Printed: 02/22/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	07/14/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Excel Healthcare and Rehab Topeka		2515 SW Wanamaker Road Topeka, KS 66614	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0689	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.		
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22686		
Residents Affected - Few	 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22686 The facility reported a census of 102 residents. The sample included four residents identified at risk for elopement (when a resident leaves the premises or safe area without staff knowledge). Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for Resident (R) 1, who was independent with ambulation, at risk for elopement, and had impairs cognition. The facility reported a census of 102 residents. The sample included four resident sedent (R) 1, who was independent with ambulation, at risk for elopement, and had impairs cognition. On 07/12/22 at approximately 10:10 AM Certified Nurse Aid M let R1 outside into the enclosed courtyard. R1 proceeded to walk towards the back area of the courtyard, out of the line of sight of CNA M. CNA M then escreted another resident tack into the building. When CNA M went back to look for R1, R1 was gone. CNA M then alerted other facility staff and staff began to search inside the facility but were unable to locate the resident. Staff began to search the surrounding area outside the facility. Approximately one ho and five minutes later. CNA N located R1 by a food establishment more than 0.5 miles from the facility. CNL M returned R1 to the facility. The facility staff failed to provide adequate supervision and allowed R1 to wander outside of visualization resulting in R1 climbed over the fence in the courtyard and left the facility without staff knowledge or supervision. This deficient practice placed R1 in Immediate Jeopardy. Findings included: R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed diagnoses of dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) encephalopathy. (a broad term for any brain disease that alters brain function or structure); late onset Alzheimer's disease, (a p		supervision to prevent an isk for elopement, and had impaired cluded four residents identified at nout staff knowledge). Based on equate supervision to prevent an isk for elopement, and had impaired let R1 outside into the enclosed out of the line of sight of CNA M. M went back to look for R1, R1 ch inside the facility but were unable the facility. Approximately one hour han 0.5 miles from the facility. CNA upervision and allowed R1 to he courtyard and left the facility in Immediate Jeopardy. diagnoses of dementia (a mental ke decisions, and solve problems); ction or structure); late onset 65); amnesia, (an inability to nearing loss following a cerebral

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Topeka		STREET ADDRESS, CITY, STATE, ZI 2515 SW Wanamaker Road Topeka, KS 66614	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	The Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering behavior daily during the assessment period. The MDS recorded R1 as independent with most activities of daily living (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive devices. The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the facility and		
Residents Affected - Few	wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or exit.		
	An admission Elopement Risk assessment dated [DATE] recorded a score of 14, which placed the residen at high risk for elopement.		
	Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement wit a score of 26.		
	R1's initial Care Plan dated 03/12/22 documented the resident was at risk for elopement distract the resident by offering pleasant diversions, attempt to identify any pattern to initiate psychiatric services evaluation if needed, and check placement of a left ankle (Wanderguard), every shift.		y pattern to target interventions,
	A Social Service Progress Note dated 05/11/22 timed 12:19 PM. documented R1 stated he was leaving the facility, and R1 removed the left ankle alarm bracelet. The note documented staff redirected R1.		
	was agitated, wanted to leave the factor	ted 07/12/22 at 08:56 AM (94 minutes l acility unaccompanied, and wanted to the ne would need to have an escort due to redirection.	ake the bus to his fiance's house
	R1's clinical record lacked any doct descriptive narrative and/or timeline	umentation regarding the circumstance e of R1'elopement from the facility.	s surrounding the elopement, or a
	X, Administrative Nurse F, and the	ted 07/12/22 at 11:49 AM (after the elo Consultant GG met with R1 to evaluate irected, and R1's responsible party was	e R1's wellbeing. R1 was agitated
	area for fresh air and left the reside had a broken lock. At 10:30 AM sta sweep to look for R1. Staff drove a AM R1 returned to the facility on his assessed the resident. Consultant	I on 07/12/22 a staff member took R1 c ont alone. It was speculated that the res off noted R1 was missing and performer round the area and looked for R1. The s own and walked in the front door. Co GG gave an order for Ativan (an antian on. The investigation noted the residen irt.	sident exited through a gate that d a room sweep, and outside investigation documented at 11:1 nsultant GG was in the facility and xiety medication) and sent the
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED		
	175172	B. Wing	07/14/2022		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE		
Excel Healthcare and Rehab Topeka		2515 SW Wanamaker Road Topeka, KS 66614			
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.		
(X4) ID PREFIX TAG			CIENCIES full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Witness Statement from Agency resident outside in the courtyard fo walked the sidewalks and walked t longer visible. The other resident w documented she assisted the fema the courtyard. Agency CNA M checks secure. Agency CNA M went inside checked R1's room and R1 was no sibling and was found near local fa A Witness Statement from Agency was called, Agency LN H searcheck mile from the facility, walking towar was headed to his family home near and return to the facility with Agence front door to his assigned room. According to Wunderground.com of variable winds and fair skies. Observation on 07/14/22 At 10:00 J duty caregiver. R1 wore a persona On 07/14/22 at 11:00 AM observat revealed an alarming maglock key Wanderguard alarm system. The c south end of which was obscured f On 07/14/22 at 11:30 AM observat heavily trafficked road with four lan per hour. R1 had to cross a busy in reach the location where he was fo On 07/14/22 at 10:00 AM R1 reme friend in the hospital. R1 then state he referred to as the tracking device fingernail trimmers. R1 stated he e wooden fence slats. R1 demonstra a leg to near the top of the door; R On 07/14/22 at 11:46 AM Agency L	Certified Nurse Assistant (CNA) M doc r a late smoke break. R1 knocked on th o the west side of the courtyard toward le resident back inside and then went t cked the locks and the door in that corn e to see if anyone saw R1 come inside t present. Agency CNA M was told R1 st-food restaurants. Licensed Nurse (LN) H documented af I for R1 in a private vehicle. Agency LN d the facility. Agency LN H circled back arby. R1 was reluctant at first, but even cy LN H. Upon return, R1 exited the vehicle and 10/13/22 at 10:53 AM the temperatur AM revealed R1 walked about the facilit alarm bracelet on R1's left ankle. ion of the area where R1 exited the faci coded door to the facility courtyard. The ourtyard itself revealed an approximate rom the entrance door to the courtyard. ion of the area where R1 was found reve es of traffic. The posted speed along the theresection with four lanes of traffic mov- uund, approximately 0.7 miles from the fa- wited the facility by climbing the brick er ted his agility by standing next to a door 1 stated it's easy for a tall guy. LN G stated the only preventative meas ated that the morning of the elopement	umented she took a female he window to come outside. R1 s the back area, where he was no out of sight. Agency CNA M o look for R1. R1 was no longer in er and everything on that side was and was told no one saw R1. Staff went over the fence and to see a ter a code grey (missing resident) H located R1 approximately one s, and R1 stated to LN H that R1 tually agreed to enter the vehicle nicle and walked through the facility re was 86 degrees Fahrenheit with ty easily, accompanied by a private lity with Administrative Staff A e door was not equipped with a ly 6-foot-high wooden fence, the realed an [NAME] area along a hat stretch of the road was 35 miles ing north/south and east/west to facility. R1 stated he was going to visit a splayed the personal alarm, which vere easily removed with a pair of neased standards between the r in the dining room and stretched uures known for R1 wandering was		

	1	1	1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Excel Healthcare and Rehab Topeka		2515 SW Wanamaker Road Topeka, KS 66614	
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile south of the facility, by a fast food restaurant. R1 was walking back toward the facility when he was found. Agency LN H stated she pulled alongside R1 and R1 said he was not coming back. Agency LN H stated she asked R1 if he would like to get some fresh air in the car and R1 said yes and got in the car.		
Residents Affected - Few	Interviewed on 07/14/22 at 10:00 AM Social Services Y stated he assisted in the search for R1and stated all staff assisted as well. Social Services YY said R1 was at a stage in his dementia where R1 did not think he should be in a facility but did not know where he should be.		
	On 07/13/22 At 12:15 PM Consultant GG stated R1 was sent to the hospital for evaluation and treatment an was diagnosed with a urinary tract infection. R1 was placed on antibiotic therapy and returned to the facility.		
	On 07/14/22 at 01:00 PM Administrative Nurse F acknowledged staff allowing R1 to be unsupervised in the courtyard did not follow the facility's policies and procedures.		
	On 07/14/22 at 11:00 AM Administrative Staff A acknowledged residents should not be left outside unattended. Administrative Staff A provided documentation of immediate staff education conducted after the incident.		
	information activation, and search	esident/Elopement revised 01/20/20 pr procedures after a resident eloped fron iny measures to prevent the elopement	n the facility. The policy however,
	The facility failed to provide adequate supervision to prevent an elopement for R1 who was independent with ambulation, at risk for elopement, and had impaired cognition when facility staff allowed R1 to wander outside of visualization resulting in R1 climbed over the fence in the courtyard and left the facility without staff knowledge or supervision. This deficient practice placed R1 in Immediate Jeopardy.		
	The deficient practice was determin corrective actions on 07/12/22 prior	ned past noncompliance when the facil r to the survey event:	ity completed the following
	R1 was evaluated at a local Hospital and returned to the facility. R1 was placed on 1:1 supervision when he returned to the facility on .		
	Psychiatric services were scheduled for R1.		
	An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions.		
	Staff were re-educated on elopement prevention, safety, and supervision of residents at all times when a resident was outside.		
	All residents in the facility were reviewed for Elopement Risk Assessments.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
Excel Healthcare and Rehab Topeka		2515 SW Wanamaker Road Topeka, KS 66614		
For information on the nursing home's	plan to correct this deficiency, please cont	l tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)	
F 0689	Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside.			
Level of Harm - Immediate jeopardy to resident health or safety	The scope and severity remained a	it a J		
Residents Affected - Few	Findings included:			
	- R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed diagnoses of dementia disorder in which a person loses the ability to think, remember, learn, make decisions, and solve encephalopathy, (a broad term for any brain disease that alters brain function or structure); late Alzheimer's disease, (a progressive memory decline occurring after age 65); amnesia, (an inabi remember events for a period of time); speech and language deficit and hearing loss following a vascular accident, (difficulty with hearing and/or articulating words following an interruption of bl the brain).			
	The Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for M score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering beha during the assessment period. The MDS recorded R1 as independent with most activities of da (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive of The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearin attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or An admission Elopement Risk assessment dated [DATE] recorded a score of 14, which placed at high risk for elopement.		1 had wandering behavior daily h most activities of daily living	
			when residents wearing one	
			e of 14, which placed the resident	
	Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement with a score of 26.			
	distract the resident by offering plea	22 documented the resident was at risk asant diversions, attempt to identify an ion if needed, and check placement of	y pattern to target interventions,	
		ted 05/11/22 timed 12:19 PM. docume kle alarm bracelet. The note document		
	A Social Service Progress Note dated 07/12/22 at 08:56 AM (94 minutes before the elopement) recorded R1 was agitated, wanted to leave the facility unaccompanied, and wanted to take the bus to his fiance's house. Social Services X explained to R1 he would need to have an escort due to his cognition and memory issues. R1 became agitated, but accepted redirection.			
	R1's clinical record lacked any doct descriptive narrative and/or timeline	umentation regarding the circumstance e of R1'elopement from the facility.	es surrounding the elopement, or a	
	(continued on next page)			

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NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Topeka		STREET ADDRESS, CITY, STATE, ZI 2515 SW Wanamaker Road Topeka, KS 66614	P CODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f			on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Social Service Progress Note dat X, Administrative Nurse F, and the and confused. R1 was calmed, redi understanding of the situation. The facility's Investigation recorded area for fresh air and left the reside had a broken lock. At 10:30 AM sta sweep to look for R1. Staff drove at AM R1 returned to the facility on his assessed the resident. Consultant i resident to the hospital for evaluation long-sleeved shirt, and an undershit A Witness Statement from Agency resident outside in the courtyard for walked the sidewalks and walked to longer visible. The other resident w documented she assisted the femat the courtyard. Agency CNA M check secure. Agency CNA M went inside checked R1's room and R1 was no sibling and was found near local fast A Witness Statement from Agency was called, Agency LN H searched mile from the facility, walking towar was headed to his family home near and return to the facility with Agence front door to his assigned room. According to Wunderground.com o variable winds and fair skies.	ded by full regulatory or LSC identifying information) ote dated 07/12/22 at 11:49 AM (after the elopement) recorded Social Service and the Consultant GG met with R1 to evaluate R1's wellbeing. R1 was agitated ad, redirected, and R1's responsible party was contacted and verbalized n. corded on 07/12/22 a staff member took R1 outside to the South patio smoking resident alone. It was speculated that the resident exited through a gate that AM staff noted R1 was missing and performed a room sweep, and outside rove around the area and looked for R1. The investigation documented at 11:1 y on his own and walked in the front door. Consultant GG was in the facility an ultant GG gave an order for Ativan (an antianxiety medication) and sent the valuation. The investigation noted the resident was dressed in overalls, a ndershirt. gency Certified Nurse Assistant (CNA) M documented she took a female vard for a late smoke break. R1 knocked on the window to come outside. R1 alked to the west side of the courtyard towards the back area, where he was no det was done smoking shortly after R1 went out of sight. Agency CNA M e female resident back inside and then went to look for R1. R1 was no longer i M checked the locks and the door in that corner and everything on that side was t inside to see if anyone saw R1 come inside and was told no one saw R1. Sta was not present. Agency CNA M was told R1 went over the fence and to see a bocal fast-food restaurants. gency Licensed Nurse (LN) H documented after a code grey (missing resident arched for R1 in a private vehicle. Agency LN H located R1 approximately one t toward the facility. Agency LN H circled back, and R1 stated to LN H that R1 me nearby. R1 was reluctant at first, but eventually agreed to enter the vehicle Agency LN H. Upon return, R1 exited the vehicle and walked through the facili or.	
	On 07/14/22 at 11:00 AM observati revealed an alarming maglock key Wanderguard alarm system. The co	on of the area where R1 exited the fac coded door to the facility courtyard. Th ourtyard itself revealed an approximate rom the entrance door to the courtyard	e door was not equipped with a ly 6-foot-high wooden fence, the
	heavily trafficked road with four lan- per hour. R1 had to cross a busy in	on of the area where R1 was found reves of traffic. The posted speed along th tersection with four lanes of traffic mov	hat stretch of the road was 35 miles ring north/south and east/west to
	reach the location where he was fo	und, approximately 0.7 miles from the	facility.

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022			
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Topeka		P CODE			
plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.			
		on)			
 On 07/14/22 at 10:00 AM R1 remembered exiting the facility on 07/13/22. R1 stated he was going to vis friend in the hospital. R1 then stated he was going to visit his sister. R1 displayed the personal alarm, whe referred to as the tracking device on his ankle, and stated the alarms were easily removed with a pair fingernail trimmers. R1 stated he exited the facility by climbing the brick encased standards between the wooden fence slats. R1 demonstrated his agility by standing next to a door in the dining room and stretce a leg to near the top of the door; R1 stated the only preventative measures known for R1 wandering the Wanderguard. Agency LN G stated that the morning of the elopement, R1 verbalized that he wanted go home so all staff watched R1 at intervals. On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile south of the facility, by a fast the restaurant. R1 was walking back toward the facility when he was found. Agency LN H stated she pulled alongside R1 and R1 said he was not coming back. Agency LN H stated she asked R1 if he would like to some fresh air in the car and R1 said yes and got in the car. 					
			Interviewed on 07/14/22 at 10:00 AM Social Services Y stated he assisted in the search for R1ar staff assisted as well. Social Services YY said R1 was at a stage in his dementia where R1 did n should be in a facility but did not know where he should be. On 07/13/22 At 12:15 PM Consultant GG stated R1 was sent to the hospital for evaluation and tr was diagnosed with a urinary tract infection. R1 was placed on antibiotic therapy and returned to		
	0	wing R1 to be unsupervised in the			
information activation, and search p	procedures after a resident eloped from	the facility. The policy however,			
ambulation, at risk for elopement, a outside of visualization resulting in	nd had impaired cognition when facility R1 climbed over the fence in the courty	y staff allowed R1 to wander yard and left the facility without sta			
		ity completed the following			
R1 was evaluated at a local Hospita returned to the facility on .	al and returned to the facility. R1 was p	laced on 1:1 supervision when he			
(continued on next page)					
	ER ka plan to correct this deficiency, please cont SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by On 07/14/22 at 10:00 AM R1 remer friend in the hospital. R1 then state he referred to as the tracking device fingernail trimmers. R1 stated he ee wooden fence slats. R1 demonstrat a leg to near the top of the door; R2 On 07/14/22 at 11:46 AM Agency L the Wanderguard. Agency LN G state go home so all staff watched R1 at On 07/14/22 at 11:48 AM Agency L restaurant. R1 was walking back to alongside R1 and R1 said he was r some fresh air in the car and R1 sail Interviewed on 07/14/22 at 10:00 A staff assisted as well. Social Service should be in a facility but did not kn On 07/13/22 At 12:15 PM Consulta was diagnosed with a urinary tract if On 07/14/22 at 01:00 PM Administr courtyard did not follow the facility's On 07/14/22 at 11:00 AM Administr unattended. Administrative Staff A incident. The facility failed to provide adequa ambulation, at risk for elopement, a outside of visualization resulting in knowledge or supervision. This defi The deficient practice was determine corrective actions on 07/12/22 prior R1 was evaluated at a local Hospitar returned to the facility on .	175172 B. Wing ER STREET ADDRESS, CITY, STATE, ZI ka Z515 SW Wanamaker Road plan to correct this deficiency, please contact the nursing home or the state survey SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati On 07/14/22 at 10:00 AM R1 remembered exiting the facility on 07/13/22, friend in the hospital. R1 then stated he was going to visit his sister. R1 di he referred to as the tracking device on his ankle, and stated the alarms vingernail trimmers. R1 stated he eakled the facility by standing next to a doc a leg to near the top of the door; R1 stated fits easy for a tall guy. On 07/14/22 at 11:46 AM Agency LN G stated the only preventative meast the Wanderguard. Agency LN G stated that the moming of the elopement go home so all staff watched R1 at intervals. On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile restaurant. R1 was walking back toward the facility when he was found. A alongside R1 and R1 said he was not coming back. Agency LN H stated is some fresh air in the car and R1 said yes and got in the car. Interviewed on 07/14/22 at 10:00 AM Social Services Y stated he assisted staff assisted as well. Social Services YY said R1 was sent to the hospi was diagnosed with a urinary tract infection. R1 was placed on antibiotic t On 07/14/22 at 01:00 PM Administrative Nurse F acknowledged residents suntate add. Administrative Staff A provided documentation of immediate incident. The facility's policy titled Missing Resident/Elopement revised 01/20/20 pr information activation, and sea			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
	FD	STREET ADDRESS, CITY, STATE, ZI	
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Topeka		2515 SW Wanamaker Road Topeka, KS 66614	PCODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0689	Psychiatric services were schedule	ed for R1.	
Level of Harm - Immediate jeopardy to resident health or safety	An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions.		
Residents Affected - Few	Staff were re-educated on elopeme resident was outside.	ent prevention, safety, and supervision	of residents at all times when a
	All residents in the facility were revi	iewed for Elopement Risk Assessment	S.
	Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside.		
	The scope and severity remained a	at a J	