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	08/29/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 44 residents. The sample included 12 residents, with one reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote dignity for Resident (R) 22, when staff called R22 Honey multiple times instead of addressing her by her proper name. This placed the resident at risk for undignified care and services. Findings included: - The Electronic Medical Record (EMR) documented R22 had diagnoses of moderate dementia with psychotic disturbance, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), agitation (feelings of aggravation or restlessness brought on by a provocation or a medical condition), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, restlessness (the inability to relax as a result of anxiety), and chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for all activities of daily living (ADLs) and had inattention and disorganized thinking. The assessment further documented that R22 had physical and verbal behaviors, and rejected care for 4 to 6 days. R22 received antipsychotic (a class of medication used to treat psychosis and other mental-emotional conditions), and antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression) medication. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for all ADLs, had disorganized thinking, and altered level of consciousness. The assessment further documented R22 had physical and verbal behaviors for 4 to 6 days and rejection of care for 1 to 3 days. R22 received antipsychotic and antidepressant medication. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Care Plan, dated 08/12/24, initiated on 03/14/22 directed staff to reminisce with the resident using photos of family and friends. The update, dated 04/19/22, directed staff to offer her a sucker or chocolate when she was anxious or agitated, encourage her to participate in activities, and if she did not want to attend, sit and talk with her for a bit. The update, dated 04/23/22, documented R22 was physically aggressive, would hit, kick, and attempt to bite during bedtime care and directed staff to give her as many choices as possible about care and activities, engage calmly in conversations, consult a psychiatrist as indicated, administer medications as ordered, answer her questions, and do not touch her until she was ready. The update, dated 06/17/22, documented R22 only tolerated one person at a time, needed personal space, and directed staff to sit her alone at a table during mealtime when she was agitated. The care plan directed staff to modify her environment, adjust the room temperature to a comfortable level, and reduce noise. The update, dated 02/24/23, directed staff to anticipate and meet her needs, provide a program of activities that were of interest, and accommodate her status. The update dated 08/06/23, directed staff to offer her the fidget board. R22's Care Plan lacked evidence the resident preferred to be called Honey. On 08/26/24 at 11:18 AM, observation revealed R22 sat at the dining table and yelled Help! Help! over and over. Certified Nurse Aid (CNA) M went to the table and asked R22 if she needed something, called her Honey multiple times, and offered to take her into the living room area to watch television. CNA M asked R22 if she wanted to watch Little House on the Prairie, and R22 stated Yes. CNA M did not change the channel to the television show R22 wanted to watch, but stated, Oh here's a farm show you would like, can I transfer you into the recliner Honey? R22 continued to yell Help and CNA made a shushing noise towards R22. CNA M stated, Let me know if you want the channel changed and she walked away. Continued observation revealed R22 started to yell, Help! Help! CNA M went to her and stated Did you not like this show Honey R22 stated, NO! CNA M asked R22 if she wanted the channel changed to Little House on the Prairie and R22 stated Yes. On 08/28/24 at 03:45 PM, Licensed Nurse (LN) G stated staff should call the resident by her name unless they have been given permission to call them by something else. On 08/29/24 at 11:30 AM Administrative Nurse D stated staff should not call R22 Honey as that is not very dignified and is unsure if R22 would like to be called Honey. The facility's Dignity policy, dated 02/2021. documented residents were treated with dignity and respect at all times and staff should promptly respond to a resident's request for toileting assistance. Staff are expected to treat cognitively impaired residents with dignity and sensitivity. The facility failed to promote dignity for R22 when staff called R22 Honey multiple times instead of addressing her by her proper name. This placed the resident at risk for undignified care and services.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 32360 The facility had a census of 44 residents. The sample included 12 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide the correct CMS Form 10055, Skilled Nursing Facility [SNF] Advanced Beneficiary Notice [ABN] which included the estimated cost to continue services for skilled services to the resident or their representative for three residents: Resident (R) 1, R16, and R145. This placed all three residents at risk for uninformed decisions regarding skilled services. Findings included: - The Medicare SNF ABN form 10055 informs the beneficiaries Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for payment of services. (3) I do not want the listed services. The facility's Medicare ABN form staff provided to R1 (or their representative) was CMS-R-131. The facility's Medicare ABN form staff provided to R16 (or their representative) was from CMS-R-131. The facility's Medicare ABN form staff provided to R145 (or their representative) was from CMS-R-131. On 08/28/24 at 08:00 AM, Social Services X stated he did not realize he had been providing the families with the correct CMS form. The facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy, dated 09/23, documented that residents were informed in advance when changes would occur to their bills, The facility would provide a Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) to residents for initiation, reduction, or termination of Medicare benefits. The facility failed to provide R1, R16, and R145 the correct SNF ABN from CMS 10055 as required. This placed all three residents at risk for uninformed decisions regarding skilled services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 44 residents. The sample included 12 residents with three reviewed for hospitalization . Based on record review and interview the facility failed to provide a written notice for a facility-initiated transfer for Resident (R) 5, R11, and R1 or their representatives when they were transferred to the hospital. The facility also failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of the discharges. This placed the residents at risk for uninformed care choices. Findings included: - R5's Electronic Medical Record (EMR) documented the resident had diagnoses of pain in the knee and hyponatremia (concentration of sodium in your blood is abnormally low). R5's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented that R5 required partial, moderate staff assistance with oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and transfers. R5 required supervision with ambulation. R5's Care Plan, revised 07/21/24, documented R5 received pain medication and was at high risk for falls pertaining to lack of vision. The care plan instructed staff to be sure R5's call light was within reach and encourage him to use it for assistance as needed, provide prompt response to all requests for assistance, and make sure R5 used his assistive device when walking. R5's Progress Notes, dated 02/26/24 at 11:00 AM and 03/18/24 at 07:00 PM documented the resident was transferred to the hospital. R5's clinical record lacked evidence the resident or representative was provided written notice. On 08/27/24 at 08:00 AM, observation revealed R5 sat in a chair at the kitchenette counter On 08/29/24 at 11:30 AM, Administrative Staff D stated she was not aware the appropriate documentation was not provided to the resident or his representative. On 08/28/24 at 07:53 AM, Social Service X stated he was unaware he was required to notify the LTCO when a resident went to the hospital. Social Service X stated he was also unaware of any written notification required to the resident or representative. Social Services X stated he provided the resident's representative with a bed hold notice. On 08/29/24 at 11:30 AM, Administrative Staff D stated she was not aware the appropriate documentation was not provided to the resident or his representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Transfer or Discharge Notice Policy, revised March 2024, documented a copy of the notice would be sent to the office of the state Long-Term Care Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative. The facility failed to provide R5 or his representative written notice regarding R5's transfer to the hospital and failed to notify the office of the LTCO. This placed the resident and/or her representative at risk of uninformed care choices. - R11's Electronic Medical Record (EMR) documented R11 had a diagnosis of heart failure. R11's Quarterly Minimum Data Set (MDS), 07/12/24, documented R11 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R11 had heart failure. R11's Care Plan, revised 07/19/24-, documented R11 had coronary artery disease (a condition that occurs when the heart's blood supply is reduced due to plaque (sticky substance) buildup in the arteries). The care plan instructed staff to administer medications to R11 as the physician ordered, encourage compliance with the treatment regimen, monitor blood pressure and notify the physician of any abnormal readings, monitor R11's cholesterol (a fat-like substance in the body) levels, and report findings to the physician. The Progress Note, dated 01/31/2024 at 12:30 PM, documented R11 was admitted to the hospital. R11's clinical record lacked evidence the resident or representative was provided a written notice when she was transferred to the hospital. On 08/27/24 at 01:00 PM, observation revealed R11 ambulated down the hall with a walker. On 08/28/24 at 07:53 AM, Social Service X stated he was unaware he was required to notify the LTCO when a resident went to the hospital. Social Service X stated he was also unaware of any written notification required to the resident or representative. Social Services X stated he provided the resident's representative with a bed hold notice. On 08/29/24 at 11:30 AM, Administrative Nurse D stated she was not aware the appropriate documentation was not provided to the resident or her representative. The facility's Transfer or Discharge Notice Policy, revised March 2024, documented a copy of the notice would be sent to the office of the state Long-Term Care Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative. The facility failed to provide R11 or her representative written notice regarding R11's facility-initiated transfer. This placed the resident at risk of uninformed care choices. 32360 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Electronic Medical Record (EMR) for R1 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough glucose is made or the body cannot respond to the insulin), edema (excess watery fluid in the tissues of the body), vaginitis (inflammation of the vagina that can result in discharge, itching, and pain), urinary tract infection (UTI-an infection in any part of the urinary system), kidney disease (damage to or disease of a kidney), and a femur fracture (broken thigh bone). The Significant Change Minimum Data Set (MDS), dated [DATE], documented R1 had severely impaired cognition and was dependent on all activities of daily living (ADLs). R1 was always incontinent of bowel and frequently incontinent of bladder. R1 received an antidepressant (medication used to treat mood disorders and relieve symptoms of depression), a diuretic (medication to promote the formation and excretion of urine), and an anticoagulant (medication that prevents blood clots from forming in the bloodstream) medication. R1's Quarterly MDS, dated [DATE], documented R1 had moderately impaired cognition and was dependent upon staff for toileting and transfers. R1 required substantial assistance with dressing and personal hygiene. R1 was always incontinent of bladder and bowel and received anticoagulant, diuretic, and opioid (narcotic pain medication) medication. R1's Care Plan, dated 06/27/24 and initiated on 03/22/22, documented R1 was dependent upon two staff for toileting and one for personal hygiene. The update, dated 04/01/22 directed staff to administer medications as ordered and monitor for edema. The update dated 04/10/24 documented R1 was a full sling lift. The Progress Note, dated 01/16/24 at 09:52 AM, documented R1 was admitted to the hospital due to increased weight and edema. The Progress Note, dated 03/25/34 at 11:23 AM, documented R1 was admitted to the hospital due to a fall with a fracture. The Progress Note, dated 06/10/24 at 02:23 AM, documented R1 was admitted to the hospital due to abnormal vaginal bleeding. R1's clinical record lacked evidence the resident or her representative was provided a written notice when she was transferred to the hospital on the above dates. On 08/26/24 at 11:56 AM, observation revealed R1 was at the dining table visiting with her family. On 08/28/24 at 07:53 AM, Social Service X stated he was unaware he was required to notify the LTCO when a resident went to the hospital. Social Service X stated he was also unaware of any written notification required to the resident or representative. Social Services X stated he provided the resident's representative with a bed hold notice. On 08/29/24 at 11:30 AM, Administrative Nurse D stated she was not aware the appropriate documentation was not provided to the resident or her representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Transfer or Discharge Notice Policy, revised March 2024, documented a copy of the notice would be sent to the office of the state Long-Term Care Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative. The facility failed to provide R11 or her representative written notice regarding R11's facility-initiated transfer. This placed the resident at risk of uninformed care choices.

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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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32358 The facility had a census of 44 residents. The sample included 12 residents, with four reviewed for accidents. Based on observation, record review, and interview the facility failed to ensure staff followed the care plan to prevent accidents when staff failed to place Resident (R) 9's alarm (a device designed to monitor a patient's movements) underneath her when she was in bed per her plan of care resulting in a fall. This also placed R9 at risk for injuries from falls. Findings included: - R9's Electronic Medical Record (EMR) documented R9 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, unsteadiness on her feet, and a history of falling. R9's Quarterly Minimum Data Assessment, (MDS) revised 07/12/24, documented R9 had a Brief Interview of Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The MDS documented R9 used a walker and had a fall with injury during the observation period. R9's Care Plan revised 04/22/24, documented R9 was a high risk for falls, and used a bed and chair alarm. The plan instructed staff to ensure the alarm was on at all times when R9 was in bed or a wheelchair. The Progress Note, dated 08/24/24 at 01:18 AM, documented that Certified Nurse Aide (CNA) N notified the nurse that R9 was on the floor. When the nurse entered the room R9 was against the bathroom door. The nurse noticed R9's bed alarm was in place but the box to the bed alarm was missing. The note documented CNA N stated he left the box in the living room and he was not aware that the box needed to be transferred to her bed alarm. On 08/27/24 at 09:44 AM, observation revealed R9 sat quietly in a wheelchair in the activity room at an exercise activity. On 08/28/24 at 02:05 PM, Licensed Nurse (LN) G stated to prevent R9 from falling staff placed a pressure alarm underneath R9 when she was in bed or a wheelchair to notify staff when R9 tried to get up. On 08/29/24 at 09:23 AM, Administrative Nurse D verified R9 had a fall on 08/24/24 at 01:18 AM from her bed because the staff had not placed the alarm box on the bed alarm as the care plan instructed. Administrative Nurse D stated staff should ensure R9's alarm device was in place at all times when R9 was in her wheelchair or bed. Administrative Nurse D stated R9 now had two separate alarms one for the bed and one for her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Falls-Clinical Protocol Policy, revised in March 2018, documented that if interventions have been successful in fall prevention, the staff would continue with current approaches. If the individual continues to fall, the staff and physician would re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and reconsider the current interventions. The facility staff failed to place an alarm underneath R9 when she was in bed per her plan of care and R9 had a fall. This also placed R9 at risk for injuries from a fall.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 44 residents. The sample included 12 residents, with one reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to provide adequate respiratory care and services for Resident (R) 22 when staff did not provide her oxygen during the breakfast meal and failed to store the oxygen tubing and cannula (a medical device that delivers supplemental oxygen to patients through their nose) in a sanitary manner when not in use. This placed R22 at risk for respiratory complications. Findings included: - The Electronic Medical Record (EMR) documented R22 had diagnoses of moderate dementia (a progressive mental disorder characterized by failing memory and confusion) with psychotic disturbance, depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for all activities of daily living (ADLs). R22 did not have shortness of breath and received oxygen daily. R22 did not receive a diuretic (treats fluid retention) medication. R22's Care Plan, dated 08/12/24, initiated on 02/28/22, directed staff to monitor her for signs and symptoms of respiratory distress and report to the physician as needed, have continuous oxygen at 2 liters (L) per minute via nasal cannula and titrate (adjust the flow) to keep the oxygen saturation above 90%. The Physician's Order, dated 08/12/24, directed staff to administer continuous oxygen via nasal cannula at 2L to keep saturation above 90%, notify the physician of all changes, and monitor R22's oxygen saturation every shift for COPD. On 08/26/24 at 11:18 AM, observation revealed R22 sat at the dining table and did not have her oxygen concentrator with her at the dining room table. Further observation revealed staff took R22 to the living room area and did not bring her oxygen to her. CNA M stated R22 refused her oxygen earlier, and staff could not force her to wear it, so she did not bring it to the table. Continued observation revealed after being questioned, CNA M brought out R22's oxygen concentrator and stated, You forgot your oxygen Honey, can I put it on? R22 responded Yes. On 08/27/24 at 09:05 AM, observation revealed R22 at the dining table. Staff attempted to fix her oxygen cannula as it was partially out of her nose but R22 did not allow it. Further observation revealed the CNA took the oxygen tubing and laid it over the handles of the wheelchair and the cannula was resting against R22's back. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 09:31 AM, CNA Q removed R22's oxygen and placed the tubing in the bag on the concentrator. CNA Q took R22 to her room for care, then brought her back and tried to put R22's oxygen on and R22 would not let her so CNA Q laid the oxygen tubing in R22's lap. On 08/28/24 at 09:30 AM, CNA Q stated she did not know why she did not place the oxygen tubing in the bag as she had previously. On 8/28/24 at 03:45 PM, Licensed Nurse (LN) G stated staff should put the oxygen tubing in the bag that was provided on the concentrator. LN G said staff should have checked R22's oxygen saturation after R22 went without oxygen for that period. On 8/29/24 at 11:30 AM Administrative Nurse D stated there were bags provided to the residents with oxygen for the staff to put the oxygen tubing in if the resident was not wearing it. The facility's Oxygen Administration policy, dated 10/2010, documented the procedure was to provide guidelines for safe oxygen administration, and if a resident refused the oxygen, document the reason why and what interventions were taken. The facility failed to provide adequate respiratory care and services for R22 when staff did not provide her oxygen during the breakfast meal and failed to store the oxygen tubing and cannula in a sanitary manner when not in use. This placed R22 at risk for respiratory complications.

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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 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. 32360 The facility had a census of 44 residents. Based on observation, interview, and record review the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week, placing all residents who reside at the facility at risk of decreased quality of care. Findings included: - The Payroll Based Journal (PBJ-a required detail of staffing information submitted by nursing homes to the Centers for Medicare and Medicaid Services) documented the facility lacked eight consecutive hours of RN coverage for the following months: April 2023- seven days May 2023- seven days June 2023- six days July 2023- eight days August 2023- six days September 2023- six days October 2023- eight days November 2023- four days December 2023- four days March 2024- four days April 2024- four days May 2024- four days June 2024- eight days July 2024- eight days August 2024- six days On 08/29/24 at 08:27 AM, Administrative Nurse D verified the facility did not have an RN on duty for eight consecutive hours on the dates listed on the PBJ. (continued on next page)

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Topside Manor Inc	210 Kansas Avenue Goodland, KS 67735

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Staffing, Sufficient and Competent Nursing policy, dated 09/22, documented the facility provided enough nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled for more than eight (8) hours depending on the acuity needs of the resident. The facility failed to provide RN coverage eight consecutive hours a day, seven days a week, placing all residents who reside at the facility at risk of lack of assessments and inappropriate care.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 44 residents. The sample included 12 residents with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on observation, record review, and interview, the facility failed to provide dementia care and services for Resident (R) 22, who had dementia and behaviors. This placed R22 at risk for abuse and decreased quality of life. Findings included: - The Electronic Medical Record (EMR) documented R22 had diagnoses of moderate dementia with psychotic disturbance, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), agitation (feelings of aggravation or restlessness brought on by a provocation or a medical condition), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear, restlessness (the inability to relax as a result of anxiety), and Chronic Obstructive Pulmonary Disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for all activities of daily living (ADLs) and had inattention and disorganized thinking. The assessment further documented R22 had physical and verbal behaviors, and rejected care for 4 to 6 days. R22 received antipsychotic (a class of medication used to treat psychosis and other mental-emotional conditions), and antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression) medication. The Quarterly MDS, dated [DATE], documented R22 had severely impaired cognition. R22 was dependent upon staff for all ADLs, had disorganized thinking, and altered level of consciousness. The assessment further documented R22 had physical and verbal behaviors for 4 to 6 days and rejection of care for 1 to 3 days. R22 received antipsychotic and antidepressant medication. R22's Care Plan, dated 08/12/24, initiated on 03/14/22 directed staff to reminisce with the resident using photos of family and friends. The update, dated 04/19/22, directed staff to offer her a sucker or chocolate when she was anxious or agitated, encourage her to participate in activities, and if she did not want to attend, sit and talk with her for a bit. The update, dated 04/23/22, documented R22 was physically aggressive, would hit, kick, and attempt to bite during bedtime care and directed staff to give her as many choices as possible about care and activities, engage calmly in conversations, consult a psychiatrist as indicated, administer medications as ordered, answer her questions, and do not touch her until she was ready. The update, dated 06/17/22, documented R22 only tolerated one person at a time, needed personal space, and directed staff to sit her alone at a table during mealtime when she was agitated. The care plan directed staff to modify her environment, adjust the room temperature to a comfortable level, and reduce noise. The update, dated 02/24/23, directed staff to anticipate and meet her needs, provide a program of activities that were of interest, and accommodate her status. The update dated 08/06/23, directed staff to offer her the fidget board. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 07/19/22, directed staff to administer quetiapine (an antipsychotic medication), 50 milligrams (mg), by mouth, twice per day, for dementia with psychotic disturbance. The Physician's Order, dated 10/21/22, directed staff to administer divalproex sodium (a medication used to prevent seizures and also used for mood and behaviors), 125 mg, by mouth, twice per day, for agitation. The Physician's Order, dated 12/13/23, directed staff to administer vilazodone (an antidepressant medication), 40 mg, by mouth, daily for depression. The Physician's Order, dated 02/06/24, directed staff to administer Remeron (an antidepressant medication), 7.5 mg, by mouth, at bedtime for appetite stimulant. The Physician's Order, dated 08/12/24, directed staff to administer continuous oxygen via nasal cannula at 2 Liters to keep saturation above 90%, notify the physician of all changes, and monitor her saturation every shift for COPD. The Nurse's Note, dated 02/14/24 at 01:46 AM, documented R22 was combative with staff at dinner. She yelled, Help! Help!, spit her food at the Certified Nurse Aide (CNA), and attempted to hit the CNA. R22 was put to bed early but continued to hit both CNAs. The Nurse's Note, dated 07/28/24 at 10:50 PM, documented that R22 was combative when assisted to bed. She bit and pinched the CNA. The Nurse's Note, dated 08/01/24 at 02:12 AM, documented R22 bit, kicked, and pinched staff during care, and received an abrasion (scrape) to her right foot. R22 was placed into bed and offered water; staff put her bed in a low position with a blue mat. The Nurse's Note, dated 08/12/24 at 10:39 PM, documented R22 yelled Help! for hours and started to lose her voice. Staff checked on R22 every 30 minutes as she tried to self-transfer out of bed. The note documented that R22 tried to bite, punch, and dig her nails into staff when she was toileted. The Nurse's Note, dated 08/25/24 at 02:34 AM, documented that R22 yelled most of the day and hit and bit staff members during care. On 08/26/24 at 11:18 AM, observation revealed R22 sat at the dining table and yelled Help! Help! over and over. Certified Nurse Aid (CNA) M went to the table and asked R22 if she needed something, called her Honey multiple times, and offered to take her into the living room area to watch television. CNA M asked R22 if she wanted to watch Little House on the Prairie, and R22 stated Yes. CNA M did not change the channel to the television show R22 wanted to watch, but stated, Oh here's a farm show you would like, can I transfer you into the recliner Honey? R22 continued to yell Help and CNA made a shushing noise towards R22. CNA M stated, Let me know if you want the channel changed and she walked away. Continued observation revealed R22 started to yell, Help! Help! CNA M went to her and stated Did you not like this show Honey R22 stated, NO! CNA M asked R22 if she wanted the channel changed to Little House on the Prairie and R22 stated Yes. CNA M changed the channel to a movie and did not change it to the program R22 wanted to watch. CNA M stated she did not know why she did not change the channel to the program R22 wanted to watch and stated that R22 had refused her oxygen earlier, so she did not bring it to the table. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 12:23 PM, the Meadowlark House dining room had residents waiting for the noon meal, and two CNAs present. One CNA cooked the meal, and one assisted the residents. R22 sat at the dining table and yelled Help! I need to go to the bathroom! loudly and as staff did not respond, the level of need in her voice raised as she continued to say she needed to go to the bathroom. Continued observation revealed CNA O looked over at the resident but did not respond to her, went into the kitchen area, and told the second CNA that R22 needed to go to the bathroom but neither CNA responded to R22. Observation revealed at 12:39 PM, R22 continued to request toileting and would often yell Help! Help!. CNA O went over to the resident and placed a blanket around her shoulders but did not offer toileting. Continued observation revealed CNA O fixed herself a plate of food took it into the nurse's room and shut the door. At 01:00 PM, CNA O came out of the room and when questioned stated R22 would be toileted when the residents were done with the meal. CNA O further stated that there were only two CNAs working in the house that day, and R22 required the assistance of two staff. CNA O said that R22 was a check and change and did not sit on the toilet. On 08/27/24 at 09:05 AM, observation revealed R22 at the dining table, yelling Help! Help! over and over. R22 looked over at another table with residents talking, and started to yell, Shut up! shut up! R22 continued to yell Help! and then yelled Shut up if anyone responded to her. The staff did not offer any other alternatives except food and fluids. R22 continued to yell throughout meal service until Consultant GG entered the household and offered to take R22 outside. On 08/28/24 at 09:31 AM, observation revealed R22 at the dining table continuously yelling Help! or Shut up! Staff offered her food but she did not want anything. R22 started to spell out her name, and then say her name out loud and another resident tried to talk to her but R22 told her to Shut up! Observation revealed at 09:30 AM, CNA Q removed R22's oxygen and placed the tubing in the bag on the concentrator. CNA Q took R22 to her room for care, then brought her back and tried to put R22's oxygen on and R22 would not let her so CNA Q laid the oxygen tubing in R22's lap. On 08/28/24 at 09:23 AM, CNA P stated she did not know what interventions to offer R22 when she had behaviors but said she would offer her food and fluids. On 08/28/24 at 09:30 AM, CNA Q stated this was her first day in the house and that she was unsure what interventions to offer R22 when she had behaviors. CNA Q further stated they receive dementia training prior to working and they are given a list of residents and how to care for them when they come on shift. On 8/28/24 at 03:45 PM, Licensed Nurse (LN) G stated staff should have called her to assist R22 with toileting. LN G stated the staff should engage with R22 and talk with her when she gets upset, especially about her farm and cat. On 08/28/24 at 04:00 PM, Certified Medication Aide (CMA) R stated the medication aides help the CNAs if they need anything and said she would assist with R22 if needed. On 8/29/24 at 11:30 AM Administrative Nurse D stated staff should have tried to get the show she wanted on TV and should offer her the activity box they have for her. Administrative Nurse D further stated staff should try to sit down and talk to her. Administrative Nurse D stated all staff gets dementia with behavior training. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Dementia- Clinical Protocol, dated 11/2018, documented individuals with confirmed dementia the staff would identify a resident-centered care plan to maximize remaining function and quality of life. The nursing assistants would receive initial training in the care of residents with dementia and related behaviors and services would be conducted annually thereafter. Interventions and the overall plan would be adjusted depending on the resident's progression of dementia. The facility failed to provide dementia care and services for R22 in order to promote and maintain R22's highest practicable well-being. This placed R22 at risk for abuse and decreased quality of life.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 32358 The facility had a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 44 residents who resided in the facility and received meals from the facility's kitchens. This placed the residents at risk for inadequate nutrition. Findings included: - On 08/27/24 at 11:22 AM, a review of the noon meal consisted of chicken parmesan, buttered penne pasta, asparagus tips, fruit crisp, and garlic toast. On 08/27/24 at 11:30 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 08/26/24 at 08:00 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she had enrolled in the classes. On 08/29/24 at 07:15 AM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification. The facility's Dietitian Policy, revised in November 2022, documented that if a dietitian is not employed full-time (35 or more hours per week) a director of food and nutrition services would be designated. This individual would: Be a certified dietary manager or be a certified food service manager or be nationally certified in food service management and safety; or Had an associate's (or higher) degree in food service management or hospitality, if the course includes food service or restaurant management from an accredited institution; or Had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management, by no later than October 1, 2023, that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing, receiving; and met any state requirement for food service or dietary managers; and received frequently scheduled consultations from a qualified dietitian or qualified nutrition professional. The facility failed to employ a full-time certified dietary manager for 44 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk of not receiving adequate nutrition.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32358 The facility had a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview the facility kitchen staff failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance when dietary staff failed to prepare all the food items on the noon menu while preparing Resident (R) 20 and R22's pureed diet. This placed the residents at risk for impaired nutrition. Findings included: - On 08/27/24 at 11:22 AM, a review of the noon meal consisted of chicken parmesan, buttered penne pasta, asparagus tips, fruit crisp, and garlic toast. On 08/27/24 at 11:22 AM, Dietary Staff (DS) CC reported the Meadowlark Kitchenette had two residents who received a pureed diet. DS CC stated staff only prepared mashed potatoes and gravy for R22 at the noon meal and R20 would receive the full pureed diet. DS CC placed a 4-ounce (oz) piece of chicken parmesan into the blender container, added two (8 oz) ladles of red marinate sauce into the container, and blended it. DS CC reported it was still too thick and added another 8-oz ladle of marinate sauce, then blended to the consistency of mashed potatoes. Further observation revealed DS CC placed an unmeasured amount of hot water into a bowl added an unmeasured amount of boxed potato flakes and stirred with a fork. Continued observation revealed at 12:13 PM, DS CC retrieved two bowls, placed them on the counter, and then placed two (4oz) scoops of cooked noodles into the blender. DS CC blended, then added one (4oz) scoop of hot water from the noodle pan and blended to the consistency of mashed potatoes. When asked about the other food items on the menu, DS CC stated she would not prepare the bread, asparagus, or the fruit crisp for the residents who were on a pureed diet; they would receive protein ice cream as their dessert and a can of V8 juice (a juice made mainly from water and tomato concentrate, and concentrate of eight vegetables, specifically: beets, celery, carrots, lettuce, parsley, watercress, spinach, and tomato). Further observation revealed DS CC retrieved a 5.5 milliliter (ml) can of V8 juice, poured it into a glass, and served it to R20. On 08/27/24 at 12:45 PM, Dietary Manager BB verified DS CC had not prepared all the food items for R20 and R22's pureed diet. On 08/28/24 at 01:15 PM, Registered Dietitian CC stated he expected staff to prepare the same food items on the menu for the residents who received a pureed diet as the other residents, but V8 juice was a good vegetable replacement. Upon request, the facility did not provide a pureed diet recipe. The facility kitchen staff failed to puree all the food items on the noon menu in one of three kitchenettes. This placed R20 and R22 at risk for impaired nutrition.

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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. 32358 The facility had a census of 44 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This placed the residents who received their meals from the facility's kitchens at risk for foodborne illness. Findings included: - On 08/26/24 at 11:48 PM observation of the noon meal, in the Sunflower House, revealed the following: Dietary Staff (DS) DD applied gloves and touched the refrigerator, counter, and pans. Then, wearing the same soiled gloves, DS DD touched a resident's roast beef while cutting it up, and then continued to serve residents their plates. Further observation revealed DS DD, with the same soiled gloves, took a baked potato out of the oven, placed it on a resident's plate, and held onto it while cutting it. Further observation revealed DS DD continued the same process, with the same soiled gloves, when plating the other residents' roast beef and baked potatoes. Continued observation revealed DS DD, wearing the same soiled gloves, wiped her right gloved hand across her nose and then served strawberry shortcakes to each resident at the dining room table. After serving the cake, DS DD removed and discarded the gloves. DS DD applied new gloves and touched the cabinets, touched the refrigerator handle, then with the same soiled gloves, used her hands to take two slices of bread out of the toaster and place them on a plate. DS DD touched the refrigerator handle, took mayonnaise out of the refrigerator, touched the jar, and then held one slice of toast at a time in her left hand while she spread mayonnaise on the two slices of toast with her right hand. Continued observation revealed DS DD, with the same soiled gloves, took the roast beef, placed it on one slice of toast, and then placed the other slice of toast on top of the roast beef, placed mayonnaise on the bread, and then placed on a plate and served to a resident. A review of the Cottonwood House kitchenette logs revealed missing documentation on the following dates in August 2024 for the kitchen refrigerator, kitchen freezer, pantry refrigerator, pantry freezer, small juice refrigerator, food, and dishwasher temperatures, and the sanitizer parts per million (PPM) tests for the dishwasher: 08/01/24-pureed diet temp, ground, casserole temp, meat temp, vegetable temp, starch temp dessert temp, dishwasher, and PPM for breakfast and lunch 08/02/24-breakfast, lunch, dinner-all temperatures and PPM tests 08/03/24- breakfast, lunch, -all temperatures and PPM tests 08/04/24-breakfast, dinner-all temperatures and PPM tests 08/05/24-breakfast, lunch, dinner all temperatures, and PPM tests (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	08/06/24-breakfast, lunch and dinner-all temperatures and PPM tests 08/07/24-breakfast, all lunch food temps missing 08/08/24-breakfast, lunch purred and ground, dinner all temperatures and PPM tests 08/09/24-breakfast, lunch, dinner all temperatures, and PPM tests 08/10/24-breakfast meat, vegetable, starch dessert, dinner all temperatures and PPM tests 08/11/24-breakfast, lunch, dinner -all meals temperatures and PPM tests 08/12/24-breakfast and lunch all temperatures and PPM test, dinner pureed and ground dishwasher temp 08/13/24-breakfast, lunch, and dinner all meals temperatures and PPM test 08/14/24-breakfast and lunch all temperatures and PPM tests 08/15/24-breakfast food items, dishwasher temperatures PPM 08/16/24-breakfast, lunch, and dinner all temperatures and PPM tests 08/17/24-breakfast and lunch, all temperatures and PPM tests 08/18/24-breakfast, lunch, dinner all temperatures, and PPM tests 08/19/24- lunch and dinner all temperatures and PPM tests. 08/20/24-breakfast -pantry refrigerator, pantry freezer, small juice refrigerator, food items temperature, and PPM test, lunch- pantry refrigerator, pantry freeze, small juice refrigerator temperatures and PPM tests and dinner all temperatures and PPM tests 08/21/24-breakfast and lunch, all temperatures and PPM tests 08/22/24- breakfast and lunch, all temperatures and PPM tests On 08/27/24 at 0154 PM, DM BB verified the lack of documentation in the above findings and stated administrative staff had identified the lack of documentation and were working on a new form for staff to document on. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/27/24 at 12:13 PM, observation in the Cottonwood House during the preparation of the pureed diets, DS CC retrieved two bowls, placed them on the counter, placed 2(4oz) scoops of noodles into a blender, blended, added 1 (4oz) scoop hot water from the pan the noodles were cooked in, blended to the consistency of mashed potatoes. DS CC left the blender container used to puree the noodles on the blender and the lid upside down on the counter. Further observation revealed at 12:35 PM, DS CC reported the facility had one ground meat diet, placed a chicken breast into the same soiled blender used to puree the noodles, blended to ground consistency, placed the ground chicken on a plate, and served it to a resident. Continued observation revealed at 12:45 PM, DS BB pushed an uncovered food tray cart down the hall to two residents' rooms. At 12:50 PM, DS BB verified she had delivered the uncovered room trays to the residents and stated she was told that staff did not have to cover the trays when delivering them down the hall due to the house being a homelike setting. On 08/28/24 at 10:23 AM, observation in the Meadowlark House dry storage room refrigerator revealed a turkey breast and a package of pork chops thawing in the same pan. The refrigerator lacked thermometers in the refrigerator and freezer. DS EE verified the finding and stated the turkey breast and pork chops should be in separate pans and the refrigerator and freezer should have backup thermometers. Observation revealed DS EE retrieved a new pan and placed the turkey breast in the pan. On 08/28/24 at 01:15 PM, Registered Dietician (RD) HH stated he expected staff to put different food items in a different pan when storing them in the refrigerator. RD HH stated staff, when plating and serving a resident's food items, should have all the items needed for the meal out of the refrigerator and should change gloves and wash hands, then deglove between tasks. RD HH stated staff should cover food items when delivering them down the hall. RD HH stated staff should record the temperatures of all refrigerators and freezers, and check PPM tests daily. The facility's Food Preparation and Service Policy, revised in November 2022, documented Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Food preparation staff should adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. The policy documented that when serving residents in a dining room or outside a resident's room where trained staff are serving food/beverage choices directly from a mobile food cart or steam table, there is no need for food to be covered. However, food should be covered when traveling a distance (down a hallway, to a different unit or floor). The policy documented that when verifying food temperatures, staff use a thermometer that is clean, sanitized, and calibrated to ensure accuracy. The policy documented that raw meat should be stored separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigerator. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. The facility's Refrigerators and Freezers Policy, revised in November 2022, documented the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and would observe food expiration guidelines. Monthly tracking sheets for all refrigerators and freezers would be posted to record temperatures. The sheets include time, refrigerator temperature, temperature of potential hazardous food (PHF), and Time/temperature control for safety (TCS) food with initials. The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This placed the residents at risk for foodborne illness.

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	08/29/2024

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 32360 The facility had a census of 44 residents. Based on interviews and record review the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter (Q) 3 indicated no licensed nurse coverage on seven dates. The PBJ report for FY 2023 Q4 recorded no licensed nurse coverage on nine dates. The PBJ report for FY 2024 Q2 recorded no licensed nurse on four dates. A review of the facility licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 08/28/24 at 07:58 AM, Administrative Staff A stated the information for the PBJ was submitted from someone off campus and she did not realize there were submission problems. Administrative Staff A further stated there was always a licensed nurse in the building and they have more registered nurses than they used to, so she was unsure why the PBJ showed they did not have licensed nurses in the building each day. The facility's Reporting Direct Care Staffing information was reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. Staffing information was collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility identified a census of 44 residents. The sample included 12 residents with five residents reviewed for immunizations to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, or obtain an informed declination or a physician-documented contraindication for the pneumococcal PCV20 vaccination to Resident (R) 9 per the latest guidance from the Centers for Disease Control and Prevention (CDC). This placed the resident at risk for pneumococcal infection and related complications. Findings included: - R9's Admission Minimum Data Set, dated dated dated [DATE] documented R9 admitted to the facility on [DATE]. The MDS documented R9 received the influenza (flu) vaccine before admitting to the facility. The MDs documented R9's pneumococcal vaccination was not up to date, and was not offered. A review of R9's clinical medical records lacked evidence the facility offered and received the vaccination or of a signed declination for the PCV20 vaccine. On 08/28/24 at 11:48 AM, Administrative Nurse D stated she could not find any documentation that R9 was offered the PCV20 on admission but stated the resident had an influenza vaccine prior to admission. Administrative Nurse D stated the pharmacy keeps track of which immunizations residents are eligible for. The facility's Pneumococcal Vaccine Policy, revised in October 2023, documented all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated are offered the vaccine series within thirty day (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. The facility failed to offer R9 the PCV20 pneumococcal vaccination. This deficient practice placed the resident at risk of acquiring, spreading, and experiencing complications from pneumonia.