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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topeka Presbyterian Manor	4712 SW 6th Ave Topeka, KS 66606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 60 residents. The sample included three residents reviewed for accidents. Based on record review, interviews, and observations, the facility failed to ensure Resident (R)1 remained free from avoidable accident hazards when staff failed to provide safe transfers using the required number of staff and the required equipment per the resident's plan of care. Subsequently, R1 sustained fractures to both her ankles/lower legs. This deficient practice also placed R1 at risk for increased pain and impaired well-being. Findings include: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, recorded diagnoses of malignant neoplasm (tumor) of the lower right lung, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), thrombocytopenia (abnormally low number of platelets, the parts of the blood that help blood to clot, sometimes associated with abnormal bleeding), long term use of anticoagulants (a class of medications sued to prevent the blood from clotting), and hypertension (elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated mildly impaired cognition. R1 had no impairment to the upper or lower extremities and used a wheelchair for mobility. R1 required partial to moderate assistance for upper body dressing. R1 required substantial to maximal assistance for showers, lower body dressing, sitting-to-standing, and all transfers. R1 was dependent on staff assistance for putting on and taking off her footwear. R1 displayed no mood concerns or behaviors. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/14/24 documented R1 had some issues with orientation and recall ability at times. R1 was able to make her needs known verbally and could hear the speaker with no issues noted. The Activities of Daily Living [ADL] CAA dated 02/14/24 documented R1 required limited to extensive assistance with ADLs, transfers, and mobility. R1 transferred with a sit-to-stand lift and used a wheelchair with the assistance of one staff member for mobility. (continued on next page)

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 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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Falls CAA dated 02/14/24 documented R1 scored a moderate risk for falls. R1's left leg was shorter than her right leg after hip surgery. R1 required transfers with extensive assistance and the sit-to-stand lift. R1's speech was clear, and she was able to make her needs known. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. R1 had no impairment to the upper or lower extremities and used a wheelchair for mobility. R1 required substantial to maximal assistance for showers, upper body dressing, and transfers. R1 was dependent on staff assistance for lower body dressing and putting on and taking off footwear. R1 displayed no mood concerns or behaviors. R1's Care Plan implemented 02/28/23 documented R1 used the sit-to-stand lift with extensive assistance of two staff members for transfers. On 09/03/24 at 06:55 AM a Social Service Note documented R1 was tearful regarding her feet and ankles. Hospice care was notified and requested to check on R1's ankles and feet during the next visit. On 09/03/24 at 10:33 AM a Registered Nurse Note documented staff received orders for X-rays of R1's bilateral ankles related to pain and swelling. On 09/03/24 at 03:34 PM the Xray Report documented R1 had significant findings of the left ankle with the impression of osteoarthritic (degenerative changes to one or many joints characterized by swelling and pain) changes, bones were osteopenic (reduced bone density), and there was acute fractures (broken bones) of the distal (away from the farthest point of origin or attachment) tibia (bone of the lower leg) and fibula (one of the two bones of the lower leg) with associated soft tissue swelling. On 09/03/24 at 03:42 PM the Xray Report documented R1 had significant findings of the right ankle with the impression of a spiral fracture (a type of complete fracture that occurs when a long bone is broken by a twisting force) across the distal tibial shaft, a nondisplaced fracture (type of fracture where the bone cracks in only one place and does not move to change alignment) of the fibular shaft, arthrosis (joint or articulation) across the hindfoot (posterior portion of the foot), midfoot (the anterior part of the foot), Achilles calcific tendinopathy (deterioration of the Achilles tendon in the heel), generalized osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), atherosclerotic disease (buildup of fats, cholesterol, and other substances in and on the artery walls), and a calcaneal (the bone that forms the heel of the foot) spur (bony projections that develop along bone edges). On 09/03/24 at 04:55 PM Registered Nurse Note documented Administrative Nurse D requested to transfer R1 to the hospital due to R1's fractured ankles. On 09/03/24 at 09:23 PM a Registered Nurse Note documented R1 was ready to return to the facility. R1's legs were splinted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Facility Investigation dated 09/11/24 documented, according to a staff interview, R1 required a pivot transfer on 09/01/24. Certified Nurse Aide (CNA) M entered R1's room and found R1 had her legs dangling over the side of the bed. CNA M reported R1 was adamant about getting up. The investigation documented two CNAs transferred R1 from the bed to R1's wheelchair, at R1's request, to prevent R1 from falling. The facility investigation documented R1 reported bilateral ankle pain, with R1's left ankle showing mild edema on 09/03/24. R1's physician obtained X-ray orders. The portable X-ray results received on 09/03/24 at 03:30 PM and identified a fracture. R1's physician gave orders to send R1 out to the emergency room for further evaluation. The investigation documented CNA M but lacked identification of any other staff who assisted in the transfer. A notarized Witness Statement dated 09/11/24 documented an interview obtained from CNA M via a phone conversation with Administrative Nurse D. CNA M reported that on 09/01/24 at approximately 10:00 AM while walking by R1's room, R1 had swung her legs out of the bed. CNA M went into R1's room and attempted to have R1 lay back down in bed, but R1 refused. CNA M reported an unidentified CNA helped CNA M stand and pivot R1 into her wheelchair because CNA M was afraid R1 would fall on the floor. The Facility Investigation lacked further staff interviews or statements from the unidentified CNA related to R1's transfer or care on 09/01/24. Review of the facility's staffing schedule for 09/01/24 indicated staff on duty were Licensed Nurse (LN) G, CNA M, CNA N, CNA O, and Certified Medication Aide (CMA) R. On 09/12/24 at 11:10 AM R1 did not respond to a knock on her door or her name. R1 lay in bed on her back with a blanket covering her midsection; her head and feet were uncovered. R1's feet were at a 90-degree angle and wrapped with braces on both feet. On 09/12/24 at 02:30 PM R1 laid in bed on her back with her feet elevated. R1 had family at her bedside. R1's feet were uncovered, and braces were visible on both feet. On 09/12/24 at 01:41 PM CNA O stated she did not help with transferring R1 on 09/01/24. On 09/12/24 at 01:58 PM CNA N stated no one helped CNA M get R1 up into the wheelchair. CNA N observed CNA M leave R1's room and R1 was up in her wheelchair with no sling underneath her to assist with getting R1 back into bed. CNA N stated she assisted CNA M in transferring R1 back into bed. CNA N stated that the transfer was an arm-in-arm transfer she did with CNA M. CNA N said CNA M and she stood on either side of R1 and lifted and pivoted R1 into bed. CNA N confirmed they did not use a gait belt or the lift. On 09/12/24 at 02:05 PM CNA M was unavailable for interview. On 09/12/24 at 02:05 PM LN G stated that she did not know who had helped CNA M transfer R1 out of bed. On 09/12/24 at 02:18 PM CMA R stated she had not helped CNA M transfer R1 out of bed. CMA R revealed that she arrived at R1's room to administer medications and observed CNA M pushing R1 out of her room in her wheelchair with no gait belt (belt used to help transfer or stabilize during activity), no sling. CMA R stated there were no other staff members in the room nor had one just exited R1's room when CMA R approached to administer R1's medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/12/24 at 03:35 PM Administrative Nurse D stated that she had completed a thorough investigation and felt she knew the cause of R1's injuries. Administrative Nurse D revealed that she only interviewed CNA M even after it was reported that the transfer was done with two staff members, but the second staff member was not identified. After learning of the statements provided by the other staff who worked with R1 on 09/01/24, Administrative Nurse D revealed she had more questions about the event but still felt she knew the cause of the injuries and that there was no abuse or neglect. Administrative Nurse D stated that if R1 was transferred with only one staff, it was to keep R1 safe and that would be acceptable if R1 was about to fall off the bed. Administrative Nurse D confirmed that in the statement received from CNA M appeared that R1 was not unsafe or about to fall off the bed. Administrative Nurse D also confirmed that an arm-in-arm transfer without the use of a gait belt was not a safe transfer for R1. The facility's policy Lifting & Transferring Residents revised 10/25/23 documented a safe work environment for resident care areas by providing and requiring the use of safety materials, equipment, and training designed to prevent injury. The policy directed that staff would utilize the proper transfer procedure for each resident. This included the use of the resident transfer devices or other lifting equipment and applying proper body mechanics. The facility did not provide a policy on accidents. The facility failed to ensure R1 remained free from avoidable accidents resulting in bilateral ankle and/or lower leg fractures. This also placed R1 at risk for increased pain and impaired well-being.