

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Topside Manor Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to store and serve food under sanitary conditions and with professional standards of food service safety by failing to document food temperatures for each meal, failing to date open food items, and failing to cover food items transported throughout the facility. Findings included: - Upon the initial tour of the facility's three kitchens, each kitchen revealed several items in each refrigerator that were not dated when opened. These items were as follows: Boxes of orange juice and apple juice Bottles of cranberry juice Gallon jugs of milk Bottles of mustard (different flavors) Bottles of ketchup Bottles of soy sauce Jars of mayonnaise Cans of [NAME]-Whip Salad dressings (several varieties) Review of the food temperature logs for one of the three kitchens revealed the notebook contained breakfast and lunch meal temperatures from July 2026. The following dates had no temperatures documented: 07/01/2026-07/02/2026 breakfast and lunch 07/06/2026-07/10/2026 breakfast and lunch (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	07/11/2026-07/13/2026 lunch 07/18/2026-07/19/2026 breakfast and lunch The log lacked evidence supper meal temperatures were assessed. During an interview on 07/21/2026 at 11:45 AM, Dietary CC stated she was aware of the food items not being dated upon opening, and the incomplete meal temperature logs. She stated the facility had an ongoing Performance Improvement Plan (PIP) related to the issues. She presented an undated PIP. During an interview on 07/21/2026 at 12:01 PM, Administrative Staff A stated she was aware this issue continued to be ongoing and said she expected to see better results by now. - On 07/21/2026 at 12:05 PM, Dietary Staff (DS) BB prepared the midday meal, plated the food, and put it on a cart for transportation to a resident's room. The cart had two beverages on it also. A different staff member came and took the cart with the uncovered food and drinks to a resident's room. On 07/22/2026 at 08:18 AM, DS BB prepared a breakfast meal, placed it on a cart, along with two cups of liquid. Certified Nurse Aide (CNA) O came and took the food and drinks to a resident's room uncovered. CNA O verified the plate and cups were not covered. DS BB verified the meal should be covered when transporting room tray meals. The facility's undated Food Preparation and Service policy stated food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Food distribution means the processes involved in getting food to the residents. When meals are assembled in the kitchen and then delivered to residents' rooms or dining areas are to be distributed, covering food is appropriate, either individually or in a mobile food cart.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to implement adequate infection control practices when staff failed to wear gloves when administering nasal spray for Resident (R) 34 and did not clean the applicator before and after use. The facility failed to ensure R4's nasal cannula (NC - a thin hollow tube that assists in providing supplemental oxygen) was stored in a sanitary manner when not in use, and continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) equipment for R4, R26 and R12 was cleaned and stored in a sanitary manner when not in use. The facility failed to implement adequate hand hygiene during care for R12. Findings include: 1. On 07/21/2026 at 09:12 AM observation revealed Certified Medical Assistant (CMA) R administered nasal spray into each nostril for R34 without performing hand hygiene or using gloves. CMA R then recapped the nasal spray without cleaning the applicator after use. In an interview on 07/21/2026 at 09:15 AM, CMA R stated gloves are supposed to be worn when administering nasal spray to residents. 2. An observation on 07/21/2026 at 03:56 PM revealed R4 sat in her room in a recliner watching tv. R4's CPAP mask lay next to machine on her nightstand. There was no bag present for sanitary storage. On 07/21/2026 at 03:58 PM, R4 stated she wished staff would clean her CPAP mask or give her a wipe so she could clean it. During an observation on 07/22/2026 at 7:32 AM, R4's CPAP machine was running, and the mask hose was on top of nightstand and oxygen nasal cannula tubing was coiled on the floor. 3. An observation on 07/21/2026 at 07:40 AM revealed resident barely awake in his recliner, wearing nasal cannula for oxygen, and the CPAP mask was on the nightstand. On 07/21/2026 at 07:48 AM, R26 stated he was supposed to be wearing his CPAP mask every night, but he did not think staff cleaned it. On 07/21/26 at 11:36 AM, Licensed Nurse (LN) G stated oxygen tubing and CPAP masks should be contained in a bag when not in use, which should be dated as to when the tubing was last replaced. On 07/22/2026 at 09:14 AM, Administrative Nurse D verified the respiratory equipment should be bagged while not in use. The Facility Assessment dated 08/2025 documented that, as part of an ongoing commitment to maintain the highest standards of care and ensure the safety and well-being of the residents and staff, the facility implemented comprehensive infection control policies and procedures. These measures were designed to prevent and manage infections effectively within the facility. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Personal Protective Equipment- Gloves, dated 2025, documented all personnel must wear gloves when exposed to blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin, and when performing device care. No policy for oxygen tubing storage was provided upon request. - On 07/21/2026 at 08:30 AM, Certified Nurse Aide (CNA) M knocked on R12's door and asked R12 if he was ready to get up. R12's wheelchair had an oxygen tank on the back, and the NC and tubing were wrapped around the top of the tank rather than stored in a bag. R12 had NC and tubing that was connected to an oxygen concentrator (a machine that provides supplemental oxygen). Certified Nurse Aide (CNA) M donned a clean gown and gloves and raised R12's bed. CNA M lowered R12's sweatpants and removed the soiled incontinence brief. CNA M provided peri care, put on a new brief, and pulled up the resident's sweatpants with the same soiled gloves. Continued observation revealed CNA M put the mechanical lift (a mobility device used to transfer individuals who cannot bear their own weight) under R12, removed his NC, and dropped it onto a black box that was beside his bed. The CNA attached the sling to the lift and transferred R12 into his wheelchair while wearing the same soiled gloves. R12 asked CNA M to turn off his air conditioner, and CNA M went and turned it off while still wearing the soiled gloves. On 07/21/2026 at 08:45 AM, CNA M stated she should have changed her gloves and washed her hands before she put the new incontinence brief on the resident and asked if it would help if she went back into the room and wiped down the areas she had touched with a Sani wipe (professional grad premoistened disposable wipe primarily used to clean, sanitize, and disinfect hard, non-porous surfaces and medical equipment). On 07/21/2026 at 02:15 AM, Licensed Nurse (LN) G stated that residents who had supplemental oxygen should have a clean bag for the NC and tubing to be stored in when not in use. LN G verified R12's tubing was not in a bag. On 07/22/2026 at 09:25 AM, Administrative Nurse D stated that the CNA should have changed her gloves and sanitized her hands before putting on R12's clean incontinence brief and stated that NC and tubing should be stored in clean bags when not in use. The facility's Personal Protective Equipment-Gloves policy, dated 12/2025, documented that gloves are used only once and discarded after use. Gloves do not replace the need for hand hygiene. Hand hygiene is always performed immediately before donning gloves and immediately after the removal of gloves. Gloves are removed, hand hygiene performed, and clean gloves are applied when moving from a contaminated body site to a clean body site on the same resident and when gloves become heavily soiled, torn, or ripped. The Facility Assessment dated 08/2025 documented that, as part of an ongoing commitment to maintain the highest standards of care and ensure the safety and well-being of our residents and staff, we have implemented comprehensive infection control policies and procedures. These measures are designed to prevent and manage infections effectively within the facility.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident (R)39 was free from antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality) without an appropriate indication of use or a physician-documented rationale, including risks versus benefits. Findings included:- R39's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion)with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), pain, chronic kidney disease, insomnia (inability to sleep), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and adjustment disorder mixed with anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depressed mood. R39's Significant Change Minimum Data Sheet (MDS), dated [DATE], documented R39 had severe cognitive impairment and required substantial/maximal assistance with functional abilities and mobility. R39 received a scheduled pain medication regimen, an antipsychotic, and an antidepressant (a class of medications used to treat mood disorders). The antipsychotics were received on a routine basis only. A gradual dose reduction (GDR) had been attempted on 04/17/2026. There was no physician documentation that it was clinically contraindicated. The Psychotropic Medication Care Area Assessment (CAA), dated 05/14/2026, documented R39 had unspecified dementia with agitation and behavior disturbance. R39 took Seroquel (an antipsychotic) for dementia with behaviors. R39's Care Plan dated 05/13/2026 documented R39 used Seroquel related to behavior management. The plan directed staff to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least every quarter, monitor for side effects, and occurrence of target behaviors symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression toward staff and others. The Physician Order dated 03/10/2026 directed staff to administer Paxil (an antidepressant) 40 milligrams (mgs) in the morning for sexual behaviors related to dementia. The Physician Order dated 05/27/2026 directed staff to administer Seroquel 25 mg at bedtime related to dementia. The Consulted Pharmacist (CP) report dated 03/17/2026 reported R39 received Paxil for sexual behaviors and to reevaluate use of Paxil and document a clinical contraindication for a gradual dose reduction (GDR). The physician declined the recommendation due to adjusting other medications. The CP report dated 04/13/2026 documented R39 had a diagnosis of dementia and received Seroquel and to evaluate the continued use. The physician response declined the recommendation and did not want to implement any changes due to decreasing the dose. The Progress Note dated 06/20/2026 at 10:52 AM documented R39 was seen by the contracted psychiatrist, and the plan of care was ongoing. On 07/20/2026 at 02:34 PM, R39 independently wheeled himself to his room, and an audible alarm sounded. Staff ran to check R39 and then encouraged him to participate in a game with another resident in the private dining area of the house. On 07/21/2026 at 11:46 AM, Certified Medication Aide (CMA) R reported R39 exhibited behaviors of being awake for up to 24 hours at a time, attempted to go into other residents' rooms, and at times was difficult to redirect. On 07/22/2026 at 09:20 AM, Administrative Nurse D reported R39 had returned from a geriatric psych unit for behaviors and returned with the Seroquel order for dementia. Administrative Nurse D verified a lack of documentation related to the indication of use or risk versus benefit statement. The facility's Psychotropic Medication Use policy dated 02/2025 documented that residents do not receive (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. If psychotropic medication is prescribed or administered as a substitute or adjunct for psychotropic medication, there is a documented clinical rationale, the medications are monitored and managed as psychotropic medication.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 8, who was at risk for falls and had wounds on her feet, had foot pedals on her wheelchair before staff propelled her out of her room. Findings included:- The Electronic Medical Record (EMR) for R8 had diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), restlessness and agitation, a history of falls, arterial ulcers (open sores caused by poor circulation and tissue oxygen deprivation), and hereditary spastic paraplegia (a group of rare genetic disorders where upper motor neurons in the brain and spinal cord slowly degenerate).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent upon staff for all activities of daily living except for setup assistance for eating. R8 had lower functional impairment on both sides, had one fall, and did not ambulate.R8's 07/16/2026 Care Plan, initiated on 04/02/2026, directed staff to remove wheelchair pedals when the resident was in her room but have them on while pushing her in her wheelchair.On 07/20/2026 at 10:30 AM, Certified Nurse Aide (CNA) Q told R8 to raise her feet so she could push her to the dining room table. R8 lifted her feet, which were barely off the ground, and she was taken to the dining room table.On 07/20/2026 at approximately 01:30 PM, a facility staff member pushed R8 in her wheelchair, without foot pedals, down the hall by the conference room. R8's feet were barely off the floor.On 07/21/2026 at 09:23 AM, CNA M told R8 to lift her feet and wheeled her to the table. R8 stated that her foot hurt and thought they had put her shoe on too tight.On 07/21/2026 at 03:39 PM, CNA N stated that when R8 was in her room, she did not need her foot pedals on her wheelchair because she moves around, but family wanted staff to make sure they put foot pedals on when she was out of her room and staff were pushing her.On 07/22/2026 at 02:15 PM, Licensed Nurse (LN) G stated that R8 was to have her foot pedals on the wheelchair whenever staff pushed her, except when she was in her room.On 07/22/2026 at 09:25 AM, Administrative Nurse D stated foot pedals should always be on the wheelchair when staff were pushing any resident in the facility.The facility's Falls and Fall Risk, Managing policy, dated 03/2018, documented that staff would identify interventions related to specific risks and causes to try to prevent the resident from falling or sustaining injuries.		

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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** Based on observation, interview, and record review, the facility failed to store the oxygen nasal cannula and nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) treatments in a sanitary manner for Resident (R) 43, who had been treated for respiratory infections. Findings included:- R43's Electronic Medical Record (EMR) documented diagnoses fluid overload, dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic obstructive pulmonary (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) disease, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R43 had moderately impaired cognition. R43 was dependent on staff for functional abilities and mobility, with the exception of partial/moderate assistance with eating. R43 had shortness of breath or trouble breathing when lying flat. The MDS further documented R43 received insulin, anti-anxiety medication, antidepressant medication, anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (a class of medications used to lower blood sugar levels), and anticonvulsant medication. R43 received oxygen therapy. R43's Care Plan dated 06/10/2026 documented R43 had altered respiratory status/difficulty breathing related to COPD. The plan directed staff to administer medications/puffers as ordered and monitor them for effectiveness and side effects; monitor for signs or symptoms of respiratory distress and notify the physician. The plan further documented the oxygen settings via nasal cannula at one to four liters to titrate to about 90 percent throughout the day if needed. The oxygen setting was two liters at all times via nasal prongs/mask. The Physician Orders dated 10/25/2025 directed staff to change nebulizer tubing and supplies every Sunday night for infection control related to COPD. The Physician Order dated 10/25/2025 directed staff to change the oxygen tubing and storage bag every Sunday night shift related to COPD. The Physician Order dated 11/15/2025 directed the staff to titrate oxygen to one to four liters to maintain oxygen saturations above 90% if needed and notify the physician of all changes or initiation of oxygen therapy related to COPD. The Progress Note dated 03/31/2026 at 04:44 PM documented R43 was seen by the provider and had been ordered to administer Azithromycin (an antibiotic) 500 milligrams (mgs) daily for five days and Amoxicillin (an antibiotic) 500 mgs three times a day for ten days with the diagnosis of pneumonia. The Progress Note dated 07/10/2026 at 12:15 PM documented the physician ordered doxycycline (antibiotic) 100 mg twice a day for ten days for an upper respiratory infection. On 07/21/2026 at 08:55 AM, R43 was brought to the dining room in her wheelchair. R43 was dressed and groomed for the day. R43 had a nasal cannula attached to R43's nose. The oxygen flow rate was two liters. On 07/21/2026 at 11:44 AM, R43 sat in her room in a recliner with her feet elevated, eyes closed; she received oxygen per nasal cannula. R43's nebulizer mask and medication dispenser were lying on the bedside stand uncovered and unbagged. On 07/21/2026 at 01:44 PM, R43 sat in her room in her wheelchair with the nebulizer treatment running. R43's oxygen concentrator was sitting next to her with the oxygen nasal cannula coiled on top of the handle, unbagged. Certified Medication Aide (CMA) R reported the licensed nursing staff administered the nebulizer treatments. On 07/21/2026 at 02:15 PM, Licensed Nurse (LN) G stated that oxygen tubing should be bagged when not in use, as well as the other oxygen equipment when not in use. On 07/21/2026 at 03:22 PM, R43 rested in bed with (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her eyes closed wearing an oxygen cannula. The nebulizer mask and medication dispenser lay unbagged atop the nebulizer machine. On 07/22/2026 at 07:43 AM, staff were in R43's room, dressing and grooming the resident for the day. Certified Nurse Aide (CNA) O left the room, guiding the oxygen concentrator with her right hand, and in her left hand had a bag of trash with the nasal cannula, touching the trash bag. The concentrator did have a clear bag attached to the machine. CNA O deposited the trash bag; she then took the concentrator to the dining room and draped the nasal cannula onto the seat of a chair next to R43's table place. On 07/22/2026 at 09:14 AM, Administrative Nurse D verified the respiratory equipment should be bagged while not in use, including transportation. Administrative Nurse verified R43 had a history of respiratory infections. The Facility Assessment dated 08/2025 documented that, as part of an ongoing commitment to maintain the highest standards of care and ensure the safety and well-being of our residents and staff, we have implemented comprehensive infection control policies and procedures. These measures are designed to prevent and manage infections effectively within the facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store drugs and biologicals adequately for Resident (R) 43 when staff failed to date an insulin when it was opened. Findings included:- On 07/21/2026 at 07:45 AM, Licensed Nurse (LN)G was preparing R43's insulin for administration. Upon review of the Novolog (fast acting insulin) insulin pen, the pen lacked a date when the pen was opened and placed in use. LN G verified the policy of the facility was to date the insulin pens when opened for use. On 07/22/26 at 12:45 PM, Administrative Nurse D verified the insulin should have been dated. Medlineplus.gov directs open, unrefrigerated Novolog, Humalog, and Lantus can be used within 28 days; after that time, they must be discarded. The facility's Medication Labeling and Storage policy, dated 02/2023, documented that multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for an open vial.		