-wipes (a disposable disinfecting wipe) were not securely stored out of the residents' reach. The facility failed to ensure interventions were put in place after Resident (R) 27 had a fall. This placed the residents at risk for avoidable falls and avoidable injury.Findings included:- On 07/27/25 at 10:15 AM, outside of room [ROOM NUMBER], the Hoyer (total body mechanical lift) lift had a container of Sani-Wipe disposable cloths on it that was easily removed from the lift. On 07/27/25 at 10:22 AM, in the Tuscany room, Sani-wipes above the ice machine were unsecured, and an Alpha HP multi-surface disinfectant spray bottle, with a label that stated: keep out of reach of children, was in an unsecured cabinet underneath the sink. On 07/29/25 at 11:24 AM, Certified Nurse Aide (CNA) M stated the Sani-wipes and cleaners should be stored and locked out of the resident's reach.On 07/29/25 at 11:32 AM, Licensed Nurse (LN) G stated that residents typically did not go to the Tuscany room, but chemicals/cleaners should not be stored in a cabinet that was not locked or anywhere that residents had access to.On 07/29/25 at 11:42 AM, Administrative Nurse D stated that chemicals and the wipes should not be left out where residents had access to them. Administrative Nurse D stated the Sani-wipes had been put on the lifts after COVID-19 (highly contagious respiratory virus), so staff could easily sanitize the lifts after use. Administrative Nurse D stated that the wipes were secured to the lift, but had not realized that the container could be pulled off the lift when the container was close to being empty. The facility policy Chemical and Hazardous Material Storage dated November 2018, documented that all chemicals and hazardous items would be stored in a manner as to protect residents. Ensure that chemicals and hazardous items were stored in a locked area. Ensure that all chemicals and hazardous items are stored in the designated area when not in use by staff.- R27's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbance (a range of problematic or disruptive behaviors that deviate from what is considered typical or expected for a given age, situation, or individual), and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).R27's Significant Change Minimum Data Set (MDS) dated 08/28/24 documented a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. R27 required the use of a wheelchair to assist with mobility. R27 required substantial to dependent from staff for assistance with her activities of daily living (ADL).R27's Falls Care Area Assessment (CAA) dated 09/03/24 documented R27 was at risk for falls related to the medications she received, poor cognition, incontinence, and her need for assistance with transfers and bed mobility. R27 also had poor trunk strength and required a high-back wheelchair. R27 had not had any falls since the prior assessment.R27's Care Plan, last revised on 06/04/25, directed staff that she required one-on-one, extensive assistance for transfers. The Care Plan directed staff that R27 needed staff to reposition her when her bottom got close to the front of the wheelchair cushion or if I am leaning back in my chair for fall prevention. The Care Plan directed staff that R27 did not have wheelchair pedals on her wheelchair because she self-propelled her wheelchair. R27's Care Plan lacked new fall interventions post fall on 03/14/25 and 07/18/25.R27's Quarterly Assessment in the EMR dated 03/16/25 documented R27 was at risk for falls. R27's Quarterly Assessment in the EMR dated 06/09/25 documented she was at risk for falls related to her impaired mobility, incontinence, the medications she received and her impaired cognition. Review of R27's Un-witnessed Fall or Fall with Head Injury #1644 report dated 03/14/25 documented R27 had an unwitnessed fall near the nurse's station around 02:50 PM. R27 was heard yelling for help. Staff immediately responded. R27 had been wheeling herself around the nursing station before the incident. R27 was observed to be on the floor at the head of Hall 1, in front of her wheelchair, with her buttocks on a leg rest and the underside of her right arm on the other leg rest. R27 has severe dementia and was unable to communicate what happened. Review of the facility video revealed that she removed her shoe and then leaned forward to replace the shoe without locking her wheelchair brakes. The wheelchair moved backwards while she leaned forward, causing her to fall. R27 was noted to have bruising to her right hand post-fall. R27 was oriented to person only but was confused with impaired gait balance and impaired memory.R27's Witnessed Fall (no head injury) #1685 report dated 07/18/25 documented the resident was found lying on the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. The facility reported a census of 44 residents. The sample included 12 residents, with two reviewed for urinary catheter care. Based on record review, interviews, and observations, the facility failed to maintain Resident (R) 2's indwelling urinary catheter in a safe and sanitary manner. This deficient practice placed R2 at risk for complications related to urinary tract infections. Findings included:- The Medical Diagnosis section within R2's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic kidney disease, and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). R2's Significant Change Minimum Data Set (MDS) completed 06/30/25, noted a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS noted she had no upper or lower extremity impairments. The MDS noted she required substantial to maximal assistance with bathing, toileting, dressing, transfers, and bed mobility. The MDS noted she had a suprapubic urinary catheter (urinary bladder catheter inserted through the abdomen into the bladder). The MDS noted R2 had a stage-one pressure ulcer (pressure wound which appears reddened, does not blanche, and may be painful but is not open). The MDS noted she had pressure-reducing devices for her bed and chair. R2's Urinary Incontinence Care Area Assessment (CAA) completed 06/18/25 indicated she had a suprapubic urinary catheter and instructed staff to monitor her catheter for infections and skin breakdown. The CAA noted interventions were care planned to minimize the risks and complications associated with her catheter. R2's Care Plan initiated 02/18/25 indicated she was at risk of skin breakdown, pressure ulcers, falls, and infections related to her suprapubic urinary catheter. The plan noted she required staff assistance for toileting, dressing, bathing, footwear, transfers, and bed mobility. The plan noted she had a suprapubic urinary catheter. The plan instructed staff to ensure the catheter drainage bag and tubing were secured in a privacy bag and not to touch the floor. The plan instructed staff to provide catheter care as needed. R2's EMR under Progress Notes revealed an admission Summary completed on 06/03/25 that indicated R2 was readmitted to the facility from an acute medical facility. The note revealed she was diagnosed with acute kidney injury (AKI) and a urinary tract infection (UTI).On 07/27/25 at 07:14 AM, R2 slept in her bed. R2's bed was in the low position. Her urinary catheter collection bag lay flat directly on the floor with yellow urine visible in the bag and collection tubing. On 07/27/25 at 10:24 AM, R2 sat in her bed. R2's urinary catheter collection bag remained on the floor, not hung on her bedframe. Yellow urine was visible in the collection bag and tubing. On 07/27/25 at 11:05 AM, R2's urinary catheter tubing and collection bag were hung on the bed frame with a privacy bag in place. On 07/29/25 at 10:10 AM, Licensed Nurse G stated that urinary catheter tubing and collection bags were to be placed in a privacy bag and not allowed to touch the floor. On 07/29/25 at 11:50 AM, Administrative Nurse D stated the urinary catheter collection bags were to be hung below the level of the bladder in a privacy bag and off the floor. The facility's Indwelling Urinary Catheter Management policy, issued 04/2018, indicated the facility was to ensure standards of practice were followed to ensure safe and sanitary urinary catheter care. The policy indicated staff were to ensure unobstructed urine flow within the catheter by inspecting the tubing for kinks, frequent emptying, and maintaining the catheter collection bag below the level of the resident's bladder. The policy instructed to ensure the catheter system be maintained in a sanitary manner to prevent infections.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 44 residents. The sample included 12 residents, with one resident reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 3's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R3 at risk for decreased psychosocial well-being and ineffective treatment. Findings included:- R3's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of PTSD, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) disorder.The Significant Change Minimum Data Set (MDS) dated 07/04/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R3 did not have any behaviors during the observation period.R3's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/15/25 documented her current medication placed her at risk for severe adverse side effects.R3's Care Plan, dated 03/23/22 documented staff would monitor for any behaviors of seeing things that are not real and had any auditory or visual hallucinations. The plan of care documented the staff would document the behaviors or adverse side effects of her medications. The plan of care documented the staff would allow R3 to talk about her feelings when she was upset and provide her with one-on-one talks. The plan of care lacked personalized interventions to assist her with coping with her PTSD.R3's EMR under the Assessment tab revealed the following Primary Care PTSD Screen dated 09/20/24 documented R3 had answered yes to having nightmares or thoughts about her PTSD when she did not want to. The PTSD assessment documented R3 had answered yes, she tried hard not to think about it, or went out of her way to avoid situations that reminded her of the trauma.On 07/29/25 at 7:43 AM, R3 laid on her back on the bed and stated she was comfortable. R3's head of her bed was elevated.On 07/29/25 at 11:20 AM, Administrative Nurse F stated that social service staff would be responsible for ensuring a trauma-based assessment was completed and the resident's plan of care was updated. Administrative Nurse F stated the social services staff would be responsible for ensuring the resident with a PTSD diagnosis care plan included the type of trauma and personalized interventions to prevent re-traumatization. On 07/29/25 at 11:25 AM, Certified Nurse Aide (CNA) M stated the charge nurse would notify the nursing staff if a resident had a diagnosis of PTSD. CNA M stated she would refer to the resident information sheets that are printed by the nurses for the resident's Kardex (nursing tool that gives a brief overview of the care needs of each resident). On 07/29/25 at 11:32 AM, Licensed Nurse (LN) G stated staff could look at the resident's EMR under the assessment tab for the PTSD assessment, plan of care, or on the resident's Kardex. LN G stated she was not sure who was responsible for completing the PTSD screening and was not sure if the type of trauma or personalized interventions would be addressed in the resident's plan of care. On 07/29/25 at 11:42 AM, Administrative Nurse D stated she would expect the physicians to determine if a resident's diagnosis of PTSD was active. Administrative Nurse D stated she would expect the nurses to complete the PTSD assessment, and the MDS coordinator would be responsible to add the information to the resident's plan of care. On 07/29/25 at 11:55 AM, Social Service Staff X stated the nurses were responsible for completing the PTSD assessment. She stated she had never completed a PTSD assessment, and the MDS coordinator was responsible for ensuring it was addressed on the resident's plan of care.The facility's Trauma Informed Care policy, last updated 11/09/21, documented the facility would ensure residents who are trauma survivors received culturally competent, trauma-informed care accounting for the resident's experiences and preferences. Trauma-informed care recognized the effects of physical, psychological, and emotional trauma on the overall well-being of residents. Trauma can result from a variety of experiences that may occur at any time throughout the resident's lifetime. A screening would be completed on residents to identify any potential experiences which may impact care needs. The Posttraumatic Stress Disorder (PTSD) Screening would be completed during the lookback period for the admission, significant Change, and Annual MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175165	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Health Center	2400 SW Urish Road Topeka, KS 66614

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility identified a census of 44 residents. Based on observation, record review, and interviews, the facility failed to provide Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week. This placed all residents who resided in the facility at risk of a lack of assessment and inappropriate care.Findings included:- The facility's April, May, June, July, August, and September 2024 nursing schedule lacked evidence of Registered Nurse coverage for eight consecutive hours a day, on the following dates: 04/06/24, 05/04/24, 06/15/24, 07/04/24, 07/20/24, and 07/27/24. The facility was unable to provide verifiable, auditable evidence of RN coverage.On 07/29/25 at 09:10 AM, Administrative Staff A stated she was unable to provide payroll documentation for RN coverage for those six days. On 07/29/25 at 11:42 AM, Administrative Nurse D stated the facility staff scheduler was responsible to ensure there was RN coverage. Administrative Nurse D stated that the weekends had been the hardest days to have RN coverage. The facility's Competent and Sufficient Staffing policy, dated November 2024, documented that the facility would provide a sufficient number of nursing staff with the skill sets and competency necessary to provide care/services for all residents in accordance with resident care plans and the Facility Assessment. A Registered Nurse provided services for at least eight consecutive hours every 24 hours, seven days a week. RNs may be scheduled more than eight hours, depending on the acuity needs of the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 44 residents with one kitchen and dining room. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to food storage and equipment cleaning. This deficient practice placed the residents at risk of food-borne illnesses and food safety concerns. Findings included:- On 07/27/25 at 10:00 AM, a walkthrough of the facility's kitchen was completed:An inspection of the food preparation area revealed a microwave oven. The inside of the microwave oven contained a bowl of uncovered green beans. The inside of the microwave oven had old food debris spattered on the walls of the inside surfaces. An inspection of the walk-in refrigerator unit revealed built-up dust and debris covering the blower vents. An inspection of the dry food storage area revealed two unboxed packages of napkins resting directly against the storage room wall without a barrier to keep them clean. An inspection of the dry food storage area revealed multiple syrup-based dessert sauce bottles with syrup residue caked on the lids of the bottles, placed on the dry food storage racks.An inspection of the dry food storage area revealed gnats flying and landing on the bread packages in the dry food storage room. On 07/29/25 at 08:30 AM, a walkthrough with Dietary Staff BB was completed. Dietary Staff BB removed the dessert sauce containers and stated that staff were expected to wipe them down after use. An inspection of the bread area revealed a small number of gnats flying around the bread. Dietary Staff BB stated the facility was working with pest-control services, and most of the gnats were removed the previous day. She stated kitchen staff were expected to clean all surfaces after each meal service to ensure sanitary conditions. The facility's Food Preparation and Service, revised 04/2020, stated the facility was to ensure food service employees handle kitchen food and equipment in a manner that complies with safe handling practices. The policy noted that all food was to be labeled and dated. The policy noted that cooking equipment would be maintained in a sanitary environment and stored in a manner to prevent contamination or soiling.

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	175165	A. Building B. Wing	07/29/2025

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 95 residents. Based on interview and record review, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ). This placed the residents at risk for impaired care due to unidentified staffing issues.Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year 2024 for Quarter 3 and Quarter 4 indicated the facility triggered for no Registered Nurse (RN) hours for 10 days. The facility provided payroll documentation of RN coverage for 04/27/24, 05/18/24, 05/19/25, and 07/13/24.On 07/29/25 at 09:10 AM, Administrative Staff A stated she was unable to provide payroll documentation for RN coverage for those other six days. The facility's Competent and Sufficient Staffing policy dated November/2024 documented the facility would provide a sufficient number of nursing staff with the skill sets and competency necessary to provide care/services for all residents in accordance with resident care plans and the Facility Assessment. A Registered Nurse provided services for at least eight consecutive hours every 24 hours, seven days a week. RNs may be scheduled more than eight hours, depending on the acuity needs of the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility identified a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) bag was properly hung. The facility failed to ensure R34 and R54's nasal cannula (NC- a hollow tube medical device that provides supplemental oxygen therapy to people who have lower oxygen levels) were properly stored when not in use. This placed R2, R34, and R54 residents at risk of infection development and possible respiratory and/or urinary complications.Findings included: - On 07/27/25 at 10:13 AM, R34 sat on the bed. R34's NC oxygen tubing was hanging over the walker railing, no bag noted.On 07/27/25 at 10:14 AM, R2 slept in her bed. R2's bed was in the low position. Her urinary catheter collection bag lay flat directly on the floor with yellow urine visible in the bag and collection tubing.On 07/27/25 at 11:05 AM, R2's urinary catheter tubing and collection bag were hung on the bed frame with a privacy bag in place. On 07/28/25 at 12:06 PM, R54's NC laid on the floor in her room. Administrative Nurse D picked up the NC from the floor and handed it to R54 to put on. Administrative Nurse D failed to discard the dirty NC and obtain a new one.On 07/29/25 at 08:52 AM, Administrative Nurse D, the facility's infection preventionist, stated that NC should be stored in the provided bag when not in use. Administrative Nurse D stated that catheter bags should never be on the floor, and she would expect staff to change out the bag and ensure that the bag was hung on the side of the bed with the dignity bag covering the bag. Administrative Nurse D stated yesterday that she had realized after the incident with R54's NC that she should have replaced the tubing with a new one and should not have given R54 the NC that had been lying on the floor. The facility's Catheter Drainage Bag policy, dated 11/28/17, documented if the drainage bag or drainage tubing came into contact with the floor, all areas of the bag and tubing must be cleansed with alcohol.The facility's Oxygen Safety and Management policy, dated 03/22/19, documented equipment used for oxygen administration would be replaced every two weeks. The equipment should be marked with the name of the resident and the date it was put into use. Oxygen cannulas and masks should not be allowed to come in contact with the floor or other potentially dirty surfaces. If this occurred, they should be replaced. The cannulas or masks should be stored in plastic bags to prevent contamination.