STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E256	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place North	1301 NE Jefferson Street Topeka, KS 66608

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to have sufficient licensed nursing staff 24 hours a day.Finding included:- On 10/14/25 at 03:00 PM, a review of Licensed Nurse (LN) H had an employment date of 09/25/23, and license verification revealed LN H's license had lapsed on 06/30/25. LN H, the only LN scheduled, worked the following dates:July 2025: 1, 2, 3, 7, 8, 9, 10, 14, 15, 16, 17, 21, 22, 23, 24, 25, 28, 29, 30, and 31.August 2025: 4, 5, 6, 7, 11, 12, 13, 14, 18, 19, 20, 21, 25, 26, 27, and 28.September 2025: 1, 2, 3, 4, 8, 9, 10,11,15, 16, 17, 18, 22, 23, 24, 25, 29, and 30.October 2025: 1, 2, 6, 7, 8, 9, 10, and 13.On 10/14/25 at 03:30 PM, Administrative Staff A and Administrative Nurse D stated they became aware of LN H's lapsed license on this day when they had checked the verification on the Kansas Board of Nursing verification. Administrative Staff A stated LN H had been removed from the schedule until the renewal process had been completed. Administrative Nurse D stated that LN H must not have been responsible enough to have gotten the renewal process completed.Upon request, the facility failed to provide a Licensed Nurse Coverage policy.

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 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. The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one kitchen. Findings included:- On 10/13/25 at 08:00 AM, observation in the kitchen revealed the following.A kitchen refrigerator labeled #1 had a 1/2 full, five-gallon container of cottage cheese with an expiration date of 09/20/25.On 10/13/25 at 08:05 AM, Certified Dietary Aide (CNA) M verified the finding and stated she was not a dietary staff member; she was helping today. CNA M discarded the cottage cheese container.On 10/13/25 at 08:10 AM, Social Services X walked into the kitchen by the prep area without a hair net, took a plate of food from CNA M, and delivered it to a resident at the dining room table.On 10/13/25 at 08:12 AM, Social Services X verified she had entered the kitchen prep area without a hair net and stated she probably forgot to put a hair net on, and she should have. On 10/13/25 at 11:08 AM, an observation revealed in a freezer, located in the dry storage room, was an unlabeled and undated plastic bag of fish patties. The freezer had 1/2 to 1 inch ice buildup on the inside top and each shelf. Dietary Staff (DS) BB verified the above finding and stated they should be labeled and dated.The Kitchen Cleaning Schedule documented tasks for dietary staff to complete before leaving their scheduled shift.The facility's Food Safety Storage Policy, revised 09/24/25, instructed staff to wrap, cover, or seal all refrigerated food and label and date per food code guidelines (provide a framework for food safety, which includes standards for cooking, storing, and handling food to prevent foodborne illnesses).

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to implement Enhanced Barrier Precautions (EBP- an infection control practice that uses personal protective equipment (PPE) to reduce the spread of multi-drug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics) for Resident (R) 4, who had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag). The facility also failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems and chronic lung disease). Findings included:- R4's Electronic Medical Record (EMR) included diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), epilepsy (brain disorder characterized by repeated seizures), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland).R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4's staff cognition assessment as modified independence, experienced inattentiveness and disorganized thinking which fluctuated, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behaviors directed toward others daily, other behaviors not directed toward others daily and rejected care for four to six days during a seven-day look-back period. R4 required setup and clean up assistance with eating and dressing, and partial to moderate assistance with oral care, toileting, and personal hygiene, and independent with mobility. R4 had an indwelling urinary catheter and was frequently incontinent of bowel.R4's Care Plan dated 08/25/25 documented R4 had potential for complications related to an indwelling suprapubic catheter. The Care Plan directed staff to assess, record, and report to the physician signs and symptoms of urinary tract infection (UTI- an infection in any part of the urinary system). Encourage fluid intake, cleanse drainage bags with vinegar solution, maintain a closed drainage system, and secure the bag to the leg. The Care Plan further directed staff to keep appointments every six weeks with urology and nursing may change the catheter as needed if dislodged or clogged. The Care Plan lacked information related to EBP.R4's Care Plan dated 08/25/25 documented R4 had potential for complications related to the indwelling catheter for chronic bladder obstruction and cryoablation (a medical procedure that uses extreme cold to destroy abnormal or diseased tissue) of prostate cancer. The Care Plan directed staff to assess, record, and report to the physician as needed, signs or symptoms of urinary tract infection.The Physician Order dated 01/27/23 directed staff to stop obtaining urine specimens unless the patient complained of symptoms, and no prophylactic (preventative in nature) antibiotic (medications used to treat infectious processes) was needed.The Progress Note dated 02/23/25 at 05:58 AM documented that staff found R4 unresponsive at 04:30 AM. After receiving physician orders to send R4 to the emergency room to evaluate and treat R4. Staff called 911, and the ambulance left with the resident at 04:50 AM.The Progress Note dated 02/25/25 at 11:22 AM documented that R4 had returned to the facility at 10:45 AM.The Progress Note dated 03/25/25 at 12:22 PM documented that R4's practitioner had been notified that R4 had a fever and a change in his level of consciousness. The practitioner ordered R4 to be sent to the emergency room. The ambulance left with R4 at 12:21 PM.The Progress Note dated 04/03/25 at 11:09 AM documented that R4 had returned to the facility.On 10/14/25 at 08:09 AM, R4 ambulated independently to the commons area toward the facility entry. He was dressed in sweatpants with a urine collection bag attached to his right lower leg. He had frequent jumping and hand gestures to point a gun and verbalized Bam.On 10/14/25 at 11:59 AM, Certified Nurse Aide (CNA) N assisted R4 to a bathroom across the hall from the residents' room. R4's room lacked EBP signage or had gown or gloves stored (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the room. CNA N explained to R4 that she was going to empty the catheter drainage bag. CNA N put on a pair of disposable gloves, emptied the drainage bag into a measuring container, wiped the drainage spout with an alcohol pad, emptied the container into the toilet, rinsed the measuring container, and returned the measuring container to a clear plastic bag. CNA N then removed the gloves and washed her hands. CNA N stated staff used gloves when handling the catheter tasks for R4 and did not wear a gown during the process. CNA N reported that gowns were available for use if the staff wanted to use them.On 10/15/25 at 09:11 AM, Administrative Nurse D stated she was not aware of EBP requirements, and staff utilized standard precautions when caring for R4's catheter.On 10/14/25 at 10:43 AM, upon requesting information for the facility's waterborne pathogen/Legionella program, Administrative Staff A stated he was not aware of the requirement and did not have a system in place for it.On 10/15/25 at 10:00 AM, Administrative Staff A reported the facility lacked a policy regarding a Legionella prevention policy but was researching the information to implement one.The facility's undated Enhanced Barrier Precaution policy documented to adhere to the Centers for Disease Control (CDC) guidelines and CMS regulatory requirements as related to Enhanced Barrier Precautions to prevent the transmission of CDC targeted multi-resistant organisms (MDRO) while promoting resident quality of life by addressing the need for psychosocial well-being of residents who are infected or colonized with an MDRO and for those residents with chronic wound or indwelling medical device.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with five reviewed for unnecessary medications. The facility failed to ensure as-needed (PRN) psychotropic medication had a stop date for Resident (R) 2, R5, and R26. The facility also failed to complete gradual dose reductions (GDR), with the physician's rationale of risk versus benefits, and if the GDR was clinically contraindicated for continued use of psychotropic medications for R2, R5, and R26.Findings included:- R2's Electronic Medical Record (EMR) documented that R2 had a diagnosis of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R2's Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R2 was independent with most activities of daily living (ADL). The MDS documented R2 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the look-back period. R2's Care Plan, revised 06/30/25, instructed staff to administer psychotropic medications as the physician ordered, monitor for side effects and effectiveness of medications, and discuss with the physician the ongoing need for use of medication. The MDS instructed staff to review behaviors/interventions and alternative therapies attempted and the effectiveness per facility, and monitor, document, and report PRN any adverse reactions of psychotropic medications. The Physician Order, dated 12/13/23, instructed staff to administer to R2, Asenapine (an antipsychotic, a class of medications used to treat major mental conditions that cause a break from reality), 10 milligrams (mg), every day, and Aripiprazole (an antipsychotic medication), 10 mg tablet by mouth at bedtime for schizophrenia. R2's EMR from 10/09/24 -10/06/25 lacked documentation regarding a recommendation from the Consulting Pharmacist (CP) for a gradual dose reduction (GDR) for R2's Aripiprazole and Asenapine. On 10/14/25 at 12:05 PM, observation revealed R2 ambulated with red tennis shoes and eyeglasses on from the dining room to the commons area with a side-to-side gait. On 10/15/25 at 09:45 AM, Administrative Nurse D verified the facility lacked documentation regarding GDRs attempted for R2. Administrative Nurse D stated the facility did not try GDRs with residents, which could make a difference in their quality of life, but the facility had started a form yesterday, for GDR recommendations for the physician to sign and give his/her rationale for keeping residents on psychotropic medications. The facility's Psychotropic Drug Use Policy, undated, documented that GDRs would be conducted per Centers for Medicare and Medicaid (CMS) guidelines. - R5's Electronic Medical Record (EMR) included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), severe intellectual disabilities (a significantly below-average (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland). R5's Annual Minimum Data Set (MDS), dated [DATE], documented that R5 had moderately impaired cognition, hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and other behavioral symptoms not directed toward others behaviors which occurred one to three days of the seven day look back period. R5 required setup and clean-up assistance with personal hygiene and eating; otherwise, R5 was independent with all other functional abilities and mobility. The MDS further documented that R5 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders). The antipsychotics were received on a routine basis only and had no gradual dose reduction (GDR) or physician documented GDR as clinically contraindicated. The Psychotropic Drug Use Care Area Assessment (CAA), dated 09/05/25, documented R5 had been prescribed Trazodone (an antidepressant) every bedtime and slept at long intervals most nights. R5's Care Plan dated 09/06/25, documented R5 needed psychotropic (alters mood or thought) medications related to schizoaffective, bipolar type, and an increased risk for falls related to psychotropic medications. R5 needed haloperidol (an antipsychotic) PRN and readily available to manage episodes of acute agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and aggression, and R5's behaviors may result in harm to self or others. The Care Plan directed staff to administer medication per the doctor's orders, to always closely supervise R5 taking medications due to a history of pocketing (holding in the mouth and not swallowing) them. The Physician Orders dated 02/11/21 directed staff to administer: Clozaril (an antipsychotic) 200 milligrams (mg) by mouth every day, related to schizoaffective disorder, bipolar type. Clozaril 200 mg, two tablets by mouth at bedtime, related to schizoaffective disorder, bipolar type. Invega Sustenna Suspension (an antipsychotic) prefilled syringe 234 mg/1.5 milliliter (ml) intramuscularly (injected into a muscle) every 28 days related to schizoaffective disorder, bipolar type. Lamotrigine (mood stabilizer) 200 mg by mouth one time a day related to schizoaffective disorder, bipolar type. Mirtazapine (an antidepressant) 15 mg by mouth at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Trazodone 100 mg, give two tablets by mouth at bedtime for insomnia (inability to sleep). Trazodone 50 mg by mouth at bedtime for insomnia. Haloperidol (an antipsychotic) 5 mg by mouth two times a day, related to schizoaffective disorder, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bipolar type. Haloperidol 5 mg/5 ml intramuscularly every 24 hours as needed for psychosis (any major mental disorder characterized by a gross impairment in reality perception) related to schizoaffective disorder, bipolar type. This order lacked a duration or a stop date. Trazodone 50 mg by mouth every 24 hours as needed for insomnia. This order lacked duration or a stop date. R5's Consultant Pharmacist Monthly Review from 10/09/24 to 10/06/25 lacked a recommendation related to a GDR of psychotropic drug use or required duration for PRN antipsychotic and antianxiety medication. On 10/14/25 at 10:31 AM, R5 was walking around the facility, dressed and groomed appropriately for the day. R5 had been to the dining room for breakfast earlier. On 10/15/25 at 09:11 AM, Administrative Nurse D reported due to the clients the facility cared for, the facility did not do GDR's and the Consultant Pharmacist had not recommended them either. Administrative Nurse D stated the facility had been working on getting stop dates for psychotropic medications. The facility's undated Psychotropic Drug Use policy documented that residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective, and would not be used for discipline or the convenience of the staff. Limit PRN orders for anti-depressant, hypnotics, and antianxiety drugs to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur. Limit PRN orders for anti-psychotics to 14 days. They may not be renewed unless the practitioner evaluates the resident for appropriateness of the drug. Gradual dose reductions would be conducted per CMS (Centers for Medicare and Medicaid Services) guidelines. The community shall elicit the Physician's response and request documentation on whether the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. - R26's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), constipation (difficulty passing stools), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R26's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R26 had intact cognition and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R26 required setup/clean up assistance with eating and showering, and was independent with all other functional abilities and mobility. R26 was always continent of urine and bowel. The MDS further documented that R26 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people). The antipsychotic was received on a routine basis, and a gradual dose reduction (GDR) was attempted on 08/07/20; the physician had documented the GDR as clinically contraindicated on 08/07/20. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Psychotropic Drug Use Care Area Assessment, dated 05/1/25, documented R26 had a medical history of hypotension (low blood pressure), COPD, constipation, and schizoaffective disorder. No analysis findings were completed. R26's Care Plan dated 09/05/25, documented R26 used psychotropic medications related to schizoaffective disorder, bipolar type, had hoarding (practice of accumulating and hiding away goods and resources), self-care deficit, and a history of aggressive behavior. The Care Plan directed staff that R26 needed hydroxyzine (used to treat anxiety- mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) 50 mg PRN to manage acute episodes of agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and aggression, and his behavior may result in harm to self or others. The Care Plan further documented that R26 would be followed by psychiatry, to monitor for extrapyramidal symptoms (EPS- movement disorder that can occur as side effect of certain medications) and tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk (TD) symptoms, would take all prescribed medications as ordered and would be monitored for effectiveness and/or side effects. The staff are to monitor/document/ report PRN any adverse reactions to psychotropic medications. On 02/03/21, the Physician Order directed staff to administer: Haloperidol (an antipsychotic) 5 milligrams by mouth two times a day for schizoaffective disorder, bipolar type. Quetiapine (an antipsychotic) 100 mg by mouth two times a day, related to schizoaffective disorder, bipolar type. Haloperidol 5 mg by mouth every four hours as needed for psychosis related to schizoaffective disorder, bipolar type (the order lacked a stop or duration date). Hydroxyzine (lacked specific dose) by mouth every six hours for itching and up to two tablets at bedtime. Lorazepam (an antianxiety) 2 mg by mouth every four hours as needed for psychosis related to schizoaffective disorder, bipolar type (the order lacked a stop or duration date). Review of R26's Consultant Pharmacist Monthly Reviews dated 10/09/24 to 10/06/25 lacked a recommendation related to a GDR of psychotropic drug use or required duration for PRN antianxiety or antipsychotic medication. On 10/14/25 at 08:30 AM, R26 was up and dressed for the day. He has finished breakfast in the dining room and is called over to the medication cart for his medications. He took them without problems. On 10/15/25 at 09:11 AM, Administrative Nurse D reported due to the clients the facility cared for, the facility did not do GDR's and the Consultant Pharmacist had not recommended them either. Administrative Nurse D stated the facility had been working on getting stop dates for psychotropic medications. The facility's undated Psychotropic Drug Use policy documented that residents will only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they are indicated and effective, and will not be used for discipline or the convenience of the staff. Limit PRN orders for anti-depressant, hypnotics, and antianxiety drugs to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur. Limit PRN orders for anti-psychotics to 14 days. They may not be renewed unless the practitioner evaluates the resident for appropriateness of the drug. Gradual dose reductions will be conducted per CMS (Centers for Medicare and Medicaid Services) guidelines. The community shall elicit the Physician's response and request documentation on whether the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents, with five reviewed for unnecessary medications. The facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities to the attending physician, the facility medical director, and the director of nursing for Resident (R) 2, R6, R5, and R26. Findings included:- R2's Electronic Medical Record (EMR) documented that R2 had a diagnosis of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R2's Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R2 independent of most activities of daily living (ADL). The MDS documented R2 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the look-back period. R2's Care Plan, revised 06/30/25, instructed staff to administer psychotropic medications as the physician ordered, monitor for side effects and effectiveness of medications, and discuss with the physician the ongoing need for use of medication. The MDS instructed staff to review behaviors/interventions and alternative therapies attempted and the effectiveness per facility, and monitor, document, and report as needed (PRN) any adverse reactions of psychotropic medications. The Physician Order dated 12/13/23 instructed staff to administer Asenapine (an antipsychotic, a class of medications used to treat major mental conditions that cause a break from reality), 10 milligrams (mg) every day, and Aripiprazole (an antipsychotic medication), 10 mg tablet by mouth at bedtime for schizophrenia. R2's EMR from 10/09/24 -10/06/25 lacked documentation. The CP identified and reported to administration the need for a gradual dose reduction (GDR) for R2's Aripiprazole and Asenapine. On 10/14/25 at 12:05 PM, observation revealed R2 ambulated with red tennis shoes and eyeglasses on from the dining room to the commons area with a side-to-side gait. On 10/15/25 at 09:45 AM, Administrative Nurse D verified the CP had not identified R2's need for a GDR for R2's psychotropic medications. Administrative Nurse D stated the facility did not try GDRs with residents, which could make a difference in their quality of life, but the facility had started a form yesterday, for GDR recommendations for the physician to sign and give their rationale for keeping residents on psychotropic medications. The facility's Pharmacy Services Policy, undated, documented that the CP would help establish procedures for conducting the monthly medication regimen review (MRR) for each resident in the facility. The facility's Psychotropic Drug Use Policy, undated, documented GDRs would be conducted per Centers for Medicare and Medicaid (CMS) guidelines. - R6 's Electronic Medical Record (EMR) documented that R6 had a diagnosis of psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception). (continued on next page)

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Brighton Place North	1301 NE Jefferson Street Topeka, KS 66608

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented R6 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS documented R6 independent of most activities of daily living (ADL). The MDS documented R6 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the look-back period. R6's Care Plan, revised 09/06/25, instructed staff to administer R6 's psychotropic medications as the physician ordered and monitor R6 for side effects and effectiveness of her medications. The plan instructed staff to consult with the CP and, physician to consider dosage reduction when clinically appropriate at least quarterly. The plan instructed staff to monitor R6 for adverse reactions to her psychotropic medications. The Physician Order dated 02/28/24 instructed staff to administer Aripiprazole (an antipsychotic medication). R6's EMR from 10/09/24 -10/06/25 lacked documentation regarding the CP identified and reported to administration the need for a gradual dose reduction (GDR) for R6's Aripiprazole. On 10/14/25 at 12:00 PM, R6 sat quietly at the dining room table with other residents, independently eating her meal. On 10/15/25 at 09:45 AM, Administrative Nurse D verified the CP had not identified R6's need for a GDR for R6's psychotropic medication. Administrative Nurse D stated the facility did not try GDRs with residents, which could make a difference in their quality of life, but the facility had started a form yesterday, for GDR recommendations for the physician to sign and give their rationale for keeping residents on psychotropic medications. The facility's Pharmacy Services Policy, undated, documented that the CP would help establish procedures for conducting the monthly medication regimen review (MRR) for each resident in the facility. The facility's Psychotropic Drug Use Policy, undated, documented GDRs would be conducted per Centers for Medicare and Medicaid (CMS) guidelines. - Resident (R) 5's Electronic Medical Record (EMR) included diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), severe intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland). R5's Annual Minimum Data Set (MDS), dated [DATE], documented that R5 had moderately impaired cognition, hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and other behavioral symptoms not directed toward others behaviors which occurred one to three days of the seven day look back period. R5 required setup and clean-up assistance with personal hygiene and eating; otherwise, R5 was independent with all other functional abilities and mobility. The MDS further documented that R5 received an antipsychotic (a class of medications used (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders). The antipsychotics were received on a routine basis only and had no gradual dose reduction (GDR) or physician documented GDR as clinically contraindicated. The Psychotropic Drug Use Care Area Assessment (CAA), dated 09/05/25, documented R5 had been prescribed Trazodone (an antidepressant) every bedtime and slept at long intervals most nights. R5's Care Plan dated 09/06/25, documented that R5 needed psychotropic (alters mood or thought) medications related to schizoaffective, bipolar type, and an increased risk for falls related to psychotropic medications. R5 needed haloperidol (antipsychotic) as needed (PRN) and readily available to manage episodes of acute agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and aggression, and R5's behaviors may result in harm to self or others. The Care Plan directed staff to administer medication per the doctor's orders, to always closely supervise R5 taking medications due to a history of pocketing (holding in the mouth and not swallowing) them. The Physician Orders dated 02/11/21 directed staff to administer: Clozaril (an antipsychotic) 200 milligrams (mg) by mouth every day, related to schizoaffective disorder, bipolar type. Clozaril 200 mg, two tablets by mouth at bedtime, related to schizoaffective disorder, bipolar type. Invega Sustenna Suspension (an antipsychotic) prefilled syringe 234 mg/1.5 milliliter (ml) intramuscularly (injected into a muscle) every 28 days related to schizoaffective disorder, bipolar type. Lamotrigine (mood stabilizer) 200 mg by mouth one time a day related to schizoaffective disorder, bipolar type. Mirtazapine (an antidepressant)15 mg by mouth at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Trazodone 100 mg, give two tablets by mouth at bedtime for insomnia (inability to sleep). Trazodone 50 mg by mouth at bedtime for insomnia. Haloperidol (an antipsychotic) 5 mg by mouth two times a day, related to schizoaffective disorder, bipolar type. Haloperidol 5 mg/5 ml intramuscularly every 24 hours as needed for psychosis (any major mental disorder characterized by a gross impairment in reality perception) related to schizoaffective disorder, bipolar type. This order lacked a duration or a stop date. Trazodone 50 mg by mouth every 24 hours as needed for insomnia. This order lacked duration or a stop date. R5's Consultant Pharmacist Monthly Review from 10/09/24 to 10/06/25 lacked a recommendation (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to a GDR of psychotropic drug use or required duration for PRN antipsychotic and antianxiety medication. On 10/14/25 at 10:31 AM, R5 was walking around the facility, dressed and groomed appropriately for the day. R5 had been to the dining room for breakfast earlier. On 10/15/25 at 09:11 AM, Administrative Nurse D reported due to the clients the facility cared for did not do GDR's and the consultant pharmacist had not recommended them either. Administrative Nurse D stated the facility had been working on getting stop dates for psychotropic medications. The facility's undated Pharmacy Services policy documented that the Licensed Pharmacist shall collaborate with staff and practitioners to address and resolve medication-related needs or problems and help the facility establish procedures for conducting the monthly medication regimen review for each resident in the facility. The facility's undated Psychotropic Drug Use policy documented that GDR dose reductions will be conducted per the Centers for Medicare and Medicaid Services (CMS) guidelines. The community shall elicit the Physician's response and request documentation on whether the benefits of the medication outweigh the risk or suspected or confirmed adverse consequences. - R26's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), bipolar type (a major mental illness that causes people to have episodes of severe high and low moods), constipation (difficulty passing stools), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R26's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R26 had intact cognition and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). R26 required setup/clean up assistance with eating and showering, and was independent with all other functional abilities and mobility. R26 was always continent of urine and bowel. The MDS further documented that R26 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety (a class of medications that calm and relax people). The antipsychotic was received on a routine basis, and a gradual dose reduction (GDR) was attempted on 08/07/20; the physician had documented the GDR as clinically contraindicated on 08/07/20. The Psychotropic Drug Use Care Area Assessment, dated 05/18/25, documented R26 had a medical history of hypotension (low blood pressure), COPD, constipation, and schizoaffective disorder. No analysis findings completed. R26's Care Plan dated 09/05/25, documented R26 used psychotropic medications related to schizoaffective disorder, bipolar type, had hoarding (practice of accumulating and hiding away goods and resources), self-care deficit, and a history of aggressive behavior. The Care Plan directed staff that R26 needed hydroxyzine (used to treat anxiety) 50 mg as needed (PRN) to manage acute episodes of agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition) and aggression, and his behavior may result in harm to self or others. The Care Plan further documented that R26 would be followed by psychiatry, to monitor for extrapyramidal symptoms (EPS-movement disorder that can occur as side effect of certain medications) and tardive dyskinesia (an (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk (TD) symptoms, would take all prescribed medications as ordered, and would be monitored for effectiveness and/or side effects. The staff are to monitor/document/ report PRN any adverse reactions of psychotropic medications. On 02/03/21, the Physician Order directed staff to administer: Haloperidol (an antipsychotic) 5 milligrams by mouth two times a day for schizoaffective disorder, bipolar type. Quetiapine (an antipsychotic) 100 mg by mouth two times a day, related to schizoaffective disorder, bipolar type. Haloperidol 5 mg by mouth every four hours as needed for psychosis related to schizoaffective disorder, bipolar type (the order lacked a stop or duration date). Hydroxyzine (lacked specific dose) by mouth every six hours for itching and up to two tablets at bedtime. Lorazepam (an antianxiety) 2 mg by mouth every four hours as needed for psychosis related to schizoaffective disorder, bipolar type (the order lacked a stop or duration date). Review of R26's Consultant Pharmacist Monthly Reviews dated 10/09/24 to 10/06/25 lacked a recommendation related to a GDR of psychotropic drug use or required duration for PRN antianxiety or antipsychotic medication. On 10/14/25 at 8:30 AM, R26 was up and dressed for the day. He had finished breakfast in the dining room and was called over to the medication cart for his medications. He took them without problems. On 10/15/25 at 09:11 AM, Administrative Nurse D reported due to the clients the facility cared for did not do GDR's and the consultant pharmacist had not recommended them either. Administrative Nurse D stated the facility had been working on getting stop dates for psychotropic medications. The facility's undated Pharmacy Services policy documented that the Licensed Pharmacist shall collaborate with staff and practitioners to address and resolve medication-related needs or problems and help the facility establish procedures for conducting the monthly medication regimen review for each resident in the facility. The facility's undated Psychotropic Drug Use policy documented that GDR dose reductions would be conducted per the Centers for Medicare and Medicaid Services (CMS) guidelines. The community shall elicit the Physician's response and request documentation on whether the benefits of the medication outweigh the risk or suspected or confirmed adverse consequences.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a Bed Hold Notification for Resident (R) 4, who was hospitalized on [DATE] and 03/25/25, and R6 hospitalization on 06/26/25. Findings included:- R4's Electronic Medical Record (EMR) included diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), epilepsy (brain disorder characterized by repeated seizures), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland). R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4's staff cognition assessment as modified independence, experienced inattentiveness and disorganized thinking which fluctuated, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behaviors directed toward others daily, other behaviors not directed toward others daily, and rejected care for four to six days during a seven-day look-back period. R4 required setup and clean up assistance with eating and dressing, and partial to moderate assistance with oral care, toileting, and personal hygiene, and independent with mobility. R4 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R4's Care Plan dated 08/25/25, documented R4 had potential for complications related to the indwelling catheter for chronic bladder obstruction and cryoablation of prostate cancer (a treatment method that uses cryotherapy to freeze and destroy cells in the prostate gland). The Care plan directed staff to assess, record, and report to the physician as needed, signs or symptoms of urinary tract infection. The Progress Note dated 02/23/25 at 05:58 AM documented that staff found R4 unresponsive at 04:30 AM. After receiving physician orders to send R4 to the emergency room to evaluate and treat R4, staff called 911. The ambulance left with the resident at 04:50 AM. The Progress Note dated 02/25/25 at 11:22 AM documented that R4 had returned to the facility at 10:45 AM. The Progress Note dated 03/25/25 at 12:22 PM documented that R4's practitioner had been notified that R4 had a fever and a change in his level of consciousness. The practitioner gave orders to send R4 to the emergency room. The ambulance left with R4 at 12:21 PM. The Progress Note dated 03/25/25 at 12:26 PM documented that the bed hold policy was sent to R4's guardian family member. The Progress Note dated 04/03/25 at 11:09 AM documented that R4 had returned to the facility. On 10/14/25 at 08:09 AM, R4 ambulated independently to the commons area toward the facility entry. He was dressed in sweatpants with a urine collection bag attached to his right lower leg. He had frequent jumping and hand gestures to point a gun and verbalized Bam. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/25 at 09:11 AM, Administrative Nurse D reported that the bed holds were to be sent when a resident went to the hospital, but at times the resident was not able to sign for themselves, or the facility would call or email the resident's representative. Administrative Nurse D stated that verbal confirmation had not been documented, or the notices were not followed up on to obtain signatures. On 10/16/25 at 10:00 AM, Social Services X stated the bed hold had not been sent for R4's hospital admission of 02/23/25, and a bed hold for the 03/25/25 hospitalization had not been returned signed from R4's guardian family member. The facility's Discharge/Transfer/Bed Hold policy, dated 12/10/24, documents that a bed hold policy would be signed by the resident or legal representative upon transfer. - R6's Electronic Medical Record (EMR) documented the resident had diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and dementia (a progressive mental disorder characterized by failing memory and confusion). R6's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R6 independent with most activities of daily living (ADL). The MDS documented R6 had no urinary tract infection (UTI- infection in any part of the urinary system). R6's Care Plan, revised 09/06/25, instructed staff to monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, or declines in function. R6's Progress Notes, dated 06/26/25, documented R6 was transferred to the hospital. The Bed Hold Policy, dated 06/26/25, lacked R6's or her representative's signature. The clinical record lacked documentation of R6, or her representative was provided written notice of her transfer to the hospital. On 10/14/25 at 02:20 PM, Social Services X verified R6, or her representative, had not signed the bed hold policy when R6 was transferred to the hospital. Social Services X stated R6 was unable to sign, and she had provided R6's representative the bed hold policy by telephone and had documented the notification in the progress notes. On 10/15/25 at 09:45 AM, Administrative Nurse D stated Social Services X was responsible for providing R6 or her representative with the bed hold policy when a resident is transferred to the hospital if the resident is unable to sign, Social Services X would notify the representative over the phone. Administrative Nurse D verified the facility had not followed up and received a signed bed hold policy from R6 or her representative. Administrative Nurse D was unaware the facility was to provide written notice to R6 or her representative, explaining the reason for R6's transfer to the hospital. The facility's Discharge/Transfer/Bed Hold policy, revised 12/10/24, documented a bed hold policy would be signed by the resident or legal representative upon transfer to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to submit a required discharge and re-entry Minimum Data Set for Resident (R) 4, who was hospitalized on [DATE] and returned to the facility on [DATE].Findings include:- R4's Electronic Medical Record (EMR) included diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), epilepsy (brain disorder characterized by repeated seizures), and hypothyroidism (a condition characterized by decreased activity of the thyroid gland).R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4's staff cognition assessment as modified independence, experienced inattentiveness and disorganized thinking which fluctuated, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), verbal behaviors directed toward others daily, other behaviors not directed toward others daily and rejected care for four to six days during a seven-day look-back period. R4 required setup and clean up assistance with eating and dressing, and partial/moderate assistance with oral care, toileting, and personal hygiene, and independent with mobility. R4 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel.R4's EMR lacked a discharge MDS for R4's admission to the hospital on [DATE] and an entry MDS on 04/03/25, when R4 was readmitted to the facility.R4's Care Plan dated 08/25/25, documented R4 had potential for complications related to the indwelling catheter for chronic bladder obstruction and cryoablation (a medical procedure that uses extreme cold to destroy abnormal or diseased tissue) of prostate cancer. The Care plan directed staff to assess, record, and report to the physician as needed, signs or symptoms of urinary tract infection (UTI- an infection in any part of the urinary system).The Progress Note dated 03/25/25 at 12:22 PM documented that R4's practitioner had been notified that R4 had a fever and a change in his level of consciousness. The practitioner gave orders to send R4 to the emergency room. The ambulance left with R4 at 12:21 PM.The Progress Note dated 04/03/25 at 11:09 AM documented that R4 had returned to the facility.On 10/14/25 at 08:09 AM, R4 ambulated independently to the commons area toward the facility entry. He was dressed in sweatpants with a urine collection bag attached to his right lower leg. He had frequent jumping and hand gestures to point a gun and verbalized Bam.On 10/15/25 at 09:11 AM, Administrative Nurse D reported that she was responsible for the MDS process, and a discharge and entry should have been done for R4's admission to the hospital on [DATE] and an entry MDS on 04/03/25.The facility's undated MDS Assessment policy documented that a Registered Nurse shall be designated the responsibility of conducting and coordinating each resident's assessment (MDS).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure the medication and biologicals for the residents were not outdated.Finding included:- On [DATE] at 09:07 AM, the facility had one medication and treatment cart. Upon initial tour of the facility treatment cart revealed Resident (R) 29 Nystatin Cream (an antifungal which treats fungal or yeast infections) had an expiration date of [DATE]. Licensed Nurse (LN) G verified the expiration date and removed it from the cart.On [DATE] at 09:11 AM, Administrative Nurse D stated it was the charge nurse's responsibility to check the expiration dates of the treatments. Administrative Nurse D reported that R29's expired medication had been removed from the treatment cart.The facility's Storage of Medication policy, dated [DATE], documented that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. The facility had a census of 33 residents. The sample included 12 residents. Based on observation, interventions, and record review, the facility failed to implement protocols to avoid unnecessary and/or inappropriate antibiotic (medications used to treat infectious processes) use, adverse events, and multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics), and to assess for infection using standardized tools and criteria before antibiotic use.Findings included:- On 10/15/25 at 09:11 AM, a review of the facility's Antibiotic Stewardship Program revealed that Administrative Nurse D provided the monthly tracking logs of infections and treatments. The tracking logs documented the type of infections to include respiratory, urinary tract, ophthalmic (pertaining to the eye), optic (pertaining to the ear), skin, wounds, gastrointestinal (pertaining to the stomach or intestinal tract), and other. The monthly tracking log also recorded the treatment course for the infections, including the start and end of antibiotic use. Administrative Nurse D stated the facility had not utilized a standardized criteria tool before antibiotics were ordered, nor a stop and watch system, and was unsure what McGeer's criteria were. Administrative Nurse D stated the staff reported signs and symptoms to the physicians, and occasionally, the physician would obtain a culture for urinary tract infections and would change the antibiotic if needed. Administrative Nurse D stated the physician would generally order a broad-spectrum antibiotic to ensure the infectious process was covered by the causing microorganism. The facility's undated Infection Control Program-Antibiotic Stewardship policy documented that the community had established an infection prevention and control program that included protocols to establish a system for the use and monitoring of adverse effects of antibiotics. Antibiotic Stewardship is a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse effects associated with antibiotic use. Loeb Criteria (minimum criteria for the initiation of antibiotics) and McGeer Criteria (surveillance criteria) were used as a guideline.