STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPEKA PRESBYTERIAN MANOR	**4712 SW 6TH AVE , TOPEKA, Kansas, 66606**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 3052530, 3045908, 3063437, and 3011454. The census was 62. The sample included four residents.	F0000		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by:	F0755		

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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F0755 SS = E	Continued from page 1 Based on observation, record review, and interviews, the facility failed to maintain an effective controlled substance reconciliation system, which included reconciling Resident (R) 1's narcotic medication upon delivery. Findings included: - R1 admitted to the facility on 08/16/2024. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), secondary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), gout (inflammation of the joints), and polyneuropathy (a condition in which a person's peripheral nerves are damaged). The "Annual Minimum Data Set (MDS)" dated 08/04/2025, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicates moderate cognitive impairment. R1 received scheduled pain medication and had no complaints of pain during the assessment. The "Quarterly MDS" dated 04/29/2026, documented R1 had a BIMS score of seven, which indicated severe cognitive impairment. R1 received scheduled and as needed (PRN) pain medication and had no complaints of pain during the assessment. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 08/05/2026, documented R1 had issues with recall ability and cognition. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 08/06/2026, documented R1 required limited to total assistance with ADLs, transfers, and mobility. R1 reported no discomfort upon interview. R1's "Care Plan" revised 02/13/2025, documented R1 had chronic pain related to arthritis, gout, and neuropathy. R1's 'Care Plan" documented the following interventions: 02/05/2025- Staff evaluated the effectiveness of	F0755		

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F0755 SS = E	Continued from page 2 pain interventions. 02/05/2025- Staff identified, recorded, and treated R1's existing conditions which may have increased pain and/or discomfort. 02/05/2025- Staff monitored/documented for side effects of pain medication. 02/05/2025- Staff monitored/recorded/reported to the nurse any signs/symptoms of R1's nonverbal pain. 02/05/2025- Staff notified the physician if R1's interventions were unsuccessful or if her current complaint was a significant change from her past experience of pain. 05/12/2025- Staff monitored/recorded pain characteristics PRN. 12/15/2025- Staff attempted non-pharmacological interventions for pain control. 12/24/2025- Staff observed and reported any changes in R1's usual routine, sleep patterns, decrease in her functional abilities, decrease in her range of motion (ROM), or any withdrawal or resistance of cares. 02/02/2026- Staff administered analgesia medications per orders, which included hydrocodone (narcotic pain medication) for pain management. R1's EMR documented an order with a start date of 11/19/2025, for hydrocodone-acetaminophen 5-325 milligrams (mg) with instructions to give one tablet every six hours as needed for moderate to severe pain related to secondary osteoarthritis. The facility's "Investigation" dated 06/23/2026, documented on 06/15/2026 between 01:30 PM and 02:00 PM, Licensed Nurse (LN) G reported R1's hydrocodone medication card and narcotic count sheet were not in the cart. Administrative Nurse D and Administrative Nurse E immediately searched all four medication carts, treatment carts, and medication rooms, including the narcotic destruction boxes, but the facility did not find the hydrocodone card. Administrative Nurse D spoke to all of the nurses on the schedule since the medication was last given. LN H gave the last dose on 06/13/2026 at 10:38 PM, and she counted and signed off with LN I who worked 06/14/2026 morning. LN I worked day	F0755		

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F0755 SS = E	Continued from page 3 and evening shifts and later counted the narcotics with another evening nurse, LN J. LN K, who worked night shift, received the keys from LN J, but did not count the narcotics until she counted with the oncoming day shift nurse on 06/15/2026. Later that shift on 06/15/2026, LN G reported the missing medication. The facility replaced R1's hydrocodone medication on 06/16/2026 and the facility was unable to identify a perpetrator. LN J's notarized witness statement on 06/14/2026, documented she counted the treatment cart and medication cart on 06/14/2026 at 09:00 PM with LN I. She stated the count was accurate. LN J's notarized witness statement on 06/16/2026, documented she arrived at the Prairie Point unit on 06/15/2026 at 12:00 AM after she was pulled from assisted living. She stated she counted the narcotics with the evening nurse for the Sunflower unit because LN J was working both Prairie Point and Sunflower units that night. She stated LN J told her that she counted with LN I, who worked evening shift on Prairie Point and had worked since 06:00 AM on 06/14/2026, then LN I left. LN J stated it was a busy night, and she did not get a chance to count the narcotics until the day shift nurse arrived. She stated she counted the number of pages and medications, and everything was correct at that time. LN I's statement, via email on 06/16/2026 at 10:18 AM, documented she worked day shift on 06/14/2026 and had counted at the beginning of the shift with the night nurse. She stated she did not notice whether R1's hydrocodone was present at the time or not. LN I stated she did not give R1 any PRN medications throughout the shifts she worked and when she counted the cart before she left on 06/14/2026 night, the count was correct. LN H's statement, via email on 06/17/2026 at 09:25 PM, documented on 06/13/2026, she gave R1 a PRN medication and returned it to the locked box. She stated she counted with the day shift nurse on 06/14/2026 and all medication cards and counts were accounted for. She stated she always counted oncoming and off-going with her peer nurses per protocol. On 07/16/2026 at 12:54 PM, R1 sat in her wheelchair in her room with her eyes closed.	F0755		

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F0755 SS = E	Continued from page 4 On 07/16/2026 at 01:12 PM, the Prairie Point treatment cart narcotic binder was reviewed. Review revealed an “Eight Hour Verification Controlled Substances Count” sheet from 07/01/2026 day shift to 07/16/2026 had 17 out of 92 possible signature spaces, blank. The “Narcotic Count Sheet Reconciliation Log” from 07/11/2026 day shift to 07/16/2026 day shift had seven out of 32 possible signature spaces, blank. On 07/16/2026 at 10:49 AM, Administrative Nurse D stated the facility never figured out what happened to R1’s hydrocodone card. On 07/16/2026 at 11:32 PM, Administrative Nurse D stated she did one-on-one education after the incident to count the narcotics every shift and sign off on the sheets. She stated she did not have any sign-in sheets for the education or documentation. On 07/16/2026 at 11:43 PM, Administrative Nurse D stated the facility did not complete abuse, neglect, and exploitation (ANE) education after the incident. On 07/16/2026 at 01:14 PM, LN L stated she counted narcotics every shift or when she exchanged keys with a nurse or Certified Medication Aide (CMA). She stated she signed on and off on the reconciliation narcotic count sheets. LN L stated if she gave a PRN narcotic, she checked the order, assessed the resident’s pain, then verified the correct dose in the narcotic box and popped the medication out. She stated she signed out the narcotic medication on the count sheet and in the computer. LN L stated each slot on the shift count sheets should have a signature, and she signed off the narcotic reconciliation sheet on and off her shift when she counted with the other nurse. She stated during count, she counted the controlled items and made sure they were accurate with the reconciliation sheet. LN L stated if she found a narcotic medication discrepancy, she notified Administrative Nurse D. She stated she counted the narcotics with every nurse or CMA if the keys changed hands and she did not let anybody use her keys. On 07/16/2026 at 01:18 PM, CMA T stated she counted narcotics at the beginning and end of the shift and signed off on the narcotic count sheet.	F0755		

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F0755 SS = E	Continued from page 5 On 07/16/2026 at 01:47 PM, Administrative Nurse E stated on 06/15/2026, LN G realized R1's hydrocodone card and narcotic count sheet were missing. He stated the last dose given was on 06/13/2026 at 10:38 PM. He stated the facility started going through who worked, how many doses were given, and where the medication could have gone. Administrative Nurse E stated the original nurse who received the hydrocodone card from pharmacy did not add the card to the reconciliation sheet and updated the count number, so the count number on the reconciliation sheet was correct when it went missing. He stated the facility obtained statements from the nurses who worked, and nobody seemed to remember if R1's card was there when they counted. He stated they looked through the medication rooms and shred box, but could not find the hydrocodone card. Administrative Nurse E stated the facility did a process of elimination and since the only new nurse to work at the facility was LN I, they canceled her through her agency. He stated the facility was unable to find the actual perpetrator. Administrative Nurse E stated the facility did not audit the other residents' narcotics to see if there were any other discrepancies. On 07/16/2026 at 01:47 PM, Administrative Nurse D stated the facility also looked in R1's room for the hydrocodone card and in discarded medications but could not find it. She stated she reviewed the camera footage, but due to the angle of the camera to where the cart sat, the camera did not catch anything. Administrative Nurse D stated she told LN I's agency the facility did not have anything on her related to the hydrocodone, but it was a recommendation from corporate to cancel LN I after the facility reviewed everything. She stated she expected that when pharmacy delivered new narcotic cards, the nurses counted the cards together and added it to the reconciliation paper. She expected nursing to count narcotics with shift change or any time the keys changed hands. Administrative Nurse D stated she expected staff to immediately notify the nurse on call with any discrepancies. The facility's "Medication Storage- Controlled Meds" policy, last revised 10/08/2021, directed the count sheet reconciliation log was placed in the front of each narcotic sign out book and each medication accountability record was logged in and out of that log. The facility counted the number of medication accountability records at the beginning	F0755		

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F0755 SS = E	Continued from page 6 of the narcotic count to see that the number matched on the reconciliation log. The policy directed at each shift change, two licensed/certified nursing staff conducted a physical inventory of controlled medications and documented on the Eight Hour Verification Controlled Substances Count form.	F0755		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to prevent misappropriation of a narcotic medication for Resident (R) 1. Findings included: - R1 admitted to the facility on 08/16/2024. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), secondary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), gout (inflammation of the joints), and polyneuropathy (a condition in which a person's peripheral nerves are damaged). The "Annual Minimum Data Set (MDS)" dated 08/04/2025, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicates moderate cognitive impairment. R1 received scheduled pain medication and had no complaints of pain during the assessment. The "Quarterly MDS" dated 04/29/2026, documented R1 had a BIMS score of seven, which indicated severe cognitive impairment. R1 received scheduled and as needed (PRN) pain medication and had no complaints of pain during the assessment.	F0602		

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F0602 SS = D	Continued from page 7 The “Cognitive Loss/Dementia Care Area Assessment (CAA)” dated 08/05/2026, documented R1 had issues with recall ability and cognition. The “Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA” dated 08/06/2026, documented R1 required limited to total assistance with ADLs, transfers, and mobility. R1 reported no discomfort upon interview. R1’s “Care Plan” revised 02/13/2025, documented R1 had chronic pain related to arthritis, gout, and neuropathy. R1’s ‘Care Plan” documented the following interventions: 02/05/2025- Staff evaluated the effectiveness of pain interventions. 02/05/2025- Staff identified, recorded, and treated R1’s existing conditions which may have increased pain and/or discomfort. 02/05/2025- Staff monitored/documented for side effects of pain medication. 02/05/2025- Staff monitored/recorded/reported to the nurse any signs/symptoms of R1’s nonverbal pain. 02/05/2025- Staff notified the physician if R1’s interventions were unsuccessful or if her current complaint was a significant change from her past experience of pain. 05/12/2025- Staff monitored/recorded pain characteristics PRN. 12/15/2025- Staff attempted non-pharmacological interventions for pain control. 12/24/2025- Staff observed and reported any changes in R1’s usual routine, sleep patterns, decrease in her functional abilities, decrease in her range of motion (ROM), or any withdrawal or resistance of cares. 02/02/2026- Staff administered analgesia medications per orders, which included hydrocodone (narcotic pain medication) for pain management. R1’s EMR documented an order with a start date of	F0602		

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F0602 SS = D	Continued from page 8 11/19/2025, for hydrocodone-acetaminophen 5-325 milligrams (mg) with instructions to give one tablet every six hours as needed for moderate to severe pain related to secondary osteoarthritis. The facility's "Investigation" dated 06/23/2026, documented on 06/15/2026 between 01:30 PM and 02:00 PM, Licensed Nurse (LN) G reported R1's hydrocodone medication card and narcotic count sheet were not in the cart. Administrative Nurse D and Administrative Nurse E immediately searched all four medication carts, treatment carts, and medication rooms, including the narcotic destruction boxes, but the facility did not find the hydrocodone card. Administrative Nurse D spoke to all of the nurses on the schedule since the medication was last given. LN H gave the last dose on 06/13/2026 at 10:38 PM and she counted and signed off with LN I who worked 06/14/2026 morning. LN I worked day and evening shift and later counted the narcotics with another evening nurse, LN J. LN K, who worked night shift, received the keys from LN J, but did not count the narcotics until she counted with the oncoming day shift nurse on 06/15/2026. Later that shift on 06/15/2026, LN G reported the missing medication. The facility replaced R1's hydrocodone medication on 06/16/2026, and the facility was unable to identify a perpetrator. LN J's notarized witness statement on 06/14/2026, documented she counted the treatment cart and medication cart on 06/14/2026 at 09:00 PM with LN I. She stated the count was accurate. LN J's notarized witness statement on 06/16/2026, documented she arrived at the Prairie Point unit on 06/15/2026 at 12:00 AM after she was pulled from assisted living. She stated she counted the narcotics with the evening nurse for the Sunflower unit because LN J was working both Prairie Point and Sunflower units that night. She stated LN J told her that she counted with LN I, who worked evening shift on Prairie Point and had worked since 06:00 AM on 06/14/2026, then LN I left. LN J stated it was a busy night, and she did not get a chance to count the narcotics until the day shift nurse arrived. She stated she counted the number of pages and medications, and everything was correct at that time. LN I's statement, via email on 06/16/2026 at 10:18 AM, documented she worked day shift on 06/14/2026 and had counted at the beginning of the	F0602		

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F0602 SS = D	Continued from page 9 shift with the night nurse. She stated she did not notice whether R1's hydrocodone was present at the time or not. LN I stated she did not give R1 any PRN medications throughout the shifts she worked, and when she counted the cart before she left on 06/14/2026 night, the count was correct. LN H's statement, via email on 06/17/2026 at 09:25 PM, documented on 06/13/2026, she gave R1 a PRN medication and returned it to the locked box. She stated she counted with the day shift nurse on 06/14/2026, and all medication cards and counts were accounted for. She stated she always counted oncoming and off-going with her peer nurses per protocol. On 07/16/2026 at 12:54 PM, R1 sat in her wheelchair in her room with her eyes closed. On 07/16/2026 at 10:49 AM, Administrative Nurse D stated the facility never figured out what happened to R1's hydrocodone card. On 07/16/2026 at 11:32 PM, Administrative Nurse D stated she did one-on-one education after the incident to count the narcotics every shift and sign off on the sheets. She stated she did not have any sign-in sheets for the education or documentation. On 07/16/2026 at 11:43 PM, Administrative Nurse D stated the facility did not complete abuse, neglect, and exploitation (ANE) education after the incident. On 07/16/2026 at 01:14 PM, LN L stated she prevented misappropriation of medications by counting narcotics every shift or when exchanging keys with a nurse or Certified Medication Aide (CMA). She stated she signed on and off on the reconciliation narcotic count sheets. LN L stated if she gave a PRN narcotic, she checked the order, assessed the resident's pain, then verified the correct dose in the narcotic box and popped the medication out. She stated she signed out the narcotic medication on the count sheet and in the computer. LN L stated if she found a narcotic medication discrepancy, she notified Administrative Nurse D. She stated she counted the narcotics with every nurse or CMA if the keys changed hands and she did not let anybody use her keys.	F0602		

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F0602 SS = D	Continued from page 10 On 07/16/2026 at 01:18 PM, CMA T stated she prevented misappropriation of medications by counting narcotics at the beginning and end of the shift and signing off the medication on the narcotic count sheet and in the EMR. On 07/16/2026 at 01:47 PM, Administrative Nurse E stated on 06/15/2026, LN G realized R1's hydrocodone card and narcotic count sheet were missing. He stated the last dose given was on 06/13/2026 at 10:38 PM. He stated the facility started going through who worked, how many doses were given, and where the medication could have gone. Administrative Nurse E stated the original nurse who received the hydrocodone card from pharmacy did not add the card to the reconciliation sheet and updated the count number, so the count number on the reconciliation sheet was correct when it went missing. He stated the facility obtained statements from the nurses who worked, and nobody seemed to remember if R1's card was there when they counted. He stated they looked through the medication rooms and shred box, but could not find the hydrocodone card. Administrative Nurse E stated the facility did a process of elimination and since the only new nurse to work at the facility was LN I, they canceled her through her agency. He stated the facility was unable to find the actual perpetrator. Administrative Nurse E stated the facility did not audit the other residents' narcotics to see if there were any other discrepancies. On 07/16/2026 at 01:47 PM, Administrative Nurse D stated the facility also looked in R1's room for the hydrocodone card and in discarded medications but could not find it. She stated she reviewed the camera footage, but due to the angle of the camera to where the cart sat, the camera did not catch anything. Administrative Nurse D stated she told LN I's agency the facility did not have anything on her related to the hydrocodone, but it was a recommendation from corporate to cancel LN I after the facility reviewed everything. She stated she expected that when pharmacy delivered new narcotic cards, the nurses counted the cards together and added it to the reconciliation paper. She expected nursing to count narcotics with shift change or any time the keys changed hands. Administrative Nurse D stated she expected staff to immediately notify the nurse on call with any discrepancies. The facility's "ANE: Abuse Prevention, Intervention,	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPEKA PRESBYTERIAN MANOR	**4712 SW 6TH AVE , TOPEKA, Kansas, 66606**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 11 Reporting, and Investigation- Staff Treatment of Residents" policy, last revised 06/25/2026, directed residents had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, exploitation, and involuntary seclusion. The policy defined misappropriation of property as deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without their consent.	F0602		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to prevent a significant medication error when on 06/27/26 at approximately 08:30 AM, Certified Medication Aide (CMA) R administered unknown medications to Resident (R) 2 without verifying she had the correct resident. Findings included: - R2 admitted to the facility on 10/10/2025. R2's Electronic Medical Record (EMR) documented diagnoses of chronic heart failure (a condition with low heart output and the body becomes congested with fluid) and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Significant Change Minimum Data Set (MDS)" dated 05/12/2026, documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 05/14/2026, documented R2 had a recent stay for respiratory failure, and she required limited to substantial assistance with ADLs, transfers, and mobility.	F0760	"Past Noncompliance - no plan of correction required"	

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F0760 SS = D	Continued from page 12 R2's "Care Plan" dated 10/17/2025, documented R2 had a potential for impaired cognitive function or impaired thought processes related to Parkison's disease and heart failure. The "Care Plan" documented the following interventions: 10/17/2025- R2 was usually alert and oriented, and she made her own decisions. 10/17/2025- R2 had a durable power of attorney (DPOA) in place in case she needed assistance in making decisions. 10/17/2025, revised 12/23/2025- Staff monitored/documented/reported as needed (PRN) any changes in cognitive function. The facility's "Investigation" dated 07/03/2026, documented on 06/27/2026 at approximately 08:30 AM in the dining room, CMA R administered a medication cup of unknown medications to R2 while she was in the dining room. Around the same time, CMA S gave R2 her morning medications and R2 then reported to CMA S that she was double dosed on medications that morning. CMA S immediately reported the medication administration error. R3 and R4 stated to Licensed Nurse (LN) PP that they had not received their morning medications. LN PP assessed R2, R3, and R4 and notified the physician, who gave orders to monitor the residents' vital signs every four hours with monitoring for signs and symptoms of changes. R3 and R4 had no observed changes noted. After the facility investigated the situation, they were unable to identify whose medications R2 received. At around 12:00 PM, R2 complained of nausea and the physician gave an order for a PRN Zofran (anti-nausea medication), which R2 received with reported improvement. At approximately 05:30 PM, staff observed R2 sitting at a dining room table with her head in her hands. LN PP assessed R2, who looked pale and shaky. R2 reported feeling unwell, lightheaded, and having an upset stomach. LN PP immediately contacted the physician, who gave orders to send R2 to the hospital. The facility contacted CMA R's agency who stated they would determine CMA R's competency and provide education to her. CMA S's notarized witness statement on 06/27/2026, documented on 06/27/2026, she went into R2's room to take her blood pressure and pulse, then R2 took her pills. She stated about 10 minutes later, R2 came out of her room and said she	F0760		

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F0760 SS = D	Continued from page 13 thinks she had the same pills she had given her this morning at breakfast. CMA S stated she told R2 that she had just gotten on shift, and her pills had not been signed out yet. CMA S stated R2 said a short, brown-headed girl had given her the pills in the dining room. CMA S stated she called CMA R and asked her about it and CMA R stated she must have given R2 another resident's pills accidentally. CMA S stated they took R2's vital signs and monitored her. CMA R's notarized witness statement on 06/29/2026, documented on 06/27/2026, CMA R passed medications in the dining room then she left at 08:30 AM. She stated she received a call at about 10:00 AM about a medication error. CMA R stated she went back to the facility, and she realized when she asked R2 her name, she verified the name. She stated she did ask for verification on resident names, but she was told after the incident that it was not the right resident. On 07/16/2026 at 01:19 PM, R2 was out of the facility at that time. On 07/16/2026 at 01:18 PM, CMA T stated she prevented medication errors by double checking for the right person, right medication, right time, and right dose. She stated she introduced herself and asked the resident their name. CMA T stated if she noticed she gave the wrong medications, she notified the nurse. On 07/16/2026 at 01:21 PM, LN L stated she prevented medication errors by following the five rights of medication administration, which were right person, right route, right drug, right dose, and right time. She stated she verified a resident's identity by their room number, by their picture in the EMR, by their date of birth if they were coherent enough to give it, by asking another staff member, and/or by asking them their name. On 07/16/2026 at 02:05 PM, Administrative Nurse E stated on 06/27/2026, CMA R passed medications first thing in the morning in the dining room. When CMA S came in later and started passing medications, she gave R2 her medications and R2 took the medications then stated she was double dosed. He stated there was no way that CMA R gave R2 her medications because she worked on a	F0760		

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F0760 SS = D	Continued from page 14 different medication cart than where R2's medications were. He stated the facility tried to figure out what medications she received and there were two residents, R3 and R4, who stated they had not received their medications that morning, but they were not good historians. Administrative Nurse E stated LN PP received orders to monitor the residents' vital signs for the day to see if anything changed. He stated around lunch, R2 started feeling nauseous and weak then around 05:30 PM, the facility sent her out to the hospital. Administrative Nurse E stated the facility notified CMA R's agency about the incident and canceled her. He stated he started educating CMAs and nurses on the five rights of administration. He stated the facility determined CMA R stated had asked R2 her name, but she did not look at the picture on the EMR to properly identify R2. On 07/16/2026 at 02:05 PM, Administrative Nurse D stated the facility completed five rights of administration education with their staff even though CMA R was not one of their staff members. She stated she expected staff to not pass medications in the dining room due to confusion with everyone in there and to give their medications before they got to the dining room. Administrative Nurse D stated she expected staff to verify the five rights of medication administration. The facility's "Medication Errors" policy, last revised 09/30/2021, defined a medication error by the type of error and could be categorized as omission, wrong dose, wrong drug, unauthorized drug, wrong dosage form, wrong time, and wrong route of administration. The facility's "Medication Administration" policy, last revised 06/02/2023, directed the procedure for medication administration included identifying the resident. The facility put the following corrections into place: 1. The facility sent R2 to the hospital for evaluation and treatment on 06/27/2026. 2. The facility notified CMA R's agency of the medication error and canceled her shifts at the facility.	F0760		

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F0760 SS = D	Continued from page 15 3. The facility educated CMAs and LNs on the five rights of medication administration on 06/29/2026. Due to the facility's completion of all corrective actions prior to the onsite visit, the deficient practice was deemed past noncompliance at a scope and severity of a “D” (isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy).	F0760		