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	06/17/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility reported a census of 68 residents. The sample included four residents, with four reviewed for accidents and supervision. Based on observations, interviews, and record review, the facility failed to provide adequate supervision for Resident (R) 1 resulting in an elopement from the facility. This deficient practice placed R1 at risk for preventable accidents and injuries. Findings included: - The Medical Diagnosis section within R1's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R1's Quarterly Minimum Data Set (MDS) completed 06/05/25 noted a Brief Interview for Mental Status (BIMS) of nine, indicating moderate cognitive impairment. The MDS noted he had physically aggressive behaviors, rejections of care, and wandering observed for one to three days. The MDS noted he had bilateral lower extremity impairments but could walk independently with his walker. The MDS noted no falls. R1's Functional Ability Care Area Assessment (CAA) completed 03/11/25 indicated he required limited to extensive assistance with his activities of daily living (ADLs). The CAA noted he could ambulate independently with his walker. The CAA noted he could speak clearly and make his needs known. The CAA noted he had no falls since the last review. R1's Behaviors CAA completed 03/11/25 noted he had physical and verbal behaviors noted in the past. The CAA noted he had wandering behaviors due to his Alzheimer's and wore a Wanderguard (proximity bracelet that alerted staff when he was close too to the exit doors). R1's Care Plan initiated on 02/24/25 indicated he was at risk for elopement related to his Alzheimer's disease. The plan noted he used a walker and was able to ambulate independently. The plan indicated he had a Wandergurad and instructed staff to check its placement each shift and functionality daily. The plan noted he would pace by the facility entrance waiting for his wife to come visit. The plan instructed staff to provide redirection, food, drinks, or activities when pacing. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's EMR under Physician's Orders revealed an order (dated 02/24/25) indicating he wore a Wanderguard bracelet on his right wrist The order instructed staff to check its placement each shift and functionality daily. R1's EMR under Progress Notes revealed a Behavior Note completed on 06/01/25. The note revealed that R1 followed someone out the door before the door's lock could engage. The note revealed the facility's Wanderguard alarm system activated alerting staff to the elopement. The note revealed staff found R1 resting against the brick wall outside the main entry to the facility. The note indicated R1 was assessed with no injuries and R1 was redirected back into the facility. A Facility Incident Report #5756 completed on 06/02/25 revealed that R1 eloped from the facility on 06/01/25 at 08:29 AM. The report indicated his Wanderguard bracelet alerted staff to the front entrance to find R1 leaning up against a brick wall waiting for his wife to arrive to take him to church. The report indicated staff escorted him back inside the facility and assessed him. The report's root-cause analysis revealed that R1 exited the facility behind a visitor leaving the facility. The report revealed all resident designated power of attorneys (DPOAs) were notified not to allow residents out of the facility without checking with staff. The report also noted signage was placed next to the door entry indicating visitors were to check with staff before allowing residents to exit the building. The report indicated all staff were provided education related to wandering and elopement. On 06/17/25 at 09:02 AM an inspection of the Main Entrance revealed signage posted next to the entry doors. The sign indicated All visitors must check with staff before allowing residents to exit the facility. On 06/17/25 at 11:15 AM, R1 rested in his bed. R1 stated he preferred to wait for his wife to arrive at the facility and often met her at the entrance. R1 stated he could not recall the elopement incident but felt he was safe to go outside when he wanted to. R1's Wanderguard bracelet was around his right wrist. On 06/17/25 at 12:05 PM, Licensed Nurse G stated R1's Wandergaurd was checked each shift and tested before bedtime. She stated he liked to wait in the front lobby area for his wife to arrive at the facility to go on outings. She stated that R1 was often confused and required supervision while being outside. On 06/17/25 at 12:20 PM, Administrative Nurse D stated that R1 would often wait for his wife and go to church with her. She stated that R1 followed a visitor out of the facility. She stated the Wanderguard system was triggered, and staff were able to get him back inside without behaviors or issues. She stated the facility had educated staff and visitors about the risks of wandering and elopement. The facility's Wandering and Elopement policy (undated) indicated the facility would monitor all residents at risk for elopement would be closely monitored. The policy noted staff would follow each resident's individualized care interventions as well as facility-wide processes. The facility implemented and completed the following corrective actions related to this incident prior to onsite survey: 1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was immediately assessed on 06/01/25. 2. The facility emailed all DPOAs education related to checking with staff before allowing residents to exit the facility and placed signage on 06/02/25. 3. The facility identified all at-risk residents with potential elopement risks on 06/02/25. 4. The facility completed an audit of all residents with Wanderguard bracelets on 06/02/25. 5. Staff training and education were provided related to wandering and elopement risks on 06/02/25. 6. A medication review was completed for R1 on 06/02/25. Due to the corrective actions completed on 06/02/25, prior to the onsite visit on 06/17/25, the deficient practice was deemed past non-compliance at a D (potential for harm) scope and severity.