STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Providence Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 69 residents. The sample included three residents. Based on record review, observation, and interview, the facility failed to ensure medications were secured and inaccessible to residents. On 02/11/26 at 07:55 PM, the pharmacy delivered three bags of medications to the facility, which included one white bag, one blue bag, and one red bag. The red bag contained 90 tablets (tabs) of alprazolam (a medication used to treat anxiety, panic disorders, and depression) and 90 tabs of lorazepam (a medication used to treat anxiety, insomnia, and seizure disorders). Licensed Nurse (LN) G took possession of the medications and left them in the nurse's station without securing them. At 09:55 PM, Resident (R) 1 and R2 identified the nurse's station was unmanned. R2 went into the unsupervised, unsecured area, obtained some drinking cups, and at the request of R1 took the red bag of medications. R2 then gave the bag of medications to R1. R1 took the pills back to his room and at an unknown time, ingested 14 alprazolam and 18 lorazepam. Early the next morning, on 02/12/26 at 12:40 AM, R1 was lethargic, could not speak, and had repeated episodes of vomiting. R1 went to the hospital, where he was intubated (a critical medical procedure involving the insertion of a tube into the windpipe to maintain an open airway, deliver oxygen, and connect patients to a mechanical ventilator (a machine used when a patient cannot breath on their own.) and treated for aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) due to inhalation of vomit.Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), suicidal ideation (thoughts of death or harm to self), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). R1's Quarterly Minimum Data Set (MDS), dated 01/12/26, documented R1 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R1 had a total mood severity score of 24, which indicated severe depression. R1 had hallucinations, delusions, and rejection of care during the look-back period. R1 was independent for all activities of daily living (ADLs). The MDS documented R1 received anti-psychotic (class of medications used to treat major mental conditions which cause a break from reality) medications, anti-anxiety (class of medications that calm and relax people) medications, and anti-depressant (class of medications used to treat mood disorders) medications during the look-back period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/26/25, documented R1 had multiple comorbidities (the presence of one or more additional conditions co-occurring with a primary disease). The CAA documented R1 had wandering behaviors and a diagnosis of schizophrenia. The Care Plan, dated 12/24/25, documented R1 experienced trauma-related distress, hallucinations, and substance use which exacerbated suicidal thoughts. The care plan directed staff to monitor grief cues, hallucinations, intoxication/withdrawals as triggers and to initiate immediate safety supports and redirection (12/24/25). The care plan documented R1 experienced intermittent passive suicidal ideation and (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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	required continued emotional support and monitoring to maintain R1's safety and emotional stability. The care plan directed staff to assess for suicidal ideation, intent, and plan each shift (especially at night). The Pharmacy Receipts, dated 02/11/26, documented the pharmacy delivered 90, 1 milligram (mg) tablets of alprazolam to the facility on [DATE] at 07:55 PM. LN G signed for the medications. The Pharmacy Receipts, dated 02/11/16, documented the pharmacy delivered 90, 0.5 mg tablets of lorazepam for R4 to the facility on [DATE] at 07:55 PM. LN G signed for the medications. The Nurses Note, dated 02/12/26 at 01:19 AM, documented R1 ambulated to the nurse's station, staggering and swaying around 12:40 AM. R1 was lethargic, unable to open his eyes, and had slurred speech. R1 was given a glass of water and then threw it as he walked back down the hallway to his room. The LN went to R1's room to perform an assessment. Upon entering R1's room the LN saw R1 vomit from his nose and mouth. The vomit was very dark. R1 had short, labored breaths, incoherent speech, and exhibited lethargic behavior. The Certified Nurse's Aide (CNA) and LN assisted R1 to the nurse's station. The primary care provider was notified, and orders were received to send R1 to the hospital. R1 continued to vomit. R1's vital signs measured as follows: blood pressure 209/190 millimeters of Mercury (mm/Hg) (high), pulse 78 beats per minute, and respirations 12 breaths per minute (low). Emergency Medical Service (EMS) responded and transported R1 to the hospital. The Social Services Note, dated 02/12/26 at 07:45 AM, documented the Social Services Designee communicated with R1's responsible party and informed her R1 was currently in the intensive care unit and was intubated. The Social Services Note, dated 02/12/26 at 08:48 AM, documented R1's responsible party notified the Social Services Designee R1 had developed pneumonia and fever secondary to suspected fluid aspiration into his lungs. R1's responsible party reported medical staff was performing a bronchoscopy-type (a procedure where a thin, lighted tube is inserted through the nose or mouth to view the airways and lungs) procedure to visualize R1's airways and remove accumulated pulmonary secretions. The unotarized e-mailed statement from LN G, dated 02/12/26, documented LN G signed for the medication and set it aside, putting them on the overflow med cart to be put away later. Later in the shift, Certified Medication Aid (CMA) R put the medications that arrived earlier in the shift away. CMA R's unnotarized Witness Statement, dated 02/12/26, documented CMA R stated she never received a hand transaction of medications from LN G or anyone on 02/11/26 and further stated she never received any narcotics or a red bag of medications. CMA R stated she saw the blue bag and white bag of medications and put them in the overflow medication cart. LN I's unnotarized Witness Statement, dated 02/12/26, documented on 02/12/26 at approximately 08:00 PM, revealed Housekeeping Staff came and told her he found a stack of pill cards in the paper towel dispenser. LN I stated there were three cards of alprazolam 1 mg tablets, two of the cards were full of 30 tablets each, and one of the cards had 12 tablets out of 30 tablets left. The medications were prescribed to R3. The other set of three cards were noted to be lorazepam 0.5 mg; two of the cards were full of 30 tablets each, and one of the cards had 16 tablets out of 30 tablets left. The medications were prescribed to R4. The Nurses Note, dated 02/16/26, documented R1's responsible party reported R1 was sedated and on a ventilator. The Facility Incident Report, dated 02/19/26, documented at approximately 11:49 AM, LN H reported that narcotic medications were missing from the medication supply for R3 and R4. The medications missing were alprazolam and lorazepam. LN H reported the medications were delivered to the facility on [DATE]. Upon notification, all medication carts on the unit were checked and the missing narcotics were not located. The pharmacy delivery forms could not be located, and the controlled substance count sheets were also not located. The pharmacy was contacted regarding the missing medications, and they reported the controlled substances were delivered on 02/11/26 at 07:55 PM. LN G stated upon receipt of the medications he gave the medications to CMA R to put away. CMA R reported putting medications away but did not recall any of them being controlled substances. Local police were notified, and camera footage was reviewed by Administrative Nurse D. Administrative Nurse D viewed LN G accepting the medication from the pharmacy delivery on 02/11/26 at 07:55 PM. LN G set the pharmacy delivery on a chair in the nurse's (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	station, which included one white bag, one blue bag, and one red bag. Shortly after, LN G left the nurse's station (at approximately 09:55 PM), R1 and R2 were standing outside of the unattended nurse's station. R2, the female resident, walked into the nurse's station and began taking items, which included drinking cups and began putting them in her pockets. R2 pointed to the pharmacy bags located in the chair and directed R2 over to the bags. R2 took the red bag then walked out of the nurse's station and out of the line of sight of the camera. On 02/12/26 at 08:00 PM, housekeeping staff opened a paper towel dispenser in a resident's room and found the medications. The medications were counted and secured. The medication counts were alprazolam 72 tablets and lorazepam 76 tablets. The Social Services Note, dated 02/20/26 at 01:01 PM, documented R1 returned from the hospital. Social Services Designee and Administrative Nurse D met with R1 to discuss his health status and R1 admitted he had taken a handful of pills from a red package but believed they would not have a significant effect due to their size. When asked directly if this was a suicide attempt, R1 denied suicidal intent and stated he would not repeat the behavior. R1 verbalized remorse for his actions, however R1's affect was somewhat incongruent with the seriousness of the event. R1's affect ranged from euthymic (a state of normal, stable, and tranquil mood) to mildly elevated with intermittent laughter and playful demeanor while discussing the incident. On 03/10/26 at 10:00 AM, observation revealed the nurse's station was unattended. The swinging gate into the nurse's station was locked with a barrel bolt lock on the inside. This surveyor reached over the gate, unbolted the lock, and walked into the nurse's station. A resident stood at the counter of the nurse's station. On 03/10/26 at 01:00 PM, observation revealed R1 lying in his bed completely covered from head to toe with a blanket. This surveyor said R1's name, and R1 yelled, Get the [expletive] out of my room. An interview with LN G could not be obtained. On 03/10/26 at 10:45 AM, CMA R stated LN G never handed off any medications to her to be placed in the med cart. She found the white and blue bag of medication in the nurse's station and put the medications away. CMA R stated she never knew any narcotics were delivered. On 03/10/26 at 11:30 AM, Administrative Nurse D stated the medications were noted to be missing on 02/12/26 around noon. R3 and R4's medications, lorazepam and alprazolam, were found to be missing. The pharmacy was notified, and the pharmacy told the facility they were delivered the previous night at 07:55 PM to LN G and further revealed he had signed for them. Camera footage was reviewed, which showed LN G accepted the pharmacy delivery, put it down in a chair in the nurse's station, and then shortly after left the nurses' station. R1 and R2 were seen outside of the unattended nurses' station. R2, the female resident, went into the nurse's station, started picking up drinking cups and other random items, and started putting them in her coat. R1 was seen pointing to the bags of medication in the chair and directed her to the red bag. Administrative Nurse D stated R1 must have known narcotics were in the red bag. R1 and R2 walked out of the camera's view. R2 admitted to the facility staff she had given R1 the red bag of pills. Administrative Nurse D stated LN G lied when he said he had handed the medications off to CMA R. LN G was fired from the facility. Administrative Nurse D stated the facility did not know what exactly happened to R1 until after they found the pills in his room, R2 admitted to giving R1 the pills, and R1 admitted to taking a handful of the pills. Administrative Nurse D stated the medications should have been secured immediately to ensure all the residents were safe. On 03/10/26 at 01:30 PM, CMA S stated all staff educated regarding narcotic diversion, securing medications promptly after delivery, keeping residents out of staff work areas, and providing necessary supervision of residents. The facility's Storage of Medications Policy, revised October 2024, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility's Accepting Delivery of Medications Policy, revised November 2023, documented community staff shall follow a consistent procedure in accepting medications The facility's Safety and Supervision of Residents Policy, revised December 2007, documented the facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. On 03/10/26 at 01:45 PM, Administrative Nurse D was provided the Immediate Jeopardy (continued on next page)

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