STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175297	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPEKA PRESBYTERIAN MANOR	4712 SW 6TH AVE TOPEKA, KS 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
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00176603 and KS00172666. The 2567 was sent electronically on 12/19/22.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/19/2022

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by:
The facility reported a census of 60 residents. The sample included three residents with one resident sampled for abuse. Based on observations, record review, and interview, the facility failed to report to the State Agency (SA), within the mandated timeframe, an allegation of abuse made by Resident (R) 1. This deficient practice placed R1 at risk for unresolved and ongoing abuse.

Findings included:

- R1 admitted to the facility on 09/21/22.

R1's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and generalized muscle weakness.

The "Admission Minimum Data Set (MDS)" dated 09/26/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required extensive physical assistance with two staff for transfers and toileting; total physical assistance with one staff for locomotion; extensive physical assistance with one staff for dressing and personal hygiene; and limited physical assistance with one staff for eating.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 09/28/22, documented R1 required extensive to total assistance with ADLs, transfers, and mobility. R1 had clear

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speech and was able to make his needs known.

The "Care Plan" dated 12/01/22, documented R1 had an alteration in thought processes, long-term and short-term memory problems, and impaired decision making due to Parkinson's disease. The "Care Plan" directed R1 communicated best by verbal communication in a quiet setting and he required extra time to process things at times.

The "Care Plan" dated 12/01/22, documented R1 had a self-care deficit related to Parkinson's disease and directed he required limited assistance of one staff for ADLs such as grooming and eating and extensive physical assistance of one staff for ADLs such as repositioning, toileting, bathing, transferring, and locomotion.

The facility's "Investigation" dated 12/13/22, documented on 12/03/22 at approximately 11:45 PM, R1 asked to speak to Licensed Nurse (LN) G. R1 stated to LN G that he wanted to make a police report regarding the previous nurse. LN G asked R1 if he was hurt in any way and he said no. LN G explained to R1 that she had other residents that were waiting on their medication and she could contact social services for him or he could use his cell phone to contact the police. LN G explained to R1 that she would return to sit and discuss his concerns. R1 told LN G to not come back, no one listened anyway. On 12/05/22, R1 reported to Administrative Nurse E that he wanted to call the police to report that Certified Nurse Aide (CNA) M and CNA N pushed him down on 12/03/22 between 07:00 PM and 10:00 PM while being repositioned. R1 stated that the staff pushed him to the floor. Administrative Nurse E assessed R1 for physical injury and no

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injuries were identified then initiated immediate investigation.

Upon request, the facility provided the e-mail for the facility reported incident for R1's allegation. The e-mail was sent to the SA on 12/07/22 at 08:20 AM.

On 12/13/22 at 11:57 AM, R1 sat in his recliner in his room and watched television.

On 12/13/22 at 02:21 PM, CNA O stated if a resident reported an allegation of abuse to her, she would report it to the head nurse or the Director of Nursing (DON) as soon as she heard it.

On 12/13/22 at 02:44 PM, LN H stated if a resident reported an allegation of abuse to him, he would call the on-call supervision and DON after assessing the situation.

On 12/13/22 at 02:48 PM, Administrative Nurse E stated on 12/05/22, she was notified that R1 wanted to call the police. She went down to R1's room to speak to him and he told her about the allegation. Administrative Nurse E stated she notified the SA on 12/07/22 then continued investigating. She stated allegations of abuse were required to be reported to the SA within two hours and the incident was not reported within a timely manner because the facility was investigating.

On 12/13/22 at 02:53 PM, Administrative Nurse D stated the facility had two hours to report allegations of abuse to the SA and that this allegation was not reported within a timely manner. She stated the investigation took a while

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and was completed by time the allegation was sent in to the SA on 12/07/22.

On 12/13/22 at 03:11 PM, Administrative Staff A stated allegations of abuse were reported within two hours and all other occurrences were reported within 24 hours. She stated this allegation was not reported in a timely manner.

The facility's "Abuse Neglect Exploitation: Abuse Prevention, Intervention, Reporting and Investigation- Staff Treatment of Residents" policy, last revised 09/07/22, directed all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported to the SA immediately and no later than two hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury.

The facility failed to report to the SA, within the mandated timeframe, an allegation of abuse made by R1. This deficient practice placed R1 at risk for unresolved and ongoing abuse.