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 02/01/2024

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

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00185377 and KS00185548. The 2567 was sent electronically on 02/14/24.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 62 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observation, the facility failed to provide an environment free from safety hazards when staff left Resident (R) 1 in a mechanical recliner, with the footrest raised, without assessing R1's ability to lower the footrest. On 01/10/24 R1 attempted to get out of the recliner by climbing over the footrest and fell. As a result, R1 sustained a fractured sternum (breastbone) and left fourth rib. This also placed R1 at risk for pain, decreased mobility, and impaired quality of life. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnosis" section, recorded diagnoses of fracture of the coccyx (small triangular bone at	F 689		

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

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the base of the spine), fall, acute posthemorrhagic anemia (type of anemia that occurs when a person loses a large amount of blood quickly), Parkinson's disorder (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), personal history of malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm (tumor) of brain, and overactive bladder.

The "Admission Minimum Data Set" (MDS) dated 01/10/24 documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R1 required substantial to maximum assistance with supervision or touching assistance with sit to stand transitions, and chair/bed to chair transfer.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 01/10/24 documented R1 required limited to extensive assistance with wheelchair mobility. R1 had some memory and decision-making difficulties.

The "Falls CAA" dated 01/10/24 documented R1 scored at moderate risk for falls.

R1's "Interdisciplinary Admit and Baseline Care Plan" dated 01/05/24 documented R1 required extensive assistance from two staff members with transferring, bed mobility, and toileting. R1 required extensive assistance from one staff member to walk in the room or corridor and for locomotion on and off the unit. R1 was at risk for falls and had a history of falls with an injury of a fractured tailbone.

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R1's "Admission Fall Risk Assessment" dated 01/05/24 documented a score of 12, which indicated R1 had a moderate fall risk.

R1's EMR lacked evidence the staff assessed R1's ability to lower the footrest on the manual recliner.

An "Interdisciplinary Team (IDT) Nurse's Note" dated 01/10/24 at 11:33 PM documented at the beginning of shift change, Certified Nurse Aide (CNA) M stated R1 was on the floor. Licensed Nurse (LN) G assessed R1 and then LN G and CNA M assisted R1 up to her wheelchair. CNA M assisted R1 to the bathroom and then back to bed.

The "IDT Nurse's Note" dated 01/11/24 at 12:48 AM documented R1 sustained an unwitnessed fall at approximately 10:10 PM (on 01/10/24). When asked what happened, R1 reported she was trying to get out of the recliner. The note documented R1's recliner footrest was extended.

The "IDT Nurse's Note" dated 01/11/24 at 03:05 AM documented R1 stated her right shoulder hurt. R1's shoulder was assessed with no noted discoloration or raised areas; the skin was intact.

The "IDT Nurse's Note" dated 01/11/24 at 09:27 AM documented R1's primary care physician (PCP) was aware of R1's fall and R1 reported pain in her left rib and chest area. R1's PCP gave an order for a portable two-view chest X-ray due to physical limitations secondary to pain after a fall. Staff notified the X-ray technician of the order.

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The "IDT Nurse's Note" dated 01/11/24 at 12:24 PM documented R1's X-ray was obtained, and staff awaited a response of results.

The "IDT Nurse's Note" dated 01/11/24 at 02:22 PM documented that R1's X-ray revealed no acute process. R1's lungs were adequately expanded and clear without suspicious mass lesions (lesions greater than three centimeters in length) or infiltration (the diffusion or acclimation of foreign substances in amounts excess of the normal). The mediastinal structures (space within your chest that contains your heart and both lungs) and heart were noted to be within normal limits. Staff notified R1's PCP with no new orders noted.

The facility investigation dated 01/31/24 documented CNA M observed R1 laying on the floor to the left of R1's recliner on 01/10/24 at 10:20 PM. The recliner footrest was extended. CNA M immediately notified LN G who assessed R1 with no injuries identified. When asked what happened, R1 stated she was getting out of the recliner and fell. When asked if she knew where she was, R1 replied she was at home and when asked the day of the week, R1 replied Saturday though the day was Wednesday. R1 was incontinent at the time of the event. R1 had her call pendant in reach but failed to activate it. R1 reported pain in her right shoulder during the night after the fall. Staff offered R1 as-needed pain medication to which R1 declined. R1's PCP ordered a bone scan related to continued chest wall pain. R1's bone scan was completed on 01/22/24 and revealed a fractured sternum and left fourth rib.

CNA M's "Witness Statement" dated 01/10/24

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documented on 01/10/24 at 10:10 PM CNA M found R1 on the floor in R1's room while doing room checks. R1 lay on her left side and to the left side of her recliner. The footrest for R1's recliner was in the raised position.

LN H's "Witness Statement" dated 01/10/24 documented on 01/10/24 at 10:10 PM LN H went to R1's room and observed R1 on the floor to the left of the recliner. The recliner footrest was extended.

LN G's "Witness Statement" dated 01/10/24 documented on 01/10/24 at 10:00 PM CNA M alerted LN G that R1 was on the floor, to the left of R1's recliner. R1 laid on her left lateral side.

R1's EMR and the facility's investigation lacked information related to when R1 was last checked, assisted to the bathroom, or observed in her recliner before the fall on 01/10/24.

On 02/01/24 at 02:45 PM, CNA N stated she thought R1 was not strong enough to maneuver the manual recliner and put the footrest down. CNA N stated she doubted R1 could have lowered the footrest on her own.

On 02/01/24 at 02:55 PM Administrative Nurse D stated that R1 had a manual recliner before the fall and afterwards, R1's family brought in an electric recliner. Administrative Nurse D stated she was unable to determine when R1 was last toileted or checked because CNA P refused to give a statement. Administrative Nurse D said CNA P stopped coming to work after R1's fall and refused to give a statement of what happened the evening R1 fell.

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On 02/01/24 at 03:10 PM, Consultant GG stated that R1 may have had the strength to maneuver the manual recliner handle but R1 had a lot of pain related to her fractured tailbone. Consultant GG revealed that R1 was working on repetitive motions with therapy and required a lot of cues to complete tasks including cueing to use the call light. Consultant GG stated R1 was forgetful.

On 02/01/24 at 03:51 PM, CNA O stated that she assisted R1 into the recliner the day R1 had the fall (01/11/24). CNA O estimated the time she assisted R1 to the recliner was approximately 06:00 PM. CNA O further stated that R1 requested the footrest be raised. CNA O stated the footrest was lifted for R1 and she asked R1 if the resident could lower the footrest, and the resident said she could. CNA O admitted she never saw R1 raise or lower the footrest. CNA O further revealed she later asked CNA P to assist R1 to bed. CNA O told CNA P that R1 was in the recliner and that R1 liked to go to bed around 09:00 PM or 09:30 PM. CNA O believed that CNA P was the staff member assigned to assist R1 to bed.

The facility's policy "Falls" revised 10/12/22 documented residents would be identified for risk of falls and interventions would be implemented to reduce risk. The "Fall Prevention Reference Sheet by Type of Fall Appendix B" lacked reference to recliner evaluations to assess resident safety.

The facility failed to provide R1 with adequate supervision or evaluation of the ability of R1 to safely lower the footrest of the manual recliner, which resulted in a fall. R1 sustained a fractured sternum and fourth left rib as a result of the

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F 689	Continued From page 6 deficient practice.	F 689		