STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175418	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Living Center	1112 SE Republican Avenue Topeka, KS 66607

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to identify an elopement that went undiscovered by staff for over eight hours as an allegation of neglect and report it to the State Agency (SA) as required. (Refer to F689) Findings included:- Resident (R)1's Electronic Medical Record (EMR) documented diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), and borderline personality disorder (disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior). R1's Annual Minimum Data Set (MDS) dated 09/23/2025 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1's MDS documented inattentive, disorganized thinking, and altered level of consciousness behaviors were present but fluctuated (comes and goes, changes in severity). The MDS documented R1 had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue, persistent belief or perception held by a person, although evidence shows it was untrue) behaviors that occurred one to three days during the look-back period. The MDS documented R1 had little interest or pleasure in doing things, The MDS documented R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. R1 was independent with her activities of daily living (ADL). R1 took antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), and anticonvulsant medications. The MDS documented R1's change in behavior or other symptoms of current behavior status, care rejection, or wandering compared to prior assessment noted to be worse. R1's Cognitive Loss Care Area Assessment (CAA) dated 09/23/2025 documented R1 had behaviors of drinking all types of alcohol related to PTSD, anxiety disorder, borderline personality disorder, and major depressive disorder. R1 would be free from drinking all types of alcohol, including hand sanitizer, and the staff would monitor R1 for alcohol drinking behaviors. R1's Psychosocial Well-Being CAA dated 09/23/2025 documented R1 had the potential to demonstrate physical behaviors with a history of hitting and kicking staff, non-compliance, worrying, pacing related to depression, a history of harm to others, and refusing showers. The CAA documented if R1 became agitated, staff were to intervene before agitation escalated, guide R1 away from the source of distress, and engage R1 calmly in conversation. If R1 responded aggressively, staff were directed to walk calmly away and approach R1 later. R1's Quarterly MDS dated 03/26/2026 documented R1 had a BIMS score of 15, which indicated cognition was intact. The MDS documented R1 had hallucinations, delusions, physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others one to three days during the look-back period. The MDS documented R1 displayed wandering behaviors that occurred four to six days during the look-back period. R1's Behaviors for Drinking All Types of Alcohol Care Plan revised 11/11/2025 documented R1 was at risk for self-harm. The plan of care further documented R1 had ingested chemicals such as laundry soap related to her diagnosis of borderline (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personality disorder and schizophrenia. R1's plan of care documented R1 would alert staff when she left the faciity on pass. R1's plan of care directed staff to report any signs or symptoms of intoxication, such as tiredness, confusion, altered mental status, agitation, refusal of care, etc., to the charge nurse. Review of R1's physician orders under the Orders tab revealed Naltrexone (prescription medication used to treat alcohol use disorder and opioid use disorder) medication 50 milligrams (mg) tablet, give one tablet by mouth at bedtime for alcohol relapse prevention ordered on 07/18/2025. Review of R1's Monitoring: Wandering on the Tasks tab dated 4/14/2026 documented R1 was wandering at 04:18 AM. Review of R1's Guardianship and Conservatorship document noted that R1 had a court-appointed guardian as of 07/21/2023. R1 was documented as an adult with an impairment in need of a guardian and conservator. R1's Nursing Note dated 06/14/2026 at 05:52 PM documented the charge nurse was informed at approximately 02:00 PM that R1 was not in her room, and it appeared that R1 had not been in her room all day. R1's room reportedly looked the same as it had when the Certified Medication Aide (CMA) went in around noon to give R1 her medications. Staff confirmed the resident had not shown up for smoke breaks. R1's room, including the bathroom and closet were searched, the smoking area, including the stairwells were searched, and R1 was not found. The facility was searched further, R1's peers were spoken to and the outside perimeter was searched. R1's roommate stated that the last time she had seen R1 was at 03:00 AM. R1's guardian was contacted and informed at 03:20 PM, and law enforcement (LE) was notified at 03:24 PM. Staff called both emergency rooms (ER) to see if R1 was there, at which both ERs denied having R1. R1's Third Eye Health Note dated 06/14/2026 at 06:18 PM documented R1 was an elopement risk with a history on eloping from a previous facility and was last seen by facility staff at 04:00 AM. The orders documented to notify clinician if R1 returned to the facility. On 06/16/2026 at 10:57 AM, Administrative Staff A stated that R1 had taken her belongings out like she left the building on a pass. Administrative Staff A stated he did not feel this was an elopement due to R1's planning. Administrative Staff A revealed that R1 did not have approval from her guardian for an overnight pass or to be out on pass. Administrative Staff A stated he felt the facility had protective oversight for R1, along with R1'but still did not feel that R1 had eloped from the facility therefore the facility had not reported it to the SA The facility's F 609, Reporting of Abuse Allegations policy, last approved in October of 2025, documented that an alleged violation was a situation or occurrence that was observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, abuse, including injuries of unknown source, and misappropriation of resident property. The facility's policy documented that should the investigation reveal findings of abuse, such findings would be reported to the State Abuse Registry or other agencies deemed appropriate by the state. If the abuse rises to the level of a suspicious crime, then the following reporting schedule is to be adhered to. The policy further documented that reporting was based upon real clock time, not business hours: Seriously bodily injuries are reported with in two-hour limit, and all others are reported within 24 hours.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, record review, and interviews, the facility failed to provide adequate supervision for Resident (R) 1, who took medications to prevent alcohol relapses and was at risk for self-harm, to prevent an elopement and the staff did not identify the resident was missing for over nine hours. On 06/14/2026 at approximately 04:18 AM staff observed R1 wandering in the facility and this was the last time staff knew R1's whereabouts. On 06/14/2026 at approximately 02:00 PM, staff identified R1 was not in her room, and it appeared she had not been there all day. During the time R1 was out of the facility, without staff knowledge or supervision, there were severe thunderstorm warnings, flash flood warnings, and the temperatures ranged from a low of 55 degrees Fahrenheit (F) to highs of 81 degrees F. The facility's failure to monitor R1 to prevent elopement and self-harming behaviors placed R1 in immediate jeopardy. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of anxiety disorder, posttraumatic stress disorder (PTSD), borderline personality disorder (disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior), insomnia, major depressive disorder, schizoaffective disorder bipolar type (a chronic mental health condition that combines symptoms of schizophrenia with episodes of mania and sometimes depression), and nicotine dependence. R1's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1's MDS documented inattention, disorganized thinking, and an altered level of consciousness with behaviors that were present but fluctuated. The MDS documented R1 had hallucinations and delusions, which occurred one to three days during the look-back period. The MDS documented R1 had little interest or pleasure in doing things, felt depressed or hopeless, had trouble falling asleep or slept too much, felt tired or had little energy, felt bad about herself and thought she would be better off dead or of hurting herself in some way, for 12 to 14 days during the look-back period. The MDS documented R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. R1 was independent with her activities of daily living (ADL). R1 took antianxiety, antidepressant, and anticonvulsant (medication used to prevent seizures) medications. The MDS documented R1's change in behavior or other symptoms of current behavior status, care rejection, or wandering compared to prior assessment were worse. R1's Cognitive Loss Care Area Assessment (CAA) dated 09/23/2025 documented R1 had behaviors of drinking all types of alcohol related to PTSD, anxiety disorder, borderline personality disorder, and major depressive disorder. R1 would be free from drinking all types of alcohol, including hand sanitizer, and the staff would monitor R1 for alcohol drinking behaviors. R1's Psychosocial Well-Being CAA dated 09/23/2025 documented R1 had the potential to demonstrate physical behaviors with a history of hitting and kicking staff, non-compliance, worrying, pacing related to depression, a history of harm to others, and refusing showers. The CAA documented if R1 became agitated, staff were to intervene before agitation escalated, guide R1 away from the source of distress, and engage R1 calmly in conversation. If R1 responded aggressively, staff were directed to walk calmly away and approach R1 later. R1's Falls CAA dated 09/23/2025 documented R1 was at risk for falls and she took psychoactive drugs that put her at risk for falls. The CAA documented R1 was encouraged to wear appropriate non-slip footwear and keep the floor free from spills, and/or clutter. R1's Quarterly MDS dated 03/26/2026 documented she had a BIMS score of 15. The MDS documented R1 had hallucinations, delusions, physical behavioral symptoms directed towards others, and other behavioral symptoms not directed towards others four to six days during the look-back period. R1's Behaviors for Drinking All Types of Alcohol Care Plan revised 11/11/2025 documented R1 was at risk for self-harm. The plan of care further documented R1 had ingested chemicals such as laundry soap related to her diagnosis of borderline personality disorder and (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	schizophrenia. R1's plan of care documented R1 would alert staff when she left the faciity on pass. R1's plan of care directed staff to report any signs or symptoms of intoxication, such as tiredness, confusion, altered mental status, agitation, refusal of care, etc., to the charge nurse. Review of R1's Guardianship and Conservatorship document revealed R1 had a court-appointed guardian as of 07/21/2023. R1 was documented as an adult with an impairment in need of a guardian and conservator. R1's Nursing: Wandering and Elopement Evaluation 2016 dated 05/13/2026 documented a score of 1.0, which indicated no wandering/elopement risk. R1's physician orders recorded an order for Naltrexone (prescription medication used to treat alcohol use disorder and opioid use disorder) medication 50 milligrams (mg) tablet by mouth at bedtime for alcohol relapse prevention ordered on 07/18/2025. Review of R1's Monitoring: Wandering on the Tasks tab dated 06/14/2026 at 04:18 AM documented R1 was wandering. R1's Nursing Note dated 06/14/2026 at 05:52 PM documented the charge nurse was informed at approximately 02:00 PM that R1 was not in her room, and it appeared she had not been in her room all day. R1's room reportedly looked the same as it had around noon when the Certified Medication Aide (CMA) went in to give R1 her medications (R1 was not in the room at that time). Staff confirmed the resident had not shown up for smoke breaks. R1's room, including the bathroom and closet, were searched as well as the smoking area including the stairwells, but R1 was not found. The facility was searched further, staff spoke with R1's peers, and the outside perimeter was searched. R1's roommate stated the last time she saw R1 was at 03:00 AM. The facility contacted and informed R1's guardian at 03:20 PM and notified law enforcement (LE) at 03:24 PM. Staff called both emergency rooms (ER) to see if R1 was there, but both ERs denied that R1 was there. R1's Third Eye Health Note dated 06/14/2026 at 06:18 PM documented R1 was an elopement risk with a history on eloping from a previous facility and was last seen by facility staff at 04:00 AM. The orders documented staff were to notify the clinician if R1 returned to the facility. R1's Nursing Note dated 06/14/2026 at 07:11 PM documented staff called LE for a status update. The facility called R1's guardian and updated him of R1's elopement status and that R1 was still not present in the facility. R1's guardian gave permission to the facility to reach out to R1's ex-spouse so staff called left a message. R1's Nursing Note dated 06/14/2026 at 09:47 PM documented facility staff updated R1's guardian that R1's room appeared to be more decluttered, and her belongings were no longer in the dresser drawers. R1's guardian stated that R1 had a history of leaving facilities in the past. The facility told R1's guardian that R1's absence appeared intentional. R1's guardian stated he would go look for R1 but did not know where to look for her. The facility stated they would keep him updated. R1's Nursing Note dated 06/14/2026 at 10:12 PM the facility contacted emergency services via 911 to provide an update that R1 had not been located and she was not returning phone calls. R1's Nursing Note dated 06/14/2026 at 10:18 PM documented the facility asked R1's guardian if he might know where R1 would have gone. R1's guardian stated that the last time R1 had done this, she was out drinking alcohol and staying behind convenience stores and other places. R1's Nursing Note dated 06/15/2026 at 03:11 PM documented the facility spoke with R1's ex-spouse, who reported R1 was not with him. He would not share family contact information with the facility when asked. R1's ex-spouse revealed R1 had two close family members who lived in town. Review of R1's June 2026 Medication Administration Record (MAR) revealed an order to monitor closely for misuse of alcohol containing perfumes and hand sanitizers every shift for a history of alcohol abuse. The MAR was blank (indicating not done). R1's June 2026 MAR recorded a 1 for most of the morning medications indicating the resident refused the medications. The noon medications were charted as 11 to indicate out [of facility] without medications. Review of R1's June Behavior Monitoring Record lacked any documentation for R1 for 06/14/26. Review of Wunderground.com for 06/14/26 to 06/16/26 revealed several thunderstorm warnings and flash flood warnings, and the temperatures ranged from a low of 55 degrees Fahrenheit (F) to highs of 81 degrees F. Licensed Nurse (LN) H's unnotarized Witness Statement dated 6/13/26 [sic] documented R1 communicated with LN H around 09:30 PM to 10:00 PM on 06/13/2026 to discuss her medications. LN H documented that around 04:00 AM (on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	06/14/2026) she had visual contact with R1. LN H documented R1 was ambulating up the hallway around the nurse's desk. CMA S's unnotarized Witness Statement dated 06/14/2026 documented CMA S went to R1's room for the noon medication pass. CMA S documented R1 was not in her room and CMA S continued her medication pass. CMA S documented that she went back to look for R1, could not locate her, and then told the charge nurse right away. LN I's unnotarized Witness Statement documented on 06/14/2026 LN J informed LN I that R1 had not been seen for some time, and LN J asked if LN I had seen R1. LN I documented she had not seen R1 and then followed LN J to attempt to locate R1. On 06/16/2026 at 10:25 AM, Certified Nurse Aide (CNA) M stated she checked on her residents every two hours. CNA M stated that if a resident normally smoked and that resident was not available at the designated smoking time, she would go look for the resident to see where they were. CNA M stated R1 usually woke up late in the day and if R1 had not come out for the smoke breaks she would have gone to look for R1. On 06/16/2026 at 10:30 AM, CMA R stated staff were supposed to check on residents every two hours. On 06/16/2026 at 10:33 AM, LN G stated that on his shift, the staff were always good at looking for the residents if the residents have not been seen for over 20 minutes. LN G stated that if a resident was not seen either by himself or another staff member, he would go check on that resident. On 06/16/2026 at 10:52 AM, Administrative Nurse D stated that R1 was located at the hospital, detoxing. On 06/16/2026 at 10:59 AM, Administrative Nurse D stated she expected her staff to locate R1 if she had not been seen for a while. On 06/16/2026 at 10:57 AM, Administrative Staff A stated R1 took her belongings out as she left the building on pass. He stated R1 had been doing this for the past three weeks after the facility started to investigate the concern. Administrative Staff A stated he did not feel this was an elopement due to R1's planning. Administrative Staff A revealed that R1 did not have approval from her guardian for an overnight pass or to be out on pass. Administrative Staff A stated he felt the facility had protective oversight for R1 with a guardian but still did not feel that R1 had eloped from the facility. On 06/16/2026 at 01:10 PM, R1's guardian stated he was notified R1 was at the ER. R1's guardian stated he went to the ER to help R1 and see about her treatment, but she left before he arrived. R1's guardian stated he was unsure where she went. R1's guardian confirmed that as of the time of the interview, R1's location was still unknown. The facility's F689 Accidents - Elopements policy, last approved June of 2025, documented the staff would evaluate, investigate, and report all cases of missing residents. The policy documented that an elopement is a situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision if necessary, and the situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration, and/or other medical complications, drowning, or being struck by a motor vehicle. The policy further documented for residents with Substance Use Disorder (SUD) staff would address the risk of leaving the community to satisfy an addiction to alcohol, prescription drugs, or illegal substances. On 06/16/26 at 02:50 PM, Administrative Staff A and Administrative Nurse D received the Immediate Jeopardy [IJ] Template and were informed that the facility's failure to provide adequate supervision to prevent an elopement and failure to monitor R1 to prevent self-harming behaviors placed R1 in immediate jeopardy. The facility submitted an acceptable IJ removal plan on 06/17/2026 which included the following corrective actions:Immediate Action Taken - Law Enforcement notification and guardian informed. Re-education sessions on elopement prevention policy were conducted with current staff. Re-education of elopement policy were completed on 06/16/2026.1:1 education with staff members was completed on 06/16/2026, with no staff member working until they were educated.The CMA that was involved in the occurrence was verbally coached on 06/14/2026 on the proper pathway of medication administration.Current licensed nursing staff were re-educated on medication administration and refusal protocols on 06/14/2026.IDT were educated on the process of Authorized Leave or Pass with differentiation of a day-pass versus an overnight pass.The involved door was immediately sealed and subsequently repaired the following day. Door checks were conducted on 06/14/2026 to ensure proper functionality. Access codes to the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	building were changed on 06/14/2026 Elopement assessments and care plans were reviewed on 06/14/2026 and updated as needed on 06/16/2026. The facility is collaborating with Guardian and Astra to coordinate placement for the resident at the a Detox Center.Re-education was provided to the Administrator and Director of Nursing per the regional team.The facility Completed an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting on 06/17/2026 regarding the event that occurred on 06/14/2026 and the elopement procedures. Implementation of the corrective actions and the removal of the immediate jeopardy was verified onsite on 06/17/2026. The deficient practice remained at a scope and severity of G (actual harm, isolated).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Findings included:- On 06/16/2026 at 02:30 PM, observation revealed the sidewalk that leads away from the patio right outside of the back doors from the dining room area had a four-foot-long by three inches wide gap in the sidewalk that dropped in depth, causing an uneven walking surface area on the sidewalk. Then approximately 16 feet down the sidewalk, going towards the back of the courtyard, there was a patched area to the sidewalk, approximately one foot wide by three feet long, with uneven cracks surrounding the outside of the patch that ranged from one inch in width to approximately six inches in width. Proceeding towards the back of the courtyard, approximately five feet further, there was another misshapen patch with cracks around the outside noted to be uneven with approximately a half an inch in depth, ranging from one inch to six inches in length. Proceeding from there, another 14 feet, another cement patch was applied with no change in depth or trip hazard seen. Proceeding four feet from that area, the sidewalk has an inch and a half wide gap the length of the sidewalk, approximately one fourth of an inch deep. About 15 feet from that gap in the sidewalk, there was a two-and-a-half-foot crack ranging in six inches to two inches in width, approximately one inch deep. At the intersection of the sidewalk that runs North and South at the back of the courtyard, the sidewalk going to the North side of the building has an area of cracked sidewalk, triangular in shape. The area was noted to have uneven ground around the crack. Proceeding to the North side, approximately six feet from the intersection, the sidewalk dropped approximately one inch across the width of the sidewalk. At the intersection of the sidewalk proceeding to the South side there are two significant cracks along the sidewalk that are angles cracks with a significant drop in height of one and a half inches on one angle, then the second angle had a height drop of an inch to a half an inch in height. On 06/16/2026 at 02:32 PM, Resident (R) 2 stated that the sidewalk was a risk for people to walk on. R2 further stated that people could fall because of those cracks. On 06/16/2026 at 02:33 PM, R3 stated that she felt the sidewalk was unsafe and was worried about people falling. On 06/16/2026 at 03:42 PM, Certified Nurses Aide (CNA) N stated that someone could trip on the holes in the sidewalk. CNA N stated she wished that the administration would repair the entire sidewalk like that one area. CNA N stated that there were big ?gashes' that someone could definitely fall or trip if they had a walker and that got stuck. On 06/16/2026 at 04:21 PM, Administrative Nurse D confirmed that the areas of the sidewalk had gaps and changes in height were present and a risk. Administrative Nurse D stated that the residents who walk out there had a risk of falling, especially if the resident has a cane or walker. The facility did not provide a policy related to environmental safety and care when asked on 06/16/2026 at 4:21 PM.