STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175361	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topside Manor Inc	210 Kansas Avenue Goodland, KS 67735

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 43 residents with three residents reviewed for falls and accidents. Based on record review and interview, the facility failed to ensure Resident (R) 1's safety during a transfer when Certified Nurse Aide (CNA) M used the ceiling-mounted full body lift to transfer R1 from her bed to her wheelchair. During the transfer, R1 slid out of the lift sling onto the floor. As a result, R1 sustained a left femoral (thigh bone) fracture and a left fibular (one of the two bones in the lower leg) fracture. This deficient practice also placed R1 at risk for pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), obesity (excessive body fat) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R1 was dependent on staff assistance for all activities of daily living except eating which required set-up assistance. The MDS documented R1 required the use of a mechanical lift and manual wheelchair. R1 had impairment to her bilateral lower extremities. The MDS documented R1 weighed 267 pounds. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/29/24, documented R1 had severe cognitive impairment which placed R1 at risk for behaviors, communication deficits, and activities of daily living (ADLs) functional decline. The Functional Abilities CAA, dated 01/29/24 documented R1 required set-up assistance for eating and was dependent on staff for toileting, bathing, dressing, bed mobility, and transfer, and was non-ambulatory with the use of a wheelchair for mobility pushed by staff. The CAA documented R1 was at risk for skin breakdown, falls, and ADL decline. R1's Care Plan, dated 06/17/22 documented staff would be educated on the proper use of the lift and directed staff to use two persons with the stand-aid. An intervention dated 01/08/24 directed staff to use a full body lift for transfers at all times but did not indicate how many staff. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Fall Risk Evaluation, dated 01/29/24, documented R1 had a fall risk score of 11.0 which indicated R1 was at risk for falls. The Health Status Note, dated 03/23/24, documented CNA M called Licensed Nurse (LN) G to R1's room at 08:18 AM. LN G entered the room in under a minute, and upon entering R1's room, LN G saw R1 sitting on the floor with her legs partially under her bed and CNA M was kneeling behind R1, keeping R1 in a sitting position. R1 was holding on to the edge of the bed. R1 was yelling out in pain and stated the pain was centralized in her left knee. LN G asked CNA M what happened and CNA M stated she was transferring R1 to her wheelchair from the bed with the ceiling lift and R1 slipped out of the sling. LN G performed a full body assessment and noted no internal or external rotation to the upper extremities or the right leg. LN G noted R1's left thigh was curved outward the kneecap was on the outside of the knee, and the calf was internally rotated with the foot slightly externally rotated. R1's left leg was out of alignment with her hip. LN G tried to perform a complete assessment of R1's left hip but was unable to find the hip joint due to R1 sitting on the floor and crying out in pain. R1 answered LN G's questions per her baseline. R1 was unable to state what happened but was able to answer questions regarding pain, and location, and described the pain clearly to LN G. LN G called CNA N into the room to assist with keeping R1 in a seated position. Staff assessed R1's vital signs and LN G asked CNA M to call emergency medical personnel (EMS) for emergency transport at 08:27 AM while LN G continued to assess R1; LN G kept R1 in position to keep her from further injury. When CNA M came back into R1's room, LN G left R1's room to print paperwork and notify the family and the emergency room of the transfer. LN G called R1's family member at 08:31 AM. The ER was notified at 08:37 AM. The EMS entered the building at 08:40 AM. At 10:50 AM, LN G contacted the ER for an update and was told R1 had fractures from her left knee to her ankle and was being transferred to a higher level of care. The Health Status Note, dated 03/23/24, documented LN G inspected the lift sling that was used on R1 at the time of the fall. The full-body sling was a size extra-large, the seams were intact, and there were no rips or holes in the sling. The Diagnostic Imaging Report, dated 03/23/24, documented R1 sustained a displaced and comminuted (a bone that has been broken in three or more places) distal (farther away) femoral shaft fracture and a proximal (closer to the body) fibular fracture. CNA M's Witness Statement, dated 03/29/24, documented CNA M retrieved an extra-large sling. CNA M stated she inspected the sling and did not see any tears. CNA M went to R1's room to get R1 ready for breakfast. CNA M changed and dressed R1. CNA M put the lift sling on R1 and hooked up the lift sling. CNA M stated she made sure the lift sling was put on properly. CNA M stated she lifted R1 partially and then checked again to ensure the lift sling was secure. CNA M stated when she started to move R1 away from the bed, R1 slipped out of the lift sling. CNA M asked R1 if she was okay and immediately called LN G. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LN G's Witness Statement, dated 03/29/24, documented CNA M called LN G to R1's room stat at 08:18 AM. LN G entered the room in under a minute. Upon entering R1's room, LN G saw R1 sitting on the floor with her legs partially under her bed and CNA M kneeling behind R1, keeping R1 in a sitting position. R1 was holding on to the edge of the bed. R1 was yelling out in pain and stated the pain was centralized in her left knee. LN G asked CNA M what happened, and CNA M stated she was transferring R1 to her wheelchair from the bed with the ceiling lift and R1 slipped out of the sling. LN G stated she inspected the lift sling that was used to transfer R1 at the time of the fall. The lift sling was a size extra-large, seemed intact, and no rips or holes were noted in the lift sling. CNA N's Witness Statement, dated 03/29/24, documented at 08:20 AM LN G called CNA N over the radio for extra assistance in R1's room. CNA N got to R1's room at 08:21 AM. LN G and CNA M were in R1's room and R1 was sitting on the floor. LN G asked CNA N to obtain the vitals machine. CNA N got the vitals machine and LN G obtained R1's vital signs. CNA N sat behind R1 so R1 could lean against her. CNA M called EMS and LN G got paperwork ready and CNA N stayed with R1. The Facility Incident Report, dated 03/29/24, documented CNA M called LN G to R1's room stat at 08:18 AM. LN G entered the room in under a minute. Upon entering R1's room, LN G saw R1 sitting on the floor with her legs partially under her bed and CNA M was kneeling behind R1 keeping R1 in a sitting position. R1 was holding on to the edge of the bed. R1 was yelling out in pain and stated the pain was centralized in her left knee. LN G asked CNA M what had happened. CNA M stated she was transferring R1 to her wheelchair from the bed with the ceiling lift and R1 slipped out of the sling. The root cause analysis was identified as being the lift sling size. The lift sling was intact and correctly attached to the lift, the technique used for R1's transfer was deemed sufficient per the manufacturer's recommendation. The report recorded an intervention that R1 would be measured and fit for the lift sling upon her return from the hospital to ensure appropriate lift sling is used. Mandatory lift transfer evaluations would occur for all nursing staff before their next shift to ensure staff understanding and competence in safely using the ceiling lift equipment. An all-staff meeting was scheduled for 04/03/24 and 04/04/24 focusing on the appropriate use, facility standards of use, and patient positioning, transfer, and care techniques. Size assessments for all patients requiring the full body lift will be conducted to match them with the correct lift sling size per the manufacturer's specifications. The size of the lift sling will also be documented for clarity and ease of identification in patient rooms. Implementation of a monthly rolling schedule for lift sling inspection and patient assessments to ensure all equipment is appropriate and in good condition for the patient's current needs. R1 was unavailable for observation or interview. On 04/01/24 at 11:30 AM, Administrative Nurse D stated the incident with R1 should have never happened. CNA M went and got a different-sized lift sling to transfer R1 from her bed to her wheelchair because CNA M didn't think the lift sling in R1's room was big enough and R1 fell through the lift sling. Administrative Nurse D stated all residents who required the full lift were going to be evaluated by the physical therapy team to measure the residents and ensure the correct size of lift sling would be used for the residents. Administrative Nurse D stated all staff meetings would take place on 04/03/24 and 04/04/24 regarding education on the proper use of the ceiling lift sling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Lifting Machine, using a Mechanical Policy, revised in July 2017, documented the purpose of the policy is to establish the general principles of safe lifting using a mechanical lifting device. At least, two nursing assistants are needed to safely move a resident with a mechanical lift. Measure the resident for proper sling size and purpose. Select a sling bar that is appropriate for the resident's size and the task. Clear an unobstructed path. Ensure there is enough room to pivot. Position the lift near the receiving surface. Place the lift at the correct height. Make sure all the necessary equipment (sling, hooks, chains, straps, and supports) is on hand and in good condition. The facility failed to ensure R1 remained free from preventable accidents involving the use of a full-body lift. This deficient practice resulted in a fractured femur and fibula for R1 and placed R1 at risk for pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 43 residents with three residents reviewed for medication errors. Based on record review and interview, the facility failed to ensure an antibiotic for a urinary tract infection (UTI-an infection in any part of the urinary system) for Resident (R) 2 was available for administration. This deficient practice placed R2 at risk for a worsening UTI and health complications. Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and UTI. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status score of three which indicated severely impaired cognition. The MDS documented R2 was dependent on staff assistance for toileting and bathing. The MDS documented R2 did not have a UTI in the last thirty days of the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/13/23, documented R2 had severe cognitive impairment and was at risk for communication deficit and activity of daily living (ADL's) decline. R2's Care Plan revised 06/05/23, directed staff R2 had bladder incontinence and used disposable briefs. Staff were directed to change R2 with each incontinent episode and as needed and clean R2's peri area with each incontinent episode. The care plan directed staff to administer R2's medications as ordered. The Other Progress Note, dated 02/06/24, documented that R2's primary care physician sent orders to obtain a urine sample for R2 due to her increased confusion and agitation. A urine collection hat was placed on R2's toilet but R2 was removing it and refusing to void in the hat. The Urinalysis Microscopic Report, dated 02/07/24, documented R2's urine had white blood cells and bacteria in her urine. The Urine Culture Report, dated 02/08/24, documented R2's urine grew out Gram-positive Enterococcus (lactic acid bacteria). On 02/08/24 the facility received a new order to administer Macrobid (antibiotic) 100 milligrams (mg) twice a day for five days for R2's UTI. The Antibiotic Monitoring Note, dated 02/10/24, documented the Macrobid had not been started yet as it had not been received from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Antibiotic Monitoring Note, dated 02/11/24, documented the Macrobid had not arrived from the pharmacy. R2's February 2024 Medication Administration Record (MAR), documented 100 mg of Macrobid was to be given to R2 twice a day for five days. R2's first dose of Macrobid was scheduled to be administered on 02/08/24 on the evening medication pass. The dose was documented as unavailable. The subsequent doses for 02/09/24, 02/10/24, 02/11/24, 02/12/24, and 02/13/24 were all documented as unavailable. R2 was not administered her antibiotic for five days. A new order for Macrobid 100 mg by mouth twice a day for five days was placed in the EMR to start on the evening medication pass on 02/13/24. The Antibiotic Monitoring Note, dated 02/13/24, documented that night was R2's first dose of antibiotic and staff will continue to monitor. R2 was unavailable for observation or interview. On 04/01/24 at 02:00 PM, Administrative Nurse D stated that she directed her staff to use the Macrobid from the emergency kit until the antibiotic was delivered from R2's pharmacy and she had not followed up to ensure R2 was receiving her antibiotic for the UTI. The Administering Medications Policy, revised in April 2019, documented that medications are to be administered in a safe and timely manner and as prescribed. The Director of Nursing supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by the resident's need and benefit, not staff convenience. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The facility failed to ensure R2's antibiotic for a UTI was available for administration. This deficient practice placed R2 at risk for a worsening urinary tract infection and health complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 43 residents with three residents reviewed for medications. Based on record review and interview, the facility failed to monitor Resident (R) 2's psychotropic (alters mood or thought) medication used off-label use for insomnia (inability to sleep) after a trial increase. This deficient practice placed R2 at risk for inadequate oversight, lack of physician involvement, and ineffective dosing for Trazodone. Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and urinary tract infection (UTI). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status score of three which indicated severely impaired cognition. The MDS documented R2 was totally dependent on staff assistance for toileting and bathing. The MDS documented R2 did not have a UTI in the last thirty days of the assessment period. The MDS documented R2 received an anti-depressant (medication used to treat mood disorders). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated [DATE], documented R2 had severe cognitive impairment and was at risk for communication deficit and activity of daily living (ADL's) decline. R2's Care Plan revised [DATE], directed staff R2 was at risk for adverse reactions to Trazodone (antidepressant) and directed staff to monitor R2 for possible signs and symptoms: falls, weight loss, fatigue, agitation, depression, lethargy, unsteadiness, confusion poor appetite, constipation, diarrhea, bruising, and red eyes. The Order Fax, dated [DATE], documented R2's primary care provider ordered Trazodone 50 milligrams (mg) at nighttime for insomnia. The Order Note, dated [DATE], documented to increase R2's Trazodone to 75 mg at nighttime and monitor R2 for over-sedation or morning drowsiness. The Order Note, dated [DATE], documented R2 continued to have insomnia and Trazodone was not helping. R2's provider ordered to increase R2's Trazodone to 100 mg for a trial for one week. The Medication Administration Record (MAR), dated [DATE] documented R2 received 75 mg of Trazodone on [DATE]. The MAR documented R2 received 100 mg of Trazodone from [DATE] through [DATE]. R2's MAR, after [DATE] documented all dosages were discontinued and the Trazodone was not administered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's clinical record lacked evidence staff monitored the effectiveness of the trail dose of Trazadone and lacked evidence staff notified the physician regarding the outcomes of the trial or to inform the order was expired and request further orders. The Order Note, dated [DATE] documented to restart Trazodone 50 mg, one and a half tabs, by mouth at nighttime for insomnia. R2 was unavailable for observation or interview. On [DATE] at 02:00 PM, Administrative Nurse D stated she normally put in the new orders, but she must not have been at the facility the day the trial order for Trazodone 100 mg was ordered by R2's primary care provider. Administrative Nurse D stated staff should have placed R2's Trazodone 75 mg on hold during the trial dosage increase of Trazodone 100 mg and then the Trazodone 75 mg dose should have been scheduled to restart the day after the trial week. Administrative Nurse D stated an order for monitoring the effectiveness of Trazodone 100 mg related to R2's insomnia should have been placed in the Treatment Administration Record (TAR) and another order to contact R2's primary care provider regarding the effectiveness of the dosage increase. The Administering Medications Policy, revised [DATE], documented medications are to be administered in a safe and timely manner and as prescribed. The Director of Nursing supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by the resident need and benefit, not staff convenience. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The facility failed to monitor R2's psychotropic medication used off-label use for insomnia after a trial increase. This deficient practice placed R2 at risk for inadequate oversight, lack of physician involvement, and ineffective dosing for Trazodone.