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 _____	C 10/12/2020

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 complaint investigation# KS00156674. The 2567 was sent to the facility on 10/15/20.	F 000		
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: he facility reported a census of 84 residents. The sample included three residents on the 100-hall health care unit identified at risk for elopement (when a cognitive impaired resident with little or poor safety awareness exits the facility without staff knowledge). Based on observation, record review, and interview, the facility failed to provide an environment free of hazards when on 10/8/20 at 4:35 P.M. Resident (R) 1, exited the healthcare unit, through an unlocked door (normally locked) into an enclosed courtyard, exited the courtyard, to a side walk in a non-secure, unsupervised location outside the facility, walked approximately 75 yards, reentered the facility at the main entrance and stated she was tired. Findings included: - R1's October 2020 electronic medical record (EMR) documented diagnoses that included:	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 689	Continued From page 1	F 689		

Alzheimer disease (a progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain).

The "Admission Minimum Data Set (MDS)" dated 07/12/20 for R1 documented staff assessed the resident with a Brief Interview for Mental Status score of four which indicated she had severely impaired cognition, and poor safety awareness. The MDS documented the resident had wandering behaviors during the seven-day assessment period, The resident ambulated without staff assistance and/or use of any assistive devices. This same assessment recorded the resident was at risk for falls and had one non-injury fall since admission.

The "Care Area Assessment (CAA)" dated 7/12/20 documented the resident had a history of anxiety, which sometimes lead to agitation when she was fearful of her surroundings. The CAA stated a care plan would be developed to address her anxiety. The CAA lacked documentation to identify the resident was at risk for elopement.

The resident's "Care Plan" dated 7/28/20 documented an intervention dated 7/1/20 for R1 to use a Wanderguard (a signaling device affixed to resident to alert staff of attempts to exit the facility) due to her increased confusion for her safety. The care plan directed staff to check the device daily to ensure that it was functioning and will replace the device every three months or as needed if found not to be functioning as it should during routine daily checks.

The "Care Plan" lacked any further information related to the resident occasional exit seeking and/or location of her Wanderguard bracelet.

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F 689	Continued From page 2	F 689		

The updated "Care Plan" 10/8/20 recorded the new intervention which directed staff to offer the resident to go outside and walk twice daily.

Review of the facility investigation/report documented the resident exited the facility on 10/8/12 at 4:35 P.M and reentered at 4:46 P.M. (after 11 minutes).

The investigation recorded on 10/8/20 at approximately 12:30 P.M. Licensed Nurse (LN) H unlocked the Meadowlark patio door so a staff member could eat outside, in order to minimize Covid-19 risk. The staff member ate outside and then came back in. LN H failed to relock the Meadowlark door.

On 10/12/20 at approximately 11:09 A.M. Administrative Staff A provided a written timeline (after viewing a video camera) of the residents exiting the facility. The account of the resident indicated between 4:37 P.M. and 4:42 P.M.: "...Elder took her jacket off an held it in her arms as she was walking, elder was walking at a slow pace and noted holding on to the brick of the building at times ... " This same timeline documented at 4:48 P.M. R1 reported she "was too tired to walk to the neighborhood, so staff escorted her back to the neighborhood per wheelchair. A Skin assessment and full set of vitals were taken once elder returned to household vitals in normal range ..."

On 10/12/20 at 10:00 A.M. observation with Administrative Staff A revealed an exit to the enclosed patio off the Meadowlark secured care unit, This exit has a panic bar that alarmed when depressed but allowed the door to open after 15

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seconds. The alarm was deactivated when the door was unlocked using a metal key to the upper right mag-lock.

On 10/12/20 at 12:01 P.M. observation revealed R1 seated upright at the dining room table. R1 smiled, and indicated her lunch was good but did not comment.

Interviewed on 10/12/20 at 11:04 AM. Certified Nurse Aid 0 stated R1 had tried to exit thru the patio door before, but staff were there to redirect her, and she was easily redirected,

Interviewed on 10/12/20 at 12:30 P.M. LN H stated she was the nurse working the day R1 exited thru the entrance. LN H indicated she forgot to lock the exit door after having let a staff member on the patio to eat his lunch,

Interviewed on 10/12/20 at 9:58 A.M. Administrative Staff A acknowledged the resident exited through the door from the facility to the patio, when the door remained unlocked. The resident exited the enclosed patio through a gate that used to be locked but was now not locked due to the local fire department informed her it could not be locked, Administrative Staff A acknowledged the resident walked 75 yards to the front of the building and stated on reentry she said this was a big building and she was tired.

On 10/12/2020 at 3:58 P.M. the facility emailed additional information, recording staff education and training, door checks.

The facility policy 'Searching for an Elder who Wanders and has Exited the Neighborhood without an Appropriate Escort or Supervision,'

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F 689	Continued From page 4 revised 8/20/2018 recorded measures to outline a search of an elder, however lacked any documentation to address the prevention of an elopement though unlocked doors. On 10/8/20 at approximately 12:30 P.M. the facility failed to reactivate an alarm, leaving an unlocked door and R1 identified with confusion, poor safety awareness and at risk, exited the facility to an unsupervised, non- secure area, exposing the resident to potential accident and/or injury.	F 689		