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 04/01/2026

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 A complaint survey was conducted on 04/01/26 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers 2960010, 2790752, 2787823, 2734516, and 2749187 were investigated. The facility census on the first day of the survey was 60. The sample included eight residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide follow-up care and services for Resident (R) 1's fractured wrist when staff failed to make an appointment and take her to a surgeon as ordered by the physician. This resulted in a non-removable device existing for longer than intended without physician oversight, which caused a Stage 3(full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer on R1's thumb.	F0686		

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 04/01/2026

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
F0686 SS = G	Continued from page 1 Findings Included: - R1's Electronic Medical Record (EMR) revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), chronic kidney disease, and a Stage 3 pressure ulcer (full-thickness pressure injury extending through the skin into the tissue below). R1's 01/22/26 “Quarterly Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded R1 was at risk for pressure ulcers and had no pressure areas or wounds at that time. R1's “Incident Note” dated 02/21/26 at 12:30 PM documented the nurse received a phone call from the hospital reporting R1 was ready to return to the facility. R1 had a fractured right wrist, which was wrapped and had a sling. R1 was to follow up with orthopedics the next week. R1 also had a fractured tailbone. R1's “Health Status Note” dated 02/21/26 at 07:52 PM, documented R1 returned from the hospital with a referral to “Orthopedic Surgery for R1's wrist fracture, at a local Orthopedics & Sports Medicine Clinic. The note listed the address and phone number of the clinic. The note documented staff were to keep the splint dry and intact until the follow-up with orthopedics, R1 should wear the sling for comfort, and return to the Emergency Room (ER) immediately if she developed numbness or tingling in her fingers, worsening pain, or any other concerns. R1's “After Visit Summary” (AVS) from the hospital dated 02/21/26 documented R1 went to the emergency room after a fall with a fracture to her right wrist. A sugar-tong splint (a temporary splint that immobilizes the wrist and elbow while allowing free use of fingers) was applied. The AVS included instructions to keep the bandage around the splint clean and dry and a referral to Orthopedics Surgery was made to the Orthopedics and Sports Medicine clinic and named the clinic. The AVS instructed the facility to call for a follow-up visit as soon as possible for R1's wrist fracture.	F0686		

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 04/01/2026

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
F0686 SS = G	Continued from page 2 R1's progress notes lacked evidence that the staff attempted to call and schedule a follow-up appointment until 03/05/26, nine business days later. R1's "Progress Note" dated 03/05/26 at 07:12 AM, documented the writer of the note tried to make an appointment with the orthopedic doctor, but R1 was not in network. The writer of the note called another orthopedic surgeon, and a referral was faxed over along with the ER note. The note documented that the surgeon's office would call the writer [of the note] back to schedule an appointment. R1's EMR lacked evidence staff attempted to contact the orthopedic surgeon regarding a follow-up appointment until 03/25/26, 31 days after the application of the sugar-tong splint. R1's "Progress Note" dated 03/25/26 at 12:06 PM, documented an appointment was made to see an orthopedic nurse practitioner for 03/27/26 at 09:15 AM. R1's "Progress Note" from the office visit with the Physician's Assistant (PA) for the Orthopedic Surgeon documented R1 had a fracture of her right wrist. It documented R1 had a fall on 02/21/26 and was seen in the emergency room. The facility failed to follow up on the order to follow up with orthopedic surgeon. The note documented R1 had pain in her fingers and hand. R1 had been in a sugar tong splint since her emergency room visit. The note contained a right-hand exam, which documented a pressure sore on the base of the thumb from the sugar splint. R1's provider note 'SKIN AND WOUND NOTE," dated 03/31/26 at 02:39 PM, documented R1 had a fall on 02/21/26 and broke her right wrist. In the emergency room, she was placed in a sugar-tong splint and somehow did not get her follow-up appointment until 03/27/26, when a cast was placed on her. R1 reported she had significant swelling in her wrist and complained of discomfort in her wrist. The note further documented that the resident had a Stage 3 pressure ulcer to her right thumb that measured 0.5 centimeters (cm) by 1.5 cm, and 0.2 cm deep. The wound was 50 percent covered with slough (dead tissue, usually cream or yellow in color). A treatment order was given to wash the wound, apply Hydrogel (a water-based gel that donates moisture	F0686		

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 04/01/2026

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
F0686 SS = G	Continued from page 3 and aids autolytic debridement), and a bordered dressing. On 04/01/26 at 01:45 PM, R1 sat in her room on her couch. R1's hand was not elevated and was swollen with a blue tint to it. R1's pressure area on her right thumb was visible, and the ordered dressing was not in place. On 04/01/26 at 01:48 PM, Licensed Nurse (LN) G stated R1 was alert and oriented most of the time with a little confusion. R1 had a new cast. She was mostly independent in her room. LN G was a contract worker, so she was not aware of the specific situation with R1 but stated when someone returned with an order to have an appointment, she filled out a transportation slip and put it on the calendar. On 04/01/26 at 02:41 PM, Administrative Nurse E stated the ER paperwork documented that the ER sent a referral to the orthopedic doctor on 02/21/26, and the facility staff did not notice the orders in the AVS directed the facility to call the surgeon to make the appointment. Administrative Nurse E verified the facility should have made a follow-up appointment with the orthopedic doctor the following week and confirmed the facility did not follow up with that orthopedic surgeon since they were waiting for the orthopedic surgeon to call to schedule the appointment. Administrative Nurse E said when she reached out to the orthopedic surgeon on 03/04/26 (11 days after the splint was applied and orders given), the clinic said that R1 was not in network, so she called another orthopedic doctor and sent them the referral paperwork. She said staff awaited a call back from the surgeon's office with an appointment and verified that staff did not follow up regarding the appointment until 03/16/26. Administrative Nurse E called the surgeon's office back and learned they had not received the referral sent on 03/04/26. Administrative Nurse E sent the referral again but did not call back until 03/25/26 (nine days later) when she was told the clinic did not require a referral, so an appointment for R1 was scheduled for 03/27/26. On 04/01/26 at 03:30 PM, Administrative Nurse D stated she was not at the facility at the time of the incident and was unsure of the policy for follow-up appointments.	F0686		

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 04/01/2026

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
F0686 SS = G	Continued from page 4 The facility's policy "Professional Medical Consulting Services and Guidelines" documents the policy is to provide medical services necessary for supporting the care and treatment of the resident.	F0686		