

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

PRINTED: 10/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/03/2013
NAME OF PROVIDER OR SUPPLIER BRIGHTON PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY 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>The following citations represent the findings of complaint investigation #68491 and #69280.</p> <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 49 residents. The sample included 3 residents reviewed for elopement. Based on interview and record review, the facility failed to ensure adequate supervision for one resident, #1, a cognitively impaired independently mobile resident who left the facility without supervision.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - According to the Physician's Order Sheet (POS) dated 8/22/13, the facility admitted resident #1 on 8/22/13. This POS recorded the diagnoses: suicidal ideations, schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction), and bipolar disorder (a major mental illness that causes people to episodes of severe high and low moods). 	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	Continued From page 1 Review of the Nursing Data Collection Tool dated 8/22/13 and timed 12:53 P.M., recorded the resident with short term memory problems, moderately impaired decision-making skills, sometimes understood communication, responded to simple, direct communication only, and impaired vision. This same assessment documented the resident was a wanderer/exit seeker, smoker and experienced behavior problems, rejected cares and had a potential for self-harm. Review of the fall risk assessment, dated 8/23/13, recorded a score of 10 (indicated a total score of 10 or higher at risk for falls. This fall risk assessment documented wandering was a risk factor. Review of the unsigned, incomplete, elopement risk assessment, dated 8/23/13, recorded the resident was cognitively impaired with poor decision-making skills; ambulated independently; and had hearing, vision, and communication problems. Review of the undated, interim behavior care plan documented the resident with a history of suicidal ideations, increased depression, tearfulness at times and directed staff to perform 15-minute checks on night and day shift. Review of resident's record, revealed staff performed the 15-minute check surveillance from 8/22/13 at 10:00 P.M., through 8/23/13 at 11:15 A.M. Review of the Nursing notes, dated 8/22/13 timed 7:00 P.M., documented the resident continued to	F 323			

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F 323	<p>Continued From page 2</p> <p>want to leave, packed his/her belongings and called family threatening to call a taxicab. Direct care staff provided continuous one on one supervision due to safety issues.</p> <p>Nursing notes dated 8/23/13 timed 8:50 A.M., documented the resident was very angry, bitter, had made two attempts to leave with packing up belongings, and the staff continued 15 minutes checks.</p> <p>Nursing notes dated 8/23/13 recorded the facility called the police to report the resident missing at 12:30 P.M.</p> <p>Nursing notes, dated 8/23/13 timed 2:20 P.M., documented the resident's child confirmed the resident was an elopement risk.</p> <p>Nursing notes recorded the resident returned to the facility on 8/23/13 at 3:45 P.M., (4 hours and 25 minutes after last seen at 11:20 A.M.).</p> <p>According the Weather Underground website, on 8/23/13 at 11:53 A.M., the heat index was 93.7 degrees Fahrenheit. At 2:53 P.M., the heat index was 95.4 degrees Fahrenheit.</p> <p>On 10/2/13 at 8:00 A.M., administrative nursing staff D reported the facility admitted the resident on 8/22/13 and started 15-minute checks at 10:00 P.M. that night. The resident was on 15-minute checks with a personal alarm at the acute care facility prior to admission. When he/she was admitted, staff had no idea he/she was at risk for elopement. When the staff discovered the resident was missing on 8/23/13 at 11:30 A.M., they immediately started searching and implemented the elopement protocol. When the</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>resident returned, he/she refused assessments and refused to tell staff where he/she had gone.</p> <p>On 10/2/13 at 9:00 A.M., administrative staff A reported the door alarm sounded when someone entered or exited the building and the nursing station had camera views of all the doors. Administrative staff A revealed the resident's child was his/her DPOA (durable power of attorney) for health care and signed the resident's admission to the facility.</p> <p>On 10/2/13 at 10:25 A.M., direct care staff Q revealed staff performed 15-minute checks on the resident and he/she was last seen at 11:20 A.M. on 8/23/13.</p> <p>On 10/2/13 at 10:50 A.M., direct care staff P reported staff performed 15-minute checks on the resident and at 11:30 A.M. on 8/23/13, staff could not find the resident.</p> <p>On 10/2/13 at 11:25 A.M., licensed nursing staff H reported staff last saw the resident, on 8/23/13 at 11:20 A.M. and performed 15-minute checks on the residents' whereabouts. Licensed nursing staff H said the resident declined assessments and did not want to be in the facility.</p> <p>On 10/2/13 at 1:15 P.M., Housekeeping/maintenance staff JJ reported the doors alarmed when opened and the alarm sounded and resets when the door closed.</p> <p>On 10/2/13 at 12:00 P.M., activity/social services staff KK reported three staff drove around a 2-mile radius to search for the resident from approximately 11:30 A.M. to his/her return in mid-afternoon.</p>	F 323			

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F 323	Continued From page 4 Review of the facility provided policy for Elopement Risk Assessment, dated 9/2011, directed all residents were assessed on admission by a licensed nurse for elopement risk utilizing an elopement risk assessment form. Interventions will be added to the residents care plan after analyzing the information obtained. The completed assessment was maintained on the clinical record. The resident's legal representative should be contacted if possible to obtain all pertinent information in relation to elopement risk and notified of the resident's risk for elopement and interventions being recommended. This information should be noted on the elopement risk assessment. The facility failed to provide adequate supervision and safety for this cognitively impaired, independently mobile resident that left the facility unsupervised for approximately 4 hours and 25 minutes exposed to warm temperatures, and without the facility knowledge.	F 323			