

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2016
FORM APPROVED
OMB NO. 0938-0391

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 C 05/17/2016
NAME OF PROVIDER OR SUPPLIER BRIGHTON PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY STREET TOPEKA, KS 66606		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 2 residents. Based on observation, interview and record review, the facility failed to provide supervision for resident #1, a cognitively impaired independently mobility resident assessed as an elopement risk, to prevent the resident from leaving the facility without the staff knowledge for approximately 15 minutes.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The POS (physician order sheet) for resident #1, dated 04/12/2016, documented diagnoses including obsessive compulsive disorder (anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), anxiety disorder 	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 323	<p>Continued From page 1</p> <p>(mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought in combination with mood disorders).</p> <p>The Annual MDS (minimal Data Set), dated 09/22/2015, documented the resident with a BIMS (brief interview for mental status) score of 9, which identified the resident had moderately impaired cognition. The resident experienced indicators of delirium, disorganized thinking, hallucinations and delusions. The resident exhibited wandering behaviors during 1 to 3 days of the assessment period, which placed the resident at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy or activities of others. the resident was independent with all his/her activities of daily living.</p> <p>The Cognitive Loss/dementia CAA (care area assessment), dated 10/05/2015, documented the resident with the diagnosis of schizophrenia and experienced delusion, which caused his/her behavior to fluctuate. The resident often made poor decisions because of his/her delusions, which affected his/her cognitive status.</p> <p>The Behavioral CAA, dated 10/05/2015, documented the resident wandered frequently. He/she made attempts to leave the facility. The resident was usually easily redirected during these times, but remained an elopement risk. He/she needed supervision while outside of the facility as he/she made poor decisions and puts him/herself in danger.</p>	F 323			

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F 323	Continued From page 2 The care plan revised on 09/15/2015 documented the resident enjoyed taking the trash from the facility out to the dumpster on the facility property, had a history of leaving the building, therefore directed staff to supervise the resident while taking the trash out of the building. The care plan directed staff to remind the resident he/she needed supervision while conducting this chore. The staff was directed to observe the resident's location at regular and frequent intervals, document wandering behavior and attempted diversional interventions. Staff advised to redirect the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, religious videos, and bible study. The resident also enjoyed cleaning the patio, and helping tidy up the building. The resident's Elopement risk assessments, dated 03/09/2016 and 02/27/2016, documented the resident at high risk for elopement with a score of 12. On 04/29/2016, the assessment documented the resident at high risk for elopement with a score of 20. The resident's fall risk assessment, dated 03/09/2016, assessed the resident as a low risk for falls due to the score of 9. Review of the facility investigation documented the resident was last seen on 4/29/16 at approximately 5:05 PM. At approximately 5:30 PM, License nursing staff I revealed the resident was let back into the facility by a neighbor of the facility. A full body assessment was performed by Staff I finding no injuries. The door alarms were checked for proper working order, which resulted	F 323			

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F 323	<p>Continued From page 3</p> <p>in no defects. The resident stated he/she left his/her room for supper and went out the side door walking to the neighbor's house which was a few houses away. The resident stated the man was standing by the house and brought him/her back to the facility. The resident further stated he/she had their coat on when he/she left because it was raining.</p> <p>The nursing note, dated 04/29/2016 at 6:24 PM, documented at approximately 5:00 PM, the resident was observed lying in his/her bed with the covers over their face. Staff woke up the resident and notified him/her of supper time.</p> <p>The nursing note, dated 04/29/2016 at 7:09 PM, documented at approximately 5:30 PM, Staff I was walking toward the front of the building, when he/she observed the front door open, and this resident was being accompanied inside by an unknown person, who advised he/she observed the resident walking outside and thought he/she may have come from the facility.</p> <p>On 05/16/2016 at 3:29 PM, License nursing staff C, stated he/she was not working when the resident eloped as it happened during the evening shift between 2 and 10 PM. The residents are assessed to see if they are an elopement risk or not. The facility had an elopement book and the residents who are elopement risks are in the red folder in the elopement book with a picture and face sheet. When staff hear the door alarm sounding, they should go check to see if someone went out the door. Staff are then to look at the sign out sheet and compare it to the census sheet to determine the residents who are supposed to be in the facility. It depends on the resident if they can sign</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>out and go with someone like family. When staff see a resident outside the building staff make sure the resident signed out. If the resident are not allowed to go out on their own then staff would have them come back inside the building.</p> <p>On 05/16/2016 at 3:39 PM, Direct care staff F stated he/she was working on the evening when the elopement occurred. Staff F looked for the resident and found him/her in his/her room. A few minutes later, staff F looked again and could not find the, the resident, who was no longer in his/her room. Staff began a building search and during that search someone not affiliated with the facility brought the resident back in.</p> <p>On 05/17/2016 at 8:30 AM, Administrative nursing staff B stated, he/she expected staff, when they heard a door alarm, to look and see if anyone went out while other staff do a head count. Staff B stated the resident had poor safety awareness.</p> <p>On 05/17/2016 at 9:15 AM, Administrative staff A stated the nurse did not do what he/she was supposed to do by turning off the alarm without checking to see if any residents had gone out the door.</p> <p>The facility policy, entitled Resident Elopement Policy, revised 05/05/2016, documented when a door monitor is sounded, all staff is to be alert as to who entered or left the building. This will be accomplished by the following procedure. When a delayed egress has occurred and the door mag lock is sounding, staff must go to the location of the alarm to verify who is attempting to exit. When verification has taken place, the charge nurse/designee may reset the door alarm. If no</p>	F 323			

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F 323	Continued From page 5 one was found outside, complete a full census check to verify all residents are accounted for. The facility failed to provide supervision to prevent the resident, identified as at risk for elopement, from leaving the facility unattended without staff knowledge.	F 323		