

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Brighton Place West		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW Oakley Street 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)
<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>(continued on next page)</p>

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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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 50 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to provide the necessary behavioral care and services for Resident (R) 1, who had moderate cognitive impairment as well as schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and a history of violence and substance abuse. On 07/07/25, R1 began refusing to take his mental health medications and demonstrated increased behaviors. On 07/10/25, around 11:06 AM, the Social Worker spoke with R1's parental guardian, who shared concerns with R1's history of medication noncompliance, erratic behaviors, and history of substance abuse. At around 03:58 PM, after asking Administrative Nurse D and Administrative Nurse E a question, R1 began kicking the door, stating he wanted to leave the facility, and made threats to kill the staff. The staff provided R1 with an Against Medical Advice (AMA) form (a document signed by a patient who is choosing to leave a healthcare facility against their physician's recommendation), which R1 signed, and allowed R1 to leave the facility. The staff did not involve R1's physician, guardians, emergency services, or law enforcement in an attempt to de-escalate or address the mental health crisis. R1 was gone from the facility, with his whereabouts unknown, for seven days before law enforcement picked him up for attempting to procure alcohol without payment and for erratic behaviors. R1 admitted to the acute hospital with sunburn and dehydration. The facility's failure to provide adequate and appropriate services, including physician and guardian involvement to treat a behavioral health crisis, placed R1 in immediate jeopardy. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of need for assistance with personal care, difficulty in walking, muscle wasting and atrophy (wasting or decrease in size of a part of the body), and age-related physical debility. The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. The MDS documented R1 required supervision or touching assistance for hygiene, showers or bathing, dressing, and moving from seated to standing position. The MDS documented R1 required supervision or touching assistance for chair or bed, shower or tub, and toilet transfers. The MDS further documented R1 required supervision or touching assistance for walking. The MDS documented R1 required partial or moderate assistance for car transfers, picking up objects, and going up curbs and steps. The Cognitive Loss / Dementia Care Area Assessment (CAA), dated 07/03/25, directed staff to monitor for signs and symptoms of acute mental status changes to help treat the underlying condition. The Falls CAA, dated 07/03/25, directed staff to anticipate and meet R1's care needs so R1 did not attempt to unsafely perform Activities of Daily Living (ADL) cares without staff assistance. R1's Care Plan revealed the following with their initiated dates: 06/27/25, R1 needed assistance with ADLs related to schizophrenia and weakness from recent hospitalization. 07/06/25, R1 had impaired cognitive function or dementia, or impaired thought processes related to psychotropic (alters mood or thought) drug use. 07/06/25, directed staff to monitor, document, and report any changes in cognitive function, specifically changes in decision-making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. 07/06/25, R1 was at risk for falls related to impaired mobility. 07/07/25, R1 would work to express and manage his emotions and behaviors. 07/07/25, directed staff to encourage R1 to discuss feelings and monitor his progression or decompensation for continued stabilization. R1's Guardianship documents, dated 01/26/22, recorded By clear and convincing evidence, [R1] is an adult with impairments and lacks the capacity to meet essential needs for physical health, safety or welfare, should not be permitted to make any decisions which affect his person, and the Co-Guardians herein appointed shall be possessed of all the powers and duties of a Guardian as set out in K.S.A. §59-3075 and the Letters of Guardianship to be issued herein shall so state. An Acute Care admission Psychiatric Evaluation dated 05/28/25, recorded R1 had diagnoses of schizophrenia and schizoaffective disorder, bipolar type (a condition that combines symptoms of schizophrenia and bipolar disorder [major mental illness that causes people to have episodes of severe high and low moods]). The document further recorded the hospital requested screening due to R1's behaviors and R1 not stabilizing. The document recorded R1 had not cleared the signs and symptoms of psychosis (any major mental disorder characterized by a gross impairment in reality perception) since 05/01/25. The document recorded R1 repeatedly physically attacked staff and peers: R1</p>		