STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089018	A. BUILDING: _____ B. WING _____	01/31/2023

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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 01/31/23.	S 000		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41 204 (i) The census totaled 24 residents. The sample included 3 residents. Based on observation, interview and record review, Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice for the use of bed assistive devices, which met the needs of 1 of 3 sampled residents (R)2. Findings included: - The "Resident Roster" obtained on 01/31/23 identified five residents as having a bed assistive device. R2's "Medical Record" revealed he admitted to the facility on 05/18/22 with diagnoses of hypertension, diabetes mellitus type II and peripheral vascular disease.	S3171		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089018	A. BUILDING: _____ B. WING _____	01/31/2023

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) COMPLETE DATE
S3171	Continued From page 1	S3171		

The "Resident Functional Capacity Screen" (FCS) dated 05/19/22 recorded the resident as independent with dressing, toileting, transfers, walk/mobility, and eating, supervision required for bathing and unable to perform management of medications and treatments. R2 was at risk for falling.

The "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP) dated 05/19/22 recorded medication management, diabetic management and monitored bathing as services provided by the facility. The NSA identified the use of a handrail on bed used for transfers.

Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment.

Observation on 01/31/23 at 02:30 PM in R2's room revealed a bed assist device to the left side of his bed. R2 stated he used the device to get out of bed.

Interview on 01/31/23 at 04:30 PM with Licensed Nurse B confirmed no safety checks and bed assistive device assessments for R2 were completed.

The FDA (food and drug administration) Hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089018	A. BUILDING: _____ B. WING _____	01/31/2023

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) COMPLETE DATE
S3171	Continued From page 2 Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of R2 regarding use of a bed assistive device.	S3171		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089018	A. BUILDING: _____ B. WING _____	01/31/2023

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) COMPLETE DATE
S3310	Continued From page 3 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 24 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 4 Staff (Licensed Nurse (LN) C, Certified Medication Aide (CMA) D, Non-Certified Staff E and Non-Certified Staff F), the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - LN C's "Employee Record" revealed a hire date of 12/29/22. LN C's record lacked evidence of TB testing completed upon hire. Record further lacked completion of a TB questionnaire upon hire. CMA D's "Employee Record" revealed a hire date of 10/08/20. CMA D's record lacked evidence of the second step of the TB testing upon hire. Non-Certified Staff E's "Employee Record" revealed a hire date of 01/11/23. Non-Certified Staff E's record lacked evidence of TB testing and completion of a TB questionnaire upon hire. Non-Certified Staff F's "Employee Record" revealed a hire date of 08/31/22. Non-Certified Staff F's record lacked evidence of TB testing and completion of a TB questionnaire upon hire.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089018	A. BUILDING: _____ B. WING _____	01/31/2023

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) COMPLETE DATE
S3310	Continued From page 4 Interview on 01/31/23 at 04:03 PM with Administrator A confirmed no documentation located on the following: second step of TB testing upon hire for CMA D, TB questionnaire upon hire for LN C, Non-Certified Staff E and Non-Certified Staff F and TB testing upon hire for LN C, Non-Certified Staff E and Non-Certified Staff F. The facility failed to follow the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		