STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175418	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Living Center	1112 SE Republican Avenue Topeka, KS 66607

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to ensure staff monitored and reported lab results to the provider as they became available in order to treat Resident (R) 1's urinary tract infection (UTI). This placed the resident at risk of ongoing pain with urination, agitation, and confusion related to delayed treatment of a UTI. Findings included:- R1's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure) and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS noted the resident required substantial assistance with oral hygiene, personal hygiene, and dressing. The resident was dependent on staff assistance for toileting and bathing.R1's Care Plan initiated on 09/13/21 and revised on 02/12/24 noted the resident had an activities of daily living (ADL) self-care deficit. An intervention revised 02/04/25 directed staff the resident required substantial to maximum assistance with toileting. The plan documented R1 was at risk for low potassium levels and directed staff to obtain lab and diagnostic work as ordered by the physician. The plan lacked interventions related to UTI.R1's EMR recorded a Nursing: Progress Note dated 07/14/25 at 11:56 AM that noted the provider saw R1 that day, and the resident reported she felt burning when urinating. The note documented the provider gave a verbal order for a urinalysis (UA) with culture (C&S) for 07/16/25.R1's Progress Note dated 07/15/25 at 11:00 PM documented a telehealth date of service of 07/16/25. The note documented a diagnosis code for dysuria (painful urination) and listed a plan for a UA with C&S. It noted the UA showed 3+ leukocytes (a type of white blood cell that may indicate UTI when found in urine) and stated Await C&S.R1's Urine Culture documented a collection date of 07/15/25 and a result date of 07/18/25. The report identified the organism of Escherichia coli ESBL (E. coli- a type of bacteria) and listed the antibiotics which the bacteria was sensitive to and resistant to.R1's Progress Note dated 07/21/25 at 07:00 AM noted the provider saw R1 for agitation and confusion. The provider documented the UA resulted with 3+ leukocytes, but no C&S was found. The note documented the provider requested the facility nurse check with the lab as to when the C&S would be back and with results, or if not run by the lab. The exam recorded suprapubic (body area where the bladder is located) tenderness and agitation. The note further documented the UA culture was not seen nor reported to the provider in results, as it was hooked and resulted in the already reviewed UA that was reviewed on 07/16/25 and not flagged as new lab; R1's confusion and agitation continued.R1's Encounter note dated 07/22/25 at 07:00 AM recorded a telehealth visit where the provider spoke with the facility Director of Nursing (DON) about R1's UA C&S. The UA C&S had not been seen nor reported to the provider as it was hooked to the UA that was reviewed on 07/16/25. The note documented the provider does R1 with ertapenem (an antibiotic used to treat severe infections) intravenously (IV- administered directly into the bloodstream via a vein).R1's Nursing note dated 07/22/25 at 03:16 PM documented the lab results were sent to the provider. R1's 'Physician Progress Note dated 07/22/25 at 03:57 PM documented the provider just received the results of the UA C&S showing E. coli ESBL and would start ertapenem IV; if the IV could not remain in, staff were to send R1 to the emergency room. The note documented the provider asked the DON to allow the provider to be the one to review and check off on lab results, and also to place a hard copy of the lab to place in the provider's inbox at the facility, and that abnormal labs be communicated to the provider through the chat system.R1's Nursing: Infection Note dated 07/25/25 at 10:48 PM noted R1 continued on ertepenam for a UTI and the resident remained confused.On 08/25/25 at 12:33 PM, R1 was in bed asleep.On 08/25/25 at 06:22 PM, Licensed Nurse (LN) G stated that lab results should populate in the system so providers can see the results from there; the nurse can see them there as well. She stated the nurses have communication logs they can use to track labs or keep track of labs they are waiting for. She stated the facility has an easy chat program so they can communicate with the provider through that about the labs. LN G said, regardless of the way it is communicated, if a provider is waiting for a lab, the nurses should keep an eye out for the results, even if the result did not show up in the system as a new result. LN G said if they knew a provider was waiting for a result, the nurses should check on it. She stated the nurses have communication sheets they pass on to ensure continued care between the nurses. LN G said she would notify the provider if she obtained lab results.On 08/25/25 at 06:49 PM, Administrative Staff A stated the facility used a lab that

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72. The sample included three residents. Based on observation, record review, and interviews, the facility failed to follow physician-ordered parameters regarding medication monitoring for Resident (R) 1. This placed the resident at risk for medication-related complications and adverse effects. Findings included:- R1's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN-high blood pressure) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS noted the resident required substantial assistance with oral hygiene, personal hygiene and dressing. The resident was dependent on staff assistance for toileting and bathing.R1's Care Plan initiated on 09/13/21 and revised on 01/30/24 documented the resident had hypertension and was at risk for side effects related to medication. An intervention dated 09/13/21 directed staff to give anti-hypertensive medications as ordered and monitor for side effects such as orthostatic hypotension (blood pressure drops upon standing) and increased heart rate and to monitor effectiveness.R1's Care Plan initiated on 09/13/21 and revised on 02/04/25 noted the resident had DM and was at risk for side effects related to metformin (medication used to lower blood sugar). An intervention dated 05/13/25 directed staff to administer medication as ordered by the physician and monitor for side effects.R1's EMR recorded the following orders under the Orders tab:Amlodipine besylate (medication used to treat HTN) give 10 milligrams (mg) one time daily for HTN; see hold parameters. Hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 millimeters (mm) of Mercury (Hg), diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was less than 50 mm/HG or heart rate was less than 50 beats per minute (BPM), dated 05/12/25, discontinued on 07/11/25.Propranolol (medication used to treat HTN) 10 mg three times daily. Hold for SBP less than 110 mm/Hg, [DBP] less than 60 mm/HG, or heart rate less than 54 BPM, dated 05/15/25, discontinued 07/17/25.Propranolol 20 mg three times daily. Hold for SBP less than 110 mm/Hg, less than 60 mm/HG [did not specify DBP] or heart rate less than 54 BPM, dated 05/15/25, discontinued 07/17/25.Hydralazine (medication used to treat HTN) 25 mg twice daily for HTN; Hold for SBP less than 110 mm/Hg, DBP less than 50 mm/HG or heart rate less than 50 BPM, dated 05/15/25, discontinued on 07/17/25.Blood sugar checks daily in the early morning (AM). Hold diabetes medication if blood sugar less than 110 mg per deciliter(dL). See glimepiride hold parameters.Glimepiride (medication used to lower blood glucose) 2 mg once daily for DM. Hold if blood glucose (BG) is less than 100 mg/dL. Call for BG greater than 400 mg/dL, dated 05/15/25, discontinued on 07/11/25.Insulin aspart (a hormone that lowers the level of glucose in the blood), inject 5 units with meals for DM. Hold if blood sugar is less than 120 mg/dL or if not eating, dated 07/12/25.R1's June 2025 Medication Administration Record (MAR) revealed the amlodipine was administered outside of ordered parameters on 06/03/25 and 06/11/25. The propranolol was administered outside the ordered parameters on 06/03/25, 06/11/25, 06/17/25, and 06/28/25. The glimepiride was administered outside of ordered parameters on 06/06/25, 06/07/25, 06/12/25, 06/18/25, 06/19/25, 06/20/25, and 06/30/25.R1's July 2025 MAR and Treatment Administration Record (TAR) revealed the amlodipine was administered outside of ordered parameters on 07/06/25. The propranolol was administered outside ordered parameters on 07/06/25, 07/08/25, 07/09/25, 07/11/25, 07/14/25, and 07/15/25. The hydralazine was given outside the ordered parameters on 07/05/25. The glimepiride was administered outside of ordered parameters on 07/05/25, 07/06/25, and 07/07/25. The insulin was given outside of ordered parameters on 07/15/25 and 07/21/25.On 08/25/25 at 12:33 PM, R1 was in bed asleep.On 08/25/25 at 06:22 PM, Licensed Nurse (LN) G stated that if the vitals were outside the ordered parameters, staff should hold the medication and contact the provider; if the medication needed to be held longer, the provider would put it on hold. LN G stated staff should never give a medication outside of the ordered parameters.On 08/25/25 at 06:49 PM, Administrative Staff A stated if the results of vital signs were found to be outside of parameters, staff needed to notify the doctor to see if the doctor wanted to do as it would be up to the doctor to hold the medication or not. Administrative Staff A stated if the doctor wanted staff to give a medication outside of the ordered parameters, there should be a progress note documenting the call to the doctor and the doctor's order to go ahead and give the medication The facility did not provide a policy related to