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 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place West	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)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 27168 The facility had a census of 48 residents. The sample included 13 residents. Based on record review and interview the facility failed to deliver mail to facility residents on Saturdays. Findings included: - On 10/14/24 at 01:00 PM during the resident council meeting, a resident verbalized there was no mail delivery on Saturdays. On 10/14/24 at 02:00 PM, Administrative Staff verified the Activity Director would get the mail during the week from the mailbox in front of the facility, then deliver to the residents. Administrative Staff A verified the key to the mailbox was kept in the Activity Directors office and said there was another key kept in the medication cart. Administrative Staff A verified that on the weekends the medication aide would get the mail and deliver the residents' personal mail and the business mail would be kept in the office. Administrative Staff said that Certified Medication Aides knew they were to get the mail on Saturdays. On 10/14/24 at 02:15 PM, Certified Medication Aide (CMA) R looked through both the facility medication carts, and the medication room, and could not find the mailbox key. CMA R said he was unaware that the CMAs were supposed to get the mail and deliver it to the residents on Saturdays. On 10/14/24 at 2:25 PM, Administrative Staff A verified the mailbox key was not in the medication carts and stated she would have to do some in-servicing to the weekend staff regarding the mail. The facility's Resident Right to Privacy in Communication, dated 08/08/2019 documented residents are to have a right to privacy in communications with entities within and external to the facility. The policy documented they would honor the resident's right to privacy in written communication including the right to send and promptly receive mail unopened. Promptly means delivery of mail or other material to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service. The facility failed to deliver mail to the residents in the facility on Saturday.

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: 175547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 48 residents. The sample included 13 residents with three reviewed for discharge. Based on observation, interview, and record review the facility failed to provide written notice for facility-initiated transfers for Residents (R) 22, R23, and R20 or their representative when they were transferred to the hospital. The facility also failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of R22, R23, and R20's discharge. This placed the residents at risk of uninformed care choices. Findings included: - R22's Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to insulin), and hypertension (elevated blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R22 required supervision for activities of daily living. R22's Care Plan dated 09/08/24 directed staff to observe the resident daily for safety. The plan recorded the resident was taking anti-anxiety medications which are associated with an increased risk of confusion, loss of balance, and cognitive impairment and increase the risk of falls. The Progress Note, dated 05/07/24 at 09:22 AM, documented R22 ambulated with an unsteady gait and staff helped R22 to a chair. R22 was drooling and unable to form a sentence and when asked to smile his right side drooped a bit. The physician ordered staff to send R22 to the emergency room . The Progress Note, dated 05/08/24 at 06:43 PM, documented R22 returned from the hospital. R22's medical record lacked documentation of written notice to R22 or his representative. On 10/14/24 at 04:15 PM, observation revealed R22 sat in a chair at the dining table reading a book with his walker beside him. On 10/15/24 at 10:55 AM, Social Services X verified he had not sent any discharge notices to the state ombudsman office. He stated he was not aware the mental health facilities were to send the notices. On 10/17/24 at 10:00 AM, Administrative Nurse D verified the facility had not provided written notice to the resident or their representative of the reason for the discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Bed Hold Policy, documented at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident or representative written notice that specifies the duration of the bed hold policy and addresses information explaining the return of the resident to the next available bed. The facility failed to provide written notice of a facility-initiated transfer to R22 or their representative when they were transferred to the hospital and also failed to notify the Office of the Long-Term Care Ombudsman of the discharge. This placed R22 at risk of uninformed care choices and impaired resident rights. - R23's Electronic Medical Record documented diagnoses of urinary tract infection (UTI-an infection in any part of the urinary system), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), chronic respiratory failure with hypoxia (inadequate supply of oxygen), and hypertension (HTN-elevated blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. The MDS documented R23 required supervision with some activities of daily living. The Progress Note, dated 09/25/24 at 05:37 PM, documented R23 was seen by her nurse practitioner and new orders included Rocephin (antibiotic), 1 milligram (mg) for UTI and continued Macrobid (antibiotic) as ordered. The Progress Note, dated 09/25/24 at 09:29 PM, documented a change in R23's condition and the physician ordered staff to send R23 to the hospital. On 10/15/24 at 10:02 AM, observation revealed R23 ambulated to the dining room and received a chocolate supplement drink. R23 poured it into the trash and went outside to sit. On 10/15/24 at 10:55 AM, Social Service X verified he had not sent any discharge notices to the state ombudsman office. He stated he was not aware the mental health facilities were supposed to send the notices. On 10/17/24 at 10:00 AM, Administrative Nurse D verified the facility had not provided written notice to the resident or their representative of the reason for the discharge. The facility's undated Bed Hold Policy, documented at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident or representative written notice that specifies the duration of the bed hold policy and addresses information explaining the return of the resident to the next available bed. The facility failed to provide written notice of a facility initiated transfer to R23 or their representative when they were transferred to the hospital and failed to notify the Office of the Long-Term Care Ombudsman of the discharge. This placed R23 at risk of uninformed care choices and impaired rights. 32358 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R20's Electronic Medical Record (EMR) documented that R20 had a diagnosis of overactive bladder (a condition that causes sudden urges to urinate that may be hard to control). R20's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R20 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R20 required staff supervision for toileting hygiene. R20's Care Plan, revised 10/01/24-, documented R20 was independent with toileting. The Progress Note, dated 12/23/23 at 04:15 PM, documented R20 was admitted to the hospital. A review of R20's clinical record lacked evidence that the resident or representative was provided written notice when she was transferred to the hospital or of notification to the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of R20's discharge. On 10/14/24 at 12:30 PM, observation revealed that R20 sat in a wheelchair by the medication cart and visited with staff. On 10/15/24 at 01:03 PM, Social Service X stated he was responsible for providing the bed hold policy to residents but was unaware he was supposed to provide notice when a resident was transferred to the hospital. Social Service X stated nursing was responsible for providing written notice to the resident or his representative when R20 was transferred to the hospital. On 10/15/24 at 01:03 PM, Licensed Nurse (LN) I stated nursing notifies the resident's representative by phone but does not give them a written notice when a resident is transferred to the hospital. On 10/17/24 at 10:00 AM, Administrative Nurse D verified the facility had not provided written notice to the resident or their representative which included the reason for the discharge when R20 was transferred to the hospital. The facility's undated Bed Hold Policy, documented at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident or representative written notice that specifies the duration of the bed hold policy and addresses information explaining the return of the resident to the next available bed. The facility failed to provide R20 or his representative with written notice regarding R20's facility-initiated transfer to the hospital and did not notify the LTCO. This placed the resident and/or her representative at risk of uninformed care choices and impaired rights.

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F 0760

Level of Harm - Actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43204

The facility identified a census of 48 residents. The sample included 13 residents with five residents reviewed for significant medication errors. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 21 remained free of significant medication errors. On 12/28/24 the facility received an order from R21's psychiatric provider to discontinue Clozaril (an antipsychotic medication used to treat major mental conditions that cause a break from reality) 25 milligrams (mg) in the morning. Licensed Nurse (LN) G discontinued both the 25 mg dose of Clozaril scheduled in the morning and the 500 mg dose of Clozaril at bedtime creating an abrupt discontinuation of the medication. This deficient practice resulted in increased auditory and visual hallucinations (sensing things while awake that appear to be real, but the mind created) for R21, which caused her significant psychosocial distress.

Findings include:

- R21's Electronic Medical Record (EMR) documented R21 had diagnoses of disorganized schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), extrapyramidal and movement disorder (movement disorders as a result of taking certain medications), and hypertension (high blood pressure).

The Quarterly Minimum Data Set (MDS), dated [DATE], documented R21 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R21 had indicators of psychosis (any major mental disorder characterized by a gross impairment in reality perception) including delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) but no hallucinations. The MDS documented R21 took antipsychotic medication during her stay at the facility.

The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 04/14/24, documented staff were to monitor for signs and symptoms of acute mental status changes to treat underlying conditions. The CAA documented staff were to use short simple sentences and allow adequate time for R21 to understand and communicate her needs. The CAA directed staff to approach R21 in a non-threatening manner to help R21 feel calm and unhurried.

The Psychotropic Drug Use CAA, dated 04/14/24, documented psychotropic (altering mood or thought) medications would be addressed in R21's plan of care. The CAA directed staff to monitor for any adverse side effects of medication usage to help prevent or minimize risks of the current medication regimen. The CAA directed staff to administer medications as ordered to help prevent any side complications.

R21's Care Plan directed staff R21 had a diagnosis of schizophrenia and this illness was first documented when she was a teen. R21 had many psychiatric hospitalization s over the years and had been in facilities for years. The care plan documented R21 had poor insight, depression, agitation, hallucinations, and delusions. The care plan directed staff to monitor R21 for acute major changes in her cognition. The care plan documented R21 was on Clozaril and staff were to administer medications as ordered, and to obtain monthly complete blood counts (CBC-blood laboratory test).

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Prescriber Order Note, dated 12/28/23, directed staff to discontinue R21's Clozaril 25 mg every day and to keep the night dose as ordered, 500 mg every night, for the diagnosis of schizophrenia. The Psychiatric Consultation Progress Note, dated 12/28/23, documented R21 was seen on a routine basis to reduce the risk of decompensation of her psychiatric stability. The plan documented that R21's morning dose of Clozaril would be discontinued. The note directed staff to monitor for any return of behaviors and to monitor R21 closely for any changes in her psychiatric stability. The Behavioral Monitoring Note, dated 12/20/24, documented R21 had occasional pacing in the hallway. The Behavioral Monitoring Note, dated 12/22/24, documented R21 had no behaviors. The Order Note, dated 12/28/24, documented the facility received an order to discontinue R21's morning dose of Clozaril. The December Medication Administration Record, dated December 2023, documented R21's Clozaril 25 mg daily in the morning and Clozaril 500 mg at bedtime were discontinued on 12/28/23. The Medication Review Report, dated 12/31/23 and signed by the physician, documented that R21's Clozaril 25 mg was discontinued on 12/28/23 and R21's Clozaril 500 mg was discontinued on 12/28/24. The Behavior Note, dated 12/31/24, documented R21 maintained a persistent delusion that the nurse was giving her injections. The nurse told R21 the nurse had never given R21 an injection besides her flu shot. R21 called the nurse a liar. The Behavioral Monitoring Note, documented that R21 was not acting her usual self. When spoken to, R21 would stare blankly and not talk. R21 was hanging out at the front door, walked out the first door, and had to be re-directed back inside. R21 would not eat her meals. An order was received to obtain a stat (immediate) complete metabolic panel (CMP-laboratory blood test)and a urine sample, start Seroquel (antipsychotic medication) 25 mg every night, and give Ativan (antianxiety medication) every six hours as needed for fourteen days. The Behavioral Monitoring Note, dated 01/06/24, documented R21 yelled out for Mommy, pounded her fists on the walls, ran out the front door, sobbed, yelled, and stayed awake for hours and would not sit down or lay down. The Order Note, dated 01/06/24, documented to restart Clozaril 25 mg every evening. The eAdmin Record - Hour of Administration Level Note, dated 01/07/24, documented R21 was on one-to-one. R21 was more cooperative with care. R21 cried out often, refused to eat, and drank small amounts of water. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The eInteract SBAR Summary for Providers Note, dated 01/07/24, documented R21 had a change in condition: abdominal pain, altered mental status, fluid and food intake decreased or unable to eat or drink adequate amounts, and functional decline. R21 was documented as talking less, being tired weak, and confused. R21 had the following medication changes in the past week: restarted Clozaril 25 mg and Seroquel 25 mg at bedtime. Nursing observations included that R21 was nonverbal. R21 yelled out when touched. R21 was weak and unable to support her body weight without assistance. R21 had difficulty standing and transferring. R21's abdomen was distended and firm. R21 did not have any intake, refused her medication, and would not open her mouth. Staff received a new order received to send R21 to the emergency room . The Hospital Nurse's Note, dated 01/11/24, documented that R21 remained confused, hallucinated, and was restless and agitated. The noted documented R21 was confused, disoriented times four, and unable to follow commands; she had poor safety awareness, and poor attention and concentration. R21 responded to auditory hallucinations and made irrelevant and incomprehensible statements. The psychiatric review documented R21 had anxiety, concentration difficulties, delusions, disorientation, hallucinations, and memory difficulties. The note documented R21's cognition was impaired due to psychosis. R21 remained psychotic but unfortunately due to medical conditions, R21 was not tolerating antipsychotics well. The plan documented to try to titrate up the dose of Seroquel to help control psychosis and mood. The History and Physical, dated 01/11/24, documented R21 admitted to the hospital with altered mental status (lethargy, hallucinations). R21 was found to have a urinary tract infection. Initially, there had been concern for a small bowel obstruction, but R21 was negative for obstruction or ileus (obstruction of the intestines, caused by immobility of the bowel). The Discharge Summary, dated 01/11/24, documented R21 discharged from the hospital on Clozaril 75 mg at bedtime and Seroquel 25 mg at bedtime. The Interdisciplinary Team Note, dated 01/11/24 documented R21 and R21's responsible party attended her care plan meeting. The note documented R21 had not had any medication changes that quarter and was stable on her medications. The Progress Note, dated 01/11/24, documented R21 admitted back to the facility from the hospital. The Behavior Note, dated 01/11/24, documented R21 was found in her bed crying with a torn gift bag wrapped around her hand and pieces thrown all over the bed and floor. R21 pulled the call light up around her neck, cried, and stated she needed to go see her angel. Staff took the call light away from R21 and tried to calm R21 down. The charge nurse was notified and stated she would look into an as-needed medication to give R21. Staff remained in the room to monitor R21 until the charge nurse could check on medication. The Nurse's Note, dated 01/12/24, documented R21 was unable to hold her posture upright when in her wheelchair. R21 leaned back in the wheelchair with her bilateral lower extremities straight out. R21 is unable to follow directions. R21 was assisted from the wheelchair to the bed by two staff. The Nurse's Note, dated 01/12/24, documented R21's psychiatric provider was notified of the change of dose of Clozaril from the hospital. Staff received a new order to keep R21's Clozaril at the previous dose of 500 mg at bedtime. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Psychiatric Order Note, dated 01/23/24, documented the provider had received a message from the facility regarding R21. Staff reported R21 was out of control, removing her clothes, and spitting out her pills and meals on her wheelchair since returning from the hospital. The note documented that while at the hospital, R21's Clozaril was decreased from 500 mg to 175 mg and Seroquel was increased to three times a day when R21 was previously only on Seroquel at bedtime. The note documented the plan for R21 was to return to the previous dosing of Clozaril and Seroquel and start Ativan to be given every four hours as needed. The orders directed staff to discontinue all (current) Seroquel, start Seroquel 25 mg at bedtime, discontinue all (current} Clozaril, start Clozaril 500 mg at bedtime, and start Ativan 2 mg every four hours as needed for anxiety and agitation. On 10/15/24 at 10:30 AM, R21 lay in her bed in pajamas. R21 had a flat affect. On 10/15/24 at 10:30 AM, R21 stated she did not remember being sick or having any medication changes at the end of December and the beginning of January. R21 did not want to talk. On 10/15/24 at 11:30 AM, Administrative Nurse D stated she realized the facility had a problem with medication orders that were connected together in the EMR in October and put in a Performance Improvement Plan (PIP) to go through all of the orders and ensure that orders that were connected together, were separated into separate orders, so if one was changed or discontinued the other order would not be affected. Administrative Nurse D stated R21's Clozaril orders should not have been connected together, but rather two separate orders should have been placed in the EMR; one for Clozaril 25 mg in the morning and one order for Clozaril 500 mg at bedtime. When LN G discontinued the 25 mg dose of Clozaril the EMR discontinued both orders. Administrative Nurse D stated part of the problem was LN G was an agency nurse and did not know the resident and her routine and the medication aides at the time were agency and did not realize R21 normally took 500 mg of Clozaril every night. Administrative Nurse D stated in the review of medications that were connected, R21's Clozaril dose had been missed. On 10/15/24 at 02:30 PM, LN H stated he had been in a nursing meeting when R21's Clozaril dose was brought up as being discontinued and he immediately knew something was wrong because R21 required Clozaril 500 mg for psychiatric stability. LN H stated as soon as the meeting was over he reviewed R21's medications and realized she was not on Clozaril 500 mg and contacted the psychiatric provider immediately to get the Clozaril 500 mg restarted. LN H stated R21 did have a decline after the Clozaril was discontinued. The facility's Use of Psychotropic Drugs Policy, dated 01/01/20, documented that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medications. A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior. The indications for initiating, withdrawing, or withholding medications, as well as the use of non-pharmacological approaches, will be determined by assessing the resident's underlying condition, current signs, symptoms, expressions, preferences, and goals for treatment, and identifying underlying causes. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regime in collaboration with residents, their families, and/or representatives, other professionals, and the interdisciplinary team. Residents who receive psychotropic medications shall receive gradual dose reductions. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure R21 remained free of significant medication errors. This deficient practice caused R21 significant psychosocial harm as evidenced by R21 having increased auditory and visual hallucinations that caused her significant distress.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27168 The facility had a census of 48 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 48 residents in the facility, who received their meals from the kitchen. This placed the residents at risk of foodborne illness. Findings included: - On 10/14/24 at 8:00 AM, during the initial tour, observations revealed the following: The refrigerator had an opened, undated half-full 2.5 pounds container of deli turkey meat, an undated peanut butter sandwich, and two plastic bags of shredded lettuce dated 09/29/24 (15 days). Observation revealed five 12-inch by three-foot fluorescent lights located above the food preparation area. Two of the plastic light covers had a brownish substance in the cover, one florescent light fixture was pulled down and not adhered to the ceiling, and three florescent light covers were cracked. One four feet by three feet ceiling mounted air conditioning unit, located on the exterior wall/ceiling of the kitchen blew air directly across the food preparation area. The air vent grills, water and condensation pipes were covered with a brown greasy substance and a gray fuzzy substance. On 10/14/24 at 12:30 PM, Dietary Staff (DS) BB verified the undated food in the refrigerator, the overhead fluorescent light fixtures with the brownish substance in the covers, the cracked covers and the fixture separating from the ceiling as well as the dirty air conditioner. DS BB verified the facility did not presently have any maintenance department staff and they would be the ones to complete any task that requires climbing a ladder. The facility's Kitchen Preventative Maintenance policy, dated 10/25/2019, documented that the facility would maintain a schedule of maintenance services to ensure that the building, grounds, and equipment are maintained in a safe and operable manner. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 48 residents residing in the facility, who received meals from the kitchen.