STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 03/30/2021.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 550	Continued From page 1	F 550		

from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 75 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect, when staff administered insulin (a medication used to regulate blood sugar levels) to Resident (R) 6 and R50 at the dining room table with two other residents in full view of the procedure.

Findings included:

- On 03/23/21 at 12:12 PM, observation revealed R6 pulled her shirt up and Licensed Nurse (LN) G injected an insulin injection subcutaneous (applied under the skin) into her abdomen. Continued observation revealed LN G then administered insulin to R50 in her left upper arm while two other residents were in the dining room in full view of the insulin injections.

On 03/23/21 at 12:12 PM, LN G verified the above observations and stated if residents were eating their meals and she needed to administer their insulin she would give it to them at the table.

On 03/25/21 at 12:23 PM, Administrative Nurse D stated if residents were at the dining room table and the nurse needed to administer their insulin,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 550	Continued From page 2 she expected the nurse to excuse the resident from the dining room and take them to their room or another private area to administer their insulin. The facility's revised "Provision of Dignity for Each Elder" policy, dated 10/06/11, documented the facility would promote care for each elder in a manner and environment that maintains or enhances each elder's dignity and respect in full recognition of his/her individuality. The facility failed to promote care for R6 and R50 in a manner to maintain and enhance dignity and respect, placing the residents at risk for an undignified experience.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The Facility had a census of 75 residents. The sample included 19 residents with one reviewed for environment. Based on observation and interview, the facility failed to provide accommodation of needs for one sampled resident, Resident (R) 19, who had a call light on her wall that was unreachable from her bed or recliner. Findings included: - On 03/22/21 at 11:00 AM, observation revealed	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 558	Continued From page 3	F 558		

R19 sat in her recliner in a dark room without the TV on. R19's call light hung on the wall unreachable to the resident.

On 03/23/21 at 11:19 AM, observation revealed R19 lying in bed, her call light hung on the wall unreachable to the resident.

03/24/21 10:53 AM observation revealed R19 lying in bed, her call light hung on the wall unreachable to the resident.

On 03/24/21 at 10:55 AM, Certified Nurse Aide (CNA) M stated the resident did not like activities, she preferred to be in her room where it was dark and quiet. CNA M stated R19 should have her call light when staff left the room, but did not know if she knew how to use it.

On 03/24/21 at 03:08 PM, CNA MM stated the resident liked to walk the halls and would come out of her room in the afternoons and evenings to walk and sit in the day room. CMA MM stated the resident was confused and didn't think she had ever used her call light on CNA MM's shift.

On 03/25/21 at 11:57 AM, Licensed Nurse (LN) I stated the resident was pretty confused and didn't think she would be able to to use a call light. LN I stated every resident should have an accessible call light.

On 03/25/21 at 12:55 PM, Administrative Nurse D stated that she expected the CNAs to make sure the resident's call light was within reach of the resident when staff left the room.

The facility's "Comfort Rounds" policy, dated 04/01/12, documented prior to leaving the elder's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 558	Continued From page 4 room, the kaizen (CNA) will inquire if there is anything else the elder might need, and ensure the elders call light is within reach. The facility failed to accommodate R19's use of the call light, placing the resident at risk for injury.	F 558		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to provide services to meet professional standards of quality for one unsampled resident, when staff failed to prime (removing air bubbles from the needle, and ensures that the needle is open and working) a Novolog insulin (fast-acting insulin) flex pen (a disposable, single-patient use, dial-a-dose insulin pen) prior to administering Resident (R) 6's insulin. Findings included: - On 03/22/21 at 12:27 PM, observation revealed Licensed Nurse (LN) J dialed two units of Novolog insulin in a flex pen and administered the insulin to R6 in her abdomen without priming the pen first. On 03/22/21 at 12:27 PM, LN J verified the above	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 658	Continued From page 5 observation and stated she was unaware she was supposed to prime the Novolog insulin flex pen. On 03/25/21 at 12:23 PM, Administrative Nurse D stated all the nurses were trained on how to prime a Novolog flex pen and she expected them to prime the pen before administrating the insulin to the resident. Review of LN J's "Insulin Injection per Insulin Pen Competency Checklist," dated 03/01/21, documented LN J was checked off by another nurse to be competent in priming an insulin flex pen. The facility's revised "Medication Administration" policy, date 04/16/20, documented insulin should be "rolled" and not shaken, to avoid creating air bubbles and should be given 30 minutes prior to meals or as ordered by the physician. Refer to manufacture guidelines regarding timing of Novolog, Lantus etc. The facility failed to provide services to meet professional standards of quality, when the nurse failed to prime R6's Novolog flex pen prior to administrating insulin to the resident, placing the resident at risk for receiving an inappropriate dose of insulin.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 684	Continued From page 6	F 684		

that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 75 residents. The sample included 19 residents with one reviewed for positioning. Based on observation, record review, and interview, the facility failed to provide interventions to assist with safety and positioning for Resident (R) 8.

Finding included:

- R8's "Quarterly Minimum Data Set" (MDS), dated 12/14/20, recorded R8 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. R8 required extensive assistance of one-two staff for all activities of daily living, received scheduled pain medication, and restorative therapy for two days during the seven day lookback period.

The "Restorative Care Plan," dated 12/15/20, recorded staff offered and R8 participated in a restorative program designed to meet her individual needs and preferences. The care plan directed staff to review the restorative care plan for R8's specific plan instructions.

The "Therapy Screen Note," dated 02/23/21, documented therapy completed a screening of R8 and after discussion with staff determined the resident did not need therapy services at this time.

The "Occupation Therapy Referral," dated 02/24/21, documented restorative therapy worked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 684	Continued From page 7	F 684		

with R8 on bilateral upper extremity flexion and extension exercises, and bilateral wrist flexion and extension 10 reps daily.

Review of R8's "Electronic Medical Record" (EMR) lacked documentation restorative therapy worked with R8 in the month of March 2021.

On 03/22/21 at 02:54 PM, observation revealed R8's head leaned back and to the right side at an awkward angle while she sat in the day room recliner, and staff did not try to straighten resident's head.

On 03/23/21 at 11:21 AM, observation revealed R8's head hyper flexed (movement of a muscle that extends beyond the body's normal range of motion) backward while she sat in a recliner in the day room.

On 03/24/21 at 08:58 AM, observation revealed R8 sat in a wheelchair with her neck hyper flexed back without any support. Staff placed their hands behind R8's neck and brought R8's head forward but R8's head then flopped backwards and hyper flexed again.

On 03/24/21 at 12:15 PM, observation revealed R8 sat in a high-backed chair for lunch and staff sat next to her. Resident's bottom was not all the way back in the chair and her neck was hyper flexed backwards. Observation revealed staff assisted R8 to eat in this position and every time R8 took a bite she coughed.

On 03/22/21 at 01:00 PM, CNA O stated R8 frequently sat in the chair with her head all the way back. CNA O stated she mentioned the positioning to therapy several times and nothing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 684	Continued From page 8	F 684		

had been done.

On 03/24/21 at 08:12 AM, CNA P stated the resident sat with her neck hyper flexed all the time. Staff tried to reposition her, but she always went back to the same position.

On 03/24/21 at 09:54 AM, Consultant (C) GG stated R8 was screened on 02/23/21 and after completion of the screen and discussing things with nursing it was decided the resident did not need any services at the time. C GG stated therapy tried cervical pillows on the resident in the past, but the resident took them out, threw them, and didn't like them.

On 03/24/21 at 11:15 AM, C GG stated she did not have any documentation of the cervical pillow being used but knew it was used. C GG stated if nursing staff and CNA's don't report any concerns, then we don't know there are concerns.

On 03/24/21 at 11:17 AM, CNA M stated R8 sat with her head all the way back and sometimes cocked to the side. CNA M stated she had reported it to therapy numerous times but nothing had been done about it. CNA M stated she always placed R8 into a high-backed chair when she was eating because if she sat in her wheelchair then her head will flop back while staff tried to assist her to eat.

On 03/24/21 at 12:30 PM, Licensed Nurse (LN) J stated the resident preferred to sit with her head hyper flexed back and would even scoot her body so that she could sit with her head back like that. LN J stated R8's positioning concerned her for a long time but staff have tried a neck pillow and it didn't work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 684	Continued From page 9	F 684		

On 03/24/21 at 01:44 PM, LN K stated that she did not know why there was not charting for restorative for R8 in March of 2021.

On 03/24/21 at 01:58 PM, CNA Q stated that she only walked the resident to lunch for her restorative exercises and did not do any upper extremity exercises with the resident. CNA Q stated restorative therapy orders came from physical therapy, occupational therapy, and speech therapy, and then to the rehab nurse manager who then gave the orders to her so she could have the resident perform the exercises.

On 03/24/21 at 02:02 PM, CNA M stated she had been concerned about the resident at lunch. When she first sat R8 down in the chair, her bottom had been all the way back in the chair and then the resident planked her body out which scooted her buttocks out from the back of the chair. CNA M stated the resident did have her head all the way back when she was eating and coughed when she took bites of food.

On 03/24/21 at 03:54 PM, LN Q stated the resident's "EMR" wasn't showing the order for restorative exercises and it didn't show up on the tasks for the restorative aide to perform. LN Q stated she put the order back in the system.

On 03/25/21 at 10:45 AM, LN I stated R8 sat with her neck hyper flexed for a while and thought R8 would benefit from using a high-backed wheelchair.

On 03 25/21 at 12:50 PM, Administrative Nurse D stated she expected if the CNA and nursing staff had concerns regarding the elder's positioning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 684	Continued From page 10 they should report it to the therapy and then therapy would do a screen on the elder to see if there was anything that could be done regarding the hyper flexion of the neck. The facility's "Restorative Nursing" policy, dated 02/05/21, stated all facility staff members will provide each elder with care, treatment, services according to his/her individualized plan of care. Facility clinical staff provide preventative care to avoid complication resulting from an elder's inactivity including maintaining proper body positioning and alignment. Facility clinical staff will provide supplies, equipment, and adaptive self-help devices to support restorative services. The facility failed to communicate concerns regarding positioning of R8 to therapy and failed to initiate interventions to prevent hyper flexion of R8's neck, placing her at risk for contractures and aspiration.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. Based on observation, record review, and interview, the facility failed to provide an environment free of accident hazards in one of four dining rooms,	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 689	Continued From page 11 when staff left a 16 ounce (oz) spray bottle of Re-juv-nal (disinfectant cleaner) in an unlocked cabinet. Findings included: - On 03/22/21 at 10:12 AM, observation revealed a 16 oz spray bottle of Re-juv-nal disinfectant in an unlocked cabinet underneath the sink in the Eagle Ridge dining room with a label that read: "Caution flammable, causes moderate eye irritation." On 03/22/21 at 10:12 AM, Social Service Designee (SS) X verified the finding, stated it should be in a locked cabinet, removed the disinfectant, and took it to a locked room. On 03/25/21 at 12:33 PM, Administrative Nurse D stated chemicals should be in a locked cabinet or behind a locked door. Administrative Nurse D stated the facility had three cognitively impaired, independently mobile residents in Eagle Ridge. The facility's revised "Safe Use of Chemicals" policy, dated 12/01/12, documented all chemicals would be stored in a locked cabinet when not in use. Chemicals used in the kitchen such as sanitizers, detergents, and cleaners for surfaces and cooking equipment would be stored in the locked cabinet. The facility failed to place a 16 oz bottle of Re-juv-nal disinfectant in a locked cabinet, placing the three cognitively impaired, independently mobile resident's at risk for injury.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 812	Continued From page 12	F 812		

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 75 residents. Based on observation, record review, and interview, the facility failed to provide a backflow device (unwanted flow of water in the reverse direction) or floor drain with a two inch air gap for the drainage system of the kitchen ice machine, used by the 75 residents who resided in the facility.

Findings Included:

- On 03/24/21 at 11:34 AM, observation revealed two flex hoses (flexible water supply tubes that connect plumbing fixtures and appliances to the plumbing system) from the back of the ice machine connected to plastic drainpipes. Continued observation revealed the drainpipes extended approximately three inches into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 812	Continued From page 13 floor drain, and the ends of the drainpipes were soiled and wet. On 03/24/21 at 11:34 AM, Maintenance Staff U verified the ice machine drainage system did not have a backflow device, and the drainpipes should have a two to three inch air gap above the floor drain to prevent possible backflow contamination into the ice supply. On 03/24/21 at 11:34 AM, Dietary Staff BB stated the ice machine drainage system should have an air gap above the floor drain to prevent possible backflow contamination into the residents' ice supply. The facility's "Ice Machine" policy, dated 10/25/11, directed staff to maintain sanitary conditions for the ice machine to prevent contamination of the ice supply. The facility failed to provide a backflow device or floor drain with a two inch air gap for the drainage system of the kitchen ice machine, placing the 75 residents who reside in the facility at risk for contaminated ice.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 880	Continued From page 14	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 880	Continued From page 15	F 880		

contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 75 residents. The sample included 19 residents with one reviewed for infection control. Based on observation, record review, and interview, the facility failed to prevent the development and transmission of infection when staff failed to properly store Resident (R) 16's oxygen tubing and humidifier.

Findings included:

- On 03/22/21 at 11:25 AM, observation revealed R16's oxygen tubing unlabeled, coiled up, unbagged, and placed under the handle of the oxygen concentrator, and the humidifier unlabeled with dated and time opened.

On 03/23/21 at 11:25 AM, observation revealed R16's oxygen tubing laying on the floor by the oxygen concentrator and the humidifier unlabeled with date and time opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 880	Continued From page 16	F 880		

On 03/24/21 at 10:16 AM, observation revealed R16's oxygen tubing unbagged and stuffed into the handle of the oxygen concentrator, and the humidifier unlabeled with dated and time opened.

On 03/25/21 at 12:36 PM, R16's humidifier continued to be unlabeled with the date and time opened.

On 03/23/21 at 09:30 AM, LN H stated R16 used his oxygen at night and when he needed it. Night shift staff changed the oxygen tubing every Sunday.

On 03/24/21 at 10:48 AM, Certified Nurse Aide (CNA) M stated the oxygen tubing should be in a bag when not in use. CNA M stated the oxygen tubing had been in a bag but did not know where the bag went.

On 03/25/21 at 10:48 AM, Licensed Nurse (LN) I stated R16 used his oxygen at night and as needed, and the oxygen tubing should be labeled or the bag that it was in should be labeled. All oxygen tubing should be in a bag and the oxygen tubing was changed weekly.

On 03/25/21 at 11:35 AM, CNA N stated R16's oxygen tubing should always be kept in a bag when it was not in use.

On 03/25/21 at 12:48 PM, Administrative Nurse D stated that she expected the oxygen tubing to be in a labeled bag that was attached to the oxygen concentrator and the humidifier should be labeled with the date and time it was opened.

The facility's "Administration of Oxygen" policy, dated 10/15/11, stated the facility would store all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 880	Continued From page 17 cannulas and nebulizer masks in plastic bags when not in use. Disposable cannulas, nebulizer masks, and tubing will be changed weekly on the night shift and plastic storage bags will be changed and dated daily on the night shift. Label humidifier with date and time opened, and change humidifier weekly. The facility failed to ensure R16's oxygen tubing was labeled and properly stored in a plastic bag, and failed to label the humidifier on the oxygen concentrator with the date and time opened, placing the resident at risk for infection.	F 880		