

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

PRINTED: 06/26/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175044		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2025	
NAME OF PROVIDER OR SUPPLIER BREWSTER HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 Recertification Survey and complaint survey regarding allegations in KS00194490.			F 000			
F 605 SS=D	The 2567 was sent elcetriconally on 06/26/25. Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3) (d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.			F 605			

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 605	Continued From page 1 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 605			

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F 605	Continued From page 2 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 75 residents. The sample included 18 residents, with six sampled residents who were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility to ensure that Resident (R) 11, R17, and R25 were free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without a Centers for Medicare and Medicaid (CMS) appropriate indication for use. These deficient practices placed R11, R17, and R25 at risk of unnecessary medication administration and	F 605			

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F 605	Continued From page 3 related complications. Findings included: - R11's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and psychosis (any major mental disorder characterized by a gross impairment perception). R11's "Annual Minimum Data Set (MDS)" dated 12/30/24 documented she had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R11 displayed no behavioral signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis. R11 the use of a walker or wheelchair to assist with mobility. R11 required supervision to partial assistance from staff for her daily functional abilities. R11 was dependent on staff for bathing. R11 received an antipsychotic and an antidepressant (a class of medications used to treat mood disorders) on a scheduled routine basis. R11's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 12/30/24 documented R11 used an antipsychotic and an antidepressant and was at risk for adverse effects. Staff monitored R11 for drug effects and the physician would be notified as needed. A gradual dose reduction (GDR) would be completed when indicated. R11's "Care Plan" last revised on 03/31/25 directed staff that she used psychotropic (alters mood or thought) medications and to administer medications as ordered by the provider. The care	F 605			

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F 605	Continued From page 4 plan directed staff to monitor R11 for side effects each shift. The care plan directed staff to consult with the pharmacy and the provider to consider dosage reduction when clinically appropriate at least quarterly. The care plan directed staff to discuss with the provider and the family regarding the ongoing need for use of medication. Staff were directed to review behaviors, interventions, and alternate therapies attempted and their effectiveness as per facility policy. The care plan directed staff to monitor, document, and report as needed any adverse reactions to Zyprexa (brand name for the medication olanzapine, an atypical antipsychotic primarily used to treat certain mental health conditions). The care plan directed staff to complete an Abnormal Involuntary Movement Scale (AIMS- a 12-item rating scale used to assess involuntary movements) assessment quarterly. R11's "Orders" tab of the EMR documented a physician's order dated 02/21/24 for Zyprexa 5 milligrams (mg) tablet, give one tablet by mouth two times a day for hallucinations (sensing things while awake that appear to be real, but the mind created). This order was discontinued on 02/21/24. R11's "Orders" tab of the EMR documented a physician's order dated 02/21/24 for Zyprexa 5 mg, give one tablet by mouth two times a day for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) as evidenced by hallucinations. This order was discontinued on 04/29/25. R11's "Orders" tab of the EMR documented a physician's order dated 04/29/25 for Zyprexa 5 mg tablet to be given by mouth twice daily for	F 605			

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F 605	Continued From page 5 hallucinations. This order was discontinued on 05/27/25. R11's "Orders" tab of the EMR documented a physician's order dated 05/27/25 for Zyprexa 5 mg tablet to give one tablet by mouth two times a day for psychotic disorder with delusional thinking-associated agitation. The "Note to Attending Physician/Prescriber" recommendation dated 04/09/25 in the EMR documented this resident was currently taking Zyprexa 5mg twice daily with a diagnosis of anxiety (resident has dementia). Per CMS guidelines, only Food and Drug Administration (FDA) approved indications were allowed for the continued use of antipsychotics in patients with dementia due to the increased rate of mortality and risk for other significant adverse effects. Please consider a trial reduction of Zyprexa to 2.5 mg twice daily to reduce inappropriate antipsychotic use and provide a clinical rationale for using this medication for this indication. If no changes were warranted, please provide a clinical rationale, along with a risk versus benefit statement. The 04/11/25 signed providers' response located under the "Misc." tab of the EMR to the 04/09/25 "Note to Attending Physician/Prescriber" recommendation with the clinical rationale for use of the medication was this medication was effective for delusional thinking manifested by agitation and aggression. Continue the medication as ordered, risk/benefit statement: the benefit was clearer thinking, decreased agitation, and increased quality of life. The risk was increased sedation and weight gain. The benefit outweighs the risk.	F 605			

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F 605	Continued From page 6 On 06/10/25 at 09:27 AM, staff assisted R11 to the toilet. R11 ambulated with the use of a walker. On 06/10/25 at 10:05 AM, Consultant GG stated the antipsychotic medications had been a topic that had been addressed monthly in QAPI. The facility, herself, the pharmacist, and the families had been making every effort to eliminate the use of antipsychotic medications without an appropriate indication. Consultant GG stated the problem mostly came down to the families wanting the resident to continue the medication. On 06/11/25 at 12:10 PM, Consultant HH stated the facility, herself, and the medical director had been holding monthly meetings about the antipsychotic medications. Consultant HH stated it had been a group effort to get the antipsychotic medications gone, however, the families a lot of the time were the ones that wanted the resident to remain on the medications. Consultant HH stated she continued to work with the facility, medical director, and providers to ensure an appropriate indication for use was used, but that was not always possible. The facility's "Medication Management" policy dated 09/18/24 documented each resident who was prescribed psychotropic medications would have a medication review conducted for the desired responses and possible side effects of the medication. Each antipsychotic medication should be reviewed on a separate "Psychotropic Medication Review" form from the contracted pharmacy. Documentation of the review was completed by the pharmacist or pharmacy consultant and reviewed by the attending physician or medical director as defined by the	F 605			

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F 605	Continued From page 7 pharmacy review process. The facility's consultant pharmacist would review the medication regiment of each resident upon admission, at least monthly or upon request for adverse consequences related to current medications. Findings and recommendations would be reported to the facility Administrator, Director of Nursing, the attending physician, and the medical director. The attending physician must document that the identified irregularity had been reviewed and what if any, action had been taken to address it. The facility's "Behavioral Health" policy dated 02/28/25 documented that psychotropic medications should only be prescribed when non-pharmacological interventions had been proven insufficient and there was a clear clinical indication. The orders must have a proper diagnosis, dosage, duration, and expected outcomes. A gradual dose reduction (GDR) must be attempted at least every six months unless contraindicated. - R17's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by a gross impairment perception), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). R17's "Annual Minimum Data Set (MDS)" dated 07/10/24 documented she had a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R17 required partial to substantial assistance from staff for her daily functional abilities. R17 received	F 605			

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F 605	Continued From page 8 an antipsychotic and an antidepressant (a class of medications used to treat mood disorders) on a scheduled basis. R17 required supplemental oxygen therapy. R17's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 07/15/24 documented she received an antidepressant medication related to depression and an antipsychotic medication for anxiety. R17 was at risk for adverse side effects. R17's "Care Plan" last revised on 06/10/25 directed staff that she took an antipsychotic medication related to inconsolable crying, fretting, and pacing. The Care Plan directed staff to always assess for and incorporate nonpharmacological interventions to alleviate room temperature discomfort, hunger, thirst, boredom, chair or bed discomfort, and toileting issues. The Care Plan directed staff to consider pharmacological interventions using medications other than antipsychotics, such as pain medication, observing for lessening behaviors, and collaborating with the interdisciplinary team. The Care Plan directed staff to discuss a reduction in dosing when target behaviors were absent and were easily altered for a specified period, but no less than quarterly. The Care Plan directed staff to discuss and educate the resident on the need to prescribe the medication, including discussion of benefit/risk issues. The Care Plan directed staff to monitor and identify potential side effects of the selected medication and monitor for clinical appearance. The Care Plan directed staff to monitor R17's social interactions, participation in activities, and self-care, as well as the frequency and intensity of symptoms; document benefits/risks, including the impact of medication	F 605			

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F 605	Continued From page 9 on behaviors. R17's "Orders" tab of the EMR documented a physician's order dated 02/21/24 for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) by mouth one time a day for anxiety as evidenced by inconsolable concerns, crying, fretting, and pacing. This order was discontinued on 04/11/25. R17's "Orders" tab of the EMR documented a physician's order dated 04/25/25 for Seroquel 12.5 mg by mouth one time a day for anxiety as evidenced by inconsolable concerns, crying, fretting, and pacing. The "Note to Attending Physician/Prescriber" recommendation dated 03/12/25 in the EMR documented that R17 currently took Seroquel 12.5 mg twice daily with a diagnosis of anxiety (resident has dementia). Per CMS guidelines, only Food and Drug Administration (FDA) approved indications were allowed for the continued use of antipsychotics in patients with dementia due to the increased rate of mortality and risk for other significant adverse effects. Please consider a trial reduction of Seroquel to reduce inappropriate antipsychotic use and provide a clinical rationale for using this medication for this indication. If no changes were warranted, please provide a clinical rationale, along with a risk versus benefit statement. R17's "Misc." tab contained the 03/14/25 physician's response to the 03/10/25 "Note to Attending Physician/Prescriber" that documented that a trial dose reduction was not appropriate at that time. The clinical rationale for the use was the medication was currently effective for sleep and worked on a therapeutic plan. The	F 605			

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F 605	Continued From page 10 continuation of the medication benefited her sleep, decreased her anxiety, and decreased her aggressions. The risk was increased sedation and increased weight gain. The benefit outweighs the risks. R17's 04/09/25 provider "Medication Regimen Review" in the "Misc." tab of the EMR documented a review of the Pharmacy Consultant's medication recommendations. R17 was currently taking Seroquel 12.5 mg nightly. It was reduced from 25 mg on 03/17/25 with no untoward consequences. Consider a discontinuation at this time. R17 was seen in her room and appeared comfortable with no distress. The Pharmacy Consultant's recommendations had been seen and reviewed in the chart as well as spoke with the appropriate staff and family to make my determination. Agree with the Pharmacy Consultant's recommendations: The resident has done well and would discontinue the medication and monitor the resident closely. R17's 04/25/25 provider "Medication Regimen Review" in the "Misc." tab of the EMR documented a review of the Pharmacy Consultant's medication recommendations. On 04/09/25 a communication was received regarding a potential for gradual dose reduction (GDR). R17 was taking Seroquel 12.5 mg nightly. The Seroquel was reduced from 25 mg on 03/17/25 with no untoward consequences. Consideration was requested to discontinue the Seroquel. This was done effective 04/11/25. On 4/22/25, a communication was received from the nursing staff that R17 was consistently up all night and day, and was confused, anxious, angry, crying, and scared. This provider spoke with the neighborhood manager, who reviewed entries in	F 605			

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F 605	Continued From page 11 the behavior documentation and per her review "4/12- current Insomnia, physical aggression, crying wandering, refusal of care, anxiety, not participating in activities, decreased intake at meals". Physical Exam: The patient seen in the room, appeared comfortable with no distress. The Pharmacy Consultant's recommendations had been seen and reviewed the chart as well. Have spoken with the appropriate staff and the family to make my determination. It appears that it was not in R17's best interest to discontinue the Seroquel. This is the 3rd attempt to gradually wean and the 3rd failure. At this time the Seroquel will be restarted at 12.5 mg daily. On 06/10/25 at 10:05 AM, Consultant GG stated the antipsychotic medications had been a topic that had been addressed monthly in QAPI. The facility, herself, the pharmacist, and the families had been making every effort to eliminate the use of antipsychotic medications without an appropriate indication. Consultant GG stated the problem mostly came down to the families wanted the resident to continue the medications. On 06/11/25 at 12:10 PM, Consultant HH stated the facility, herself, and the medical director had been holding monthly meetings about the antipsychotic medications. Consultant HH stated it had been a group effort to get the antipsychotic medications gone, however, the families a lot of the time were the ones that wanted the resident to remain on the medications. Consultant HH stated she continued to work with the facility, medical director, and providers to ensure an appropriate indication for use was used, but that was not always possible. The facility's "Medication Management" policy	F 605			

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F 605	Continued From page 12 dated 09/18/24 documented each resident who was prescribed psychotropic medications would have a medication review conducted for the desired responses and possible side effects of the medication. Each antipsychotic medication should be reviewed on a separate "Psychotropic Medication Review" form from the contracted pharmacy. Documentation of the review was completed by the pharmacist or pharmacy consultant and reviewed by the attending physician or medical director as defined by the pharmacy review process. The facility's consultant pharmacist would review the medication regiment of each resident upon admission, at least monthly or upon request for adverse consequences related to current medications. The findings and recommendations would be reported to the facility Administrator, Director of Nursing, the attending physician, and the medical director. The attending physician must document that the identified irregularity had been reviewed and what if any, action had been taken to address it. The facility's "Behavioral Health" policy dated 02/28/25 documented psychotropic medications should only be prescribed when non-pharmacological interventions had been proven insufficient and there was clear clinical indication. The orders must have a proper diagnosis, dosage, duration, and expected outcomes. A gradual dose reduction (GDR) must be attempted at least every six months unless contraindicated. - R25's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and anxiety (mental or emotional reaction characterized by apprehension,	F 605			

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F 605	Continued From page 13 uncertainty, and irrational fear). R25's "Quarterly Minimum Data Set" (MDS), dated 05/16/25, recorded R25 had severely impaired cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADL). The MDS recorded the resident received antipsychotic medication during the observation period. The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/30/24, recorded R25 received antipsychotic medication and had dementia, anxiety, and depression diagnoses. R25's "Care Plan," dated 05/21/25, recorded R25 received antipsychotic medication for the diagnosis of dementia with behaviors and staff were to monitor for side effects and effectiveness. The care plan documented the facility would consult with the pharmacist and physician to consider dose reduction when clinically appropriate. The "Physician's Order," initial order date 06/03/25, directed the staff to administer Seroquel 25 milligrams (mg), take 12.5 mg once daily for diagnoses of anxiety and senile degeneration of the brain. R25's EMR lacked a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits statement for the Seroquel use. On 06/10/25 at 10:00 AM, observation revealed R25 sat in a wheelchair dressed in street clothes and nicely groomed, in the living room. Continued	F 605			

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F 605	Continued From page 14 observation revealed the resident watching TV with three other residents. On 06/09/25 at 03:25 PM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of anxiety with senile degeneration of the brain. Administrative Nurse D verified the facility had been working with the physician to get the appropriate diagnoses for the residents on antipsychotic medications. The facility's "Medication Management" policy dated 09/18/24, recorded the facility would ensure that all medications and biologicals were managed by the licensed nursing staff or medication aides in accordance with state standards of practice, and a medical care provider's order, each manufacturer's recommendations, and in a safe and sanitary manner. The policy recorded each resident who was prescribed psychotropic medications would have a medication review conducted for the desired response and possible side effects of the medication. The licensed nurse is responsible for communicating the evaluation of the medication to the physician or health care provider for follow-up action. Medications completed for review include antipsychotic medications, and documentation of the review by a pharmacist or contracted pharmacist review would be reviewed by the attending physician or the medical director.	F 605			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609			

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F 609	Continued From page 15 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents, with one reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure staff reported and investigated the physical incident between R63 and R66. This placed the residents at risk for ongoing abuse and/or mistreatment. Findings included: - R63's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental	F 609			

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F 609	Continued From page 16 disorder characterized by falling memory, and confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R63's "Quarterly Minimum Data Set" (MDS), dated 05/14/25, recorded R63 had severely impaired cognition. The MDS recorded he required staff assistance for transfers and activities of daily living (ADL.) The MDS further documented R63 had no behaviors and had two falls and no injuries. R63's "Care Plan," dated 05/14/25, recorded R63 requires staff assistance with most ADL cares. R63's "Care Plan" documented the resident ambulates with a walker but will try to ambulate without the use of the walker. The resident does not like someone walking directly beside him due to not liking others being in his personal space, staff to walk within reaching distance for the resident's safety. The care plan documented the resident was restless, combative, and received antipsychotic medications. The care plan directed staff to watch for targeted behaviors that include pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff and others, and document per facility protocol. The "Nurse's Note," dated 05/13/25 at 04:44 AM, documented resident was noted with increased anxiety on the evening shift and some physical aggression as well. The nurses' notes documented R63 would not use his walker and insisted on ambulating unassisted for short distances. R63 kept going to different seats in the	F 609			

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F 609	Continued From page 17 living room area. R63 moved to different residents, trying to sit in the seats those residents were already seated in. R63 did try to push R66 (severely cognitively impaired resident) at one point and did actually touch her chest. Staff intervened immediately and R63 was assisted back to his room. The notes documented he has come out a few more times on the night shift, and he cannot stay long in one spot. The notes documented staff continued to monitor and check R63 frequently. On 06/10/25 at 04:00 PM, observation revealed R63 stood in front of his walker on the Meadowlark unit hall and staff was standing 1:1 with the resident. Continued observation revealed that R63's wife was seated in the dining room adjacent to the hall and the resident walked over to his wife and firmly put his hands on her walker, looked directly at her, and said something that was word salad. Staff intervened and directed R63 away from his wife and the wife stood and quickly ambulated out of the unit. On 06/10/25 at 03:05 PM, Administrative Staff A and Administrative Nurse D stated they had not been informed of R63's resident-to-resident incident on 05/11/25 and the staff should report an incident involving a resident-to-resident altercation to the unit supervisor and administration and an investigation would be completed along with witness statements and reports to the state if needed. Administrative Staff A and Administrative Nurse D verified the facility had an Abuse Neglect Exploitation Inservice in April 2025, and the nurse who failed to report the incident attended the in-service. The facility's "Reporting Abuse, Neglect, or	F 609			

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F 609	Continued From page 18 Misappropriation" policy, dated 06/05/24, documented the policy of the facility that "abuse" allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported per Federal and State law. The facility would ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of residents' property, are reported immediately, but not later than 2 hours after the allegation is made, if the event that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency and adult protective services in accordance with State law through these established procedures. In addition, local law enforcement would be notified of any reasonable suspicion of a crime against a resident in the facility per agreement with the local law enforcement agency. All employees are expected to report all actual or potential incidents of abuse, neglect, or misappropriation of a resident's property immediately to their team leader, the Administrator, or the State Agency Complaint hotline. The facility reviews all actual or potential incidents involving residents who live in the facility through the multi-disciplinary team. The policy documented all employees and volunteers are educated during new-employee orientation and at least annually concerning their responsibility to immediately report any abuse, neglect, or exploitation they witness, are aware of, or suspect to the Administrator and to the State any abuse or neglect they witness, are aware of or suspect.	F 609			

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F 609	Continued From page 19 The DON, Administrator, or other designated investigating individual would begin their own internal investigation and notify the State Agency within twenty-four hours of cooperating with the investigative agency.	F 609			
F 628 SS=D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 628			

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F 628	Continued From page 20 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 628			

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F 628	Continued From page 21 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information	F 628			

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F 628	Continued From page 22 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 628			

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F 628	Continued From page 23 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on interview and record review, the facility failed to notify the State Long term Care Ombudsman (LTCO) of Resident (R) 34's facility-initiated discharge to the hospital. This placed R34 at risk for impaired rights. Findings included: - R34's Electronic Health Record (EHR) revealed diagnoses of chronic kidney disease (longstanding disease of the kidneys leading to renal failure) with behavioral disturbance, osteoporosis (abnormal loss of bone density and	F 628			

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F 628	Continued From page 24 deterioration of bone tissue with an increased fracture risk), and encephalopathy (inflammatory condition of the brain.) R34's "5 Day scheduled Minimum Data Set" (MDS), dated 05/30/25, recorded R34 had severe cognitive impairment (problems with thinking, learning, remembering, and using judgment.) The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident had frequent incontinence and ambulated with a walker and wheelchair. The "Care Area Assessment" (CAA), dated 07/25/24, recorded R34 required staff assistance with ADLs due to impaired functional ability. The CAA documented the resident had incontinence of urine with a diagnosis of chronic kidney disease and required assistance with toileting transfers and hygiene. R34's "Care Plan," dated 04/23/25, recorded R34 required staff assistance with most ADL care. R34's "Care Plan" documented the resident required staff assistance with incontinent cares and assistance. The care plan documented staff were to allow the resident privacy when using the restroom, however, stay near the bathroom and ready to provide assistance when R34 required it. The care plan documented R34 had the potential for falls related to needing assistance with ADL and staff would encourage her to call for assistance when needed. On 05/20/25 at 03:25 PM, "Nurse's Notes" documented R34 complained of hoarseness and the staff notified the physician, and received an order for a Coronavirus disease Covid (a	F 628			

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NAME OF PROVIDER OR SUPPLIER BREWSTER HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SW 29TH ST TOPEKA, KS 66611		
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F 628	Continued From page 25 contagious respiratory illness caused by the SARS0CoV-2 virus) test, to increase fluids, and saltwater gargle three times a day for three days was received. The Covid test results were negative. On 05/21/25 at 12:07 PM, "Nurses Notes" documented R34 had a change in mental status and was not helping staff with routine cares and was unable to help with transfers that she normally would help with. The note documented staff notified the physician and she came to the facility to examine R34 and stated the resident was "just slow this morning." At 11:30 AM the speech therapist notified the nurse R34 leaned to the left and drooled from her mouth. The physician was notified and ordered R34 to be sent to the hospital for evaluation. The Dural Power of Attorney (DPOA) agreed to send R34 to the hospital for evaluation. At 11:57 AM the facility called for an ambulance transport, and they arrived at 12:10 PM. The resident left the facility at 12:17 PM. On 05/21/24 at 05:30 PM, "Nurse's Notes" documented the hospital called the facility stating R34 would be admitted to the hospital for a Urinary Tract Infection (UTI) and Para Influenzas 2 (one of the four types of human parainfluenza viruses (HPIVs) viruses that cause upper and lower respiratory illnesses). On 05/24/25 at 11:40 AM, "Nurse's Notes" documented the resident was admitted back to the facility at 11:00 AM, per facility van, and in a wheelchair. R34 was alert and oriented and was placed on contact precautions until 05/29/25. The physician and the DPOA were notified of the resident's readmission.	F 628			

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F 628	Continued From page 26 R34's clinical record lacked documentation staff notified the LTCO of R34's discharge from the facility. On 06/10/25 at 08:25 AM, Administrative Staff A stated they do not send any notification of discharge to the Ombudsman regarding the resident discharge. Administrator Staff A stated they sent the Assisted Living Residents' discharge to the Ombudsman but did not and have not sent any long-term Care Residents to the Ombudsman but would start. The facility's "Admission, Discharge and Transfer," policy," dated 06/05/24, documented the transfer out of the facility and discharge includes movement of a resident to a bedroom outside of the certified neighborhoods of the facility whether the bed is on a larger facility campus or not. The policy documented if/when staff mandates a transfer out of the facility or discharge from the facility, staff will document the reason(s) and for conditions under which the resident is mandated to transfer out of the facility or be discharged and the method(s) for transitioning the responsibility for the resident's care from one clinical, organization, program or service to another, in addition, the following document documentation requirements include the basis of the transfer and the specific resident need(s) that cannot be met at the facility. The policy documented the facility staff would document in the clinical record the discharge information provided to the resident and the receiving organization. The policy documented if applicable; the basis for the transfer, specific needs that could not be met by the facility, the facility attempts to meet the needs of the resident,	F 628			

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F 628	Continued From page 27 a physician progress note to include why the resident needs to be transferred or discharged, why the facility cannot meet the needs of the resident, what services the resident needs following discharge that cannot be met by the facility, and the reason for transfer, discharge, or referral. The policy documented the State Ombudsman would be notified of any/all facility-initiated discharges for assistance with transition and support for the resident and representative.	F 628			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656			

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F 656	Continued From page 28 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive plan of care for Resident (R) 28 for Care Area Assessments (CAA) triggered from the Minimum Data Set (MDS). This placed R28 at risk for resident-centered unmet care needs. Findings included: - R28's Electronic Medical Record (EMR) documented diagnoses of displaced fracture (broken bone) of the greater trochanter (hip joint area) of the right femur (thigh bone), malignant (cancer) neoplasm (tumor) of the mouth and mandible (lower jawbone), laceration (cut) without	F 656			

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F 656	Continued From page 29 foreign body of right forearm, and spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities). The "Admission Minimum Data Set" (MDS), dated 05/22/25, documented that R28 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R28 had a functional range of motion impairment of one side lower extremity and required supervision or touching assistance with toileting, upper and lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and walking ten to 50 feet. The MDS further documented a walker and a wheelchair used for mobility. R28 had occasional incontinence of urine and frequent incontinence of bowel, and had almost constant pain which occasionally affected sleep. The MDS further documented that R28 had a fall in the prior month and six months before admission, with a fracture related to a fall. R28 had speech, occupational, and physical therapy services. R28 had complaints of difficulty or pain when swallowing and received opioids (medication used to treat pain), antiplatelet (medication that prevents blood clots), and anticonvulsant (drugs used to prevent seizures or abnormal electrical activity in the brain). The "Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment" (CAA), dated 05/29/25, documented R28 had times of poor cognition, staff provided cuing, reminders, and assistance with decisions as needed.	F 656			

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F 656	Continued From page 30 The "Functional Abilities CAA," dated 05/29/25, documented R28 needed staff assistance to complete activities of daily living. Staff assisted as needed with all the cares. R28 had therapy services to improve strength and endurance. The "Urinary Incontinence CAA," dated 05/29/25, documented R28 at times had bladder incontinence and was at risk for skin breakdown and infection. Staff assisted with all toileting and incontinent care as needed. The "Psychosocial Well-Being CAA," dated 05/29/25, documented R28 was at risk for social isolation and situational depression. Staff to continue to offer/encourage R28 to participate in activities of interest. The "Falls CAA," dated 05/29/25, documented R28 had impaired mobility, a recent fall with fracture, at risk for falling. Staff assist with all activities of daily living and care as needed. R28 had therapy to improve strength and endurance. The "Nutritional StatusCAA," dated 05/29/25, documented R28 had a mechanically altered diet, which could lead to loss of appetite, weight loss, and malnutrition due to taste, texture, and appearance. The "Pain CAA," dated 05/29/25, documented R28 had times of pain, and medication was received as ordered to control pain. R28 had pain assessed daily and as needed. The "Dental Care CAA," dated 05/29/25, documented R28 had a diagnosis of mandible cancer and reported mouth pain. Staff were to assist with all oral care as needed. Weight and	F 656			

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F 656	Continued From page 31 oral intake were monitored. The physician was notified as needed, and medications as ordered. R28's "Care Plan," dated 06/01/25, included R28's risk for falls due to weakness, poor balance, medication use, and actual fall without injury. R28 received multiple medications for diagnosis, some of which have a black box warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration). R28's "Comprehensive Care Plan" failed to address cognitive loss/dementia, psychosocial well-being, nutritional status, and dental care as required within 21 days of admission. The "Progress Note" dated 05/16/25 at 01:08 PM documented that R28 arrived at the facility, having been a patient in the hospital. R28's admitting diagnosis of displaced fracture of the greater trochanter of the right femur was alert and oriented times four, had a port to the right chest, skin tear to the right forearm, scab to knees, and generalized bruising to both thighs. The "Progress Note" dated 05/23/25 at 08:36 AM, recorded R28 continued respite stay, was alert with some forgetfulness, pleasant, cooperative, and normal affect. The note further documented R28 complained of fatigue, had swelling of the jaw due to cancer of the mandible bone, had severe pain, was up with one staff stand-by assistance, and had occasional bowel and bladder incontinence. On 06/09/25 at 03:03 PM, R28 was sitting on the edge of the bed, with a gait belt around his waist. The walker was against the wall and not within	F 656			

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F 656	Continued From page 32 reach of the resident. On 06/11/25 at 11:11 AM, Certified Nurse Aide (CNA) M reported she was aware of the cancer diagnosis and R28 was on a mechanically altered diet and had pain, and CNA M reported changes to the nurse. CNA M reported the temporary cares were kept in the care plan book. On 06/11/25 at 11:12 AM, Licensed Nurse (LN) I, R28's MDS was completed by the MDS coordinator. LN I stated she was unsure of who was responsible for the care plan process due to recent staff changes. LN reported that the admitting nurse and therapists were responsible for the baseline care plans. On 06/11/25 at 12:17 PM, Administrative Nurse D reported that the comprehensive MDS with triggered CAAs should have been part of the care plan process, and concerns should be addressed on the care plan. Upon request, the facility failed to provide a comprehensive care plan policy.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657			

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F 657	Continued From page 33 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent falls for Resident (R) 67 and R70. This placed the residents at risk for injuries due to uncommunicated care needs. Findings included: - R67's Electronic Medical Record (EMR) documented diagnoses of weakness, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late-onset, dementia (a progressive mental disorder characterized by failing memory and confusion), mood disturbance, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).	F 657			

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F 657	Continued From page 34 R67's "Admission Minimum Data Set" (MDS), dated 03/19/25, documented severe cognitive impairment, no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception) or exhibited behaviors. R67 had no functional range of motion impairment, and used a walker and wheelchair for mobility. R67 required partial/moderate assistance with toileting hygiene, lower body dressing, putting on and taking off footwear and supervision, and touching assistance with personal hygiene, rolling in bed, lying to sitting, transfers, and walking ten to 50 feet. The MDS further documented R67 was frequently incontinent of urine, and had frequent pain which occasionally interfered with day-to-day activities. R67 had a fall in the month prior to admission, and two falls in the last 6 months. The "Fall Care Area Assessment", dated 03/20/25 documented R67 had impaired mobility, weakness, and was at risk of falling. Staff assisted R67 with all activities of daily living and care as needed. R67's "Fall Care Plan" initiated 04/22/25, documented R67 was a high fall risk related to confusion, left hip pain, glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and a history of falling. The care plan directed staff to keep frequently used items within easy reach, needed supervision/touching assistance with transfer, lower body dressing, and walk up to 50 feet with supervision. The "Progress Note" dated 04/01/25 at 04:35 AM, documented at 03:45 AM R67 was in her room,	F 657			

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F 657	Continued From page 35 on the floor trying to go to the bathroom. The call light was not utilized and R67 reported landing on her bottom. R67 had non-skid socks on, but a walker was not utilized. Upon request, the facility failed to provide a fall investigation for an unwitnessed fall on 04/01/25. The "Progress Note" dated 04/03/25 at 04:50 AM documented R67 found on the floor in the bathroom. Urine covered the floor, as R67 had urinated while attempting to self-transfer to the bathroom. R67 bed was locked and in the lowest position, the call light was not activated, no socks or shoes on, poorly lit room, no ambulatory aide, and the staff were not aware she was getting up to the bathroom. The "Fall Investigation" dated 04/03/25, documented that R67 had an unwitnessed non-injury fall in her bathroom. R67 was confused per baseline. The floor was wet since she was incontinent of urine during self-transfer in the bathroom. The call light intervention was to remind R67 to use the call light and wait for staff. The root cause was that R67 needed to use the bathroom and attempted to transfer self. No new fall intervention was added to the care plan. The "Progress Note" dated 04/11/25 at 01:12 AM documented the location in the resident's room, baseline confusion, laceration, and hematoma to the back of the head. The Progress Note lacked a description of the event that led to the laceration and hematoma. The "Fall Investigation" dated 04/11/25, documented at 12:45 AM, R67 had an unwitnessed fall with injury in her room. R67 was	F 657			

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F 657	Continued From page 36 found by nursing staff on the floor by her bed . R67 had a noticeable hematoma to her left lateral posterior head with a laceration at the top of her head. R67 was confused at her baseline and was attempting to ambulate without assistance. The fall investigation further documented interventions of placing a pancake light and taking R67 to the toilet at midnight and 04:00 AM. The determined root cause was the need to use the bathroom. The care plan lacked initiation of intervention. The "Progress Note" dated 04/23/25 at 10:54 AM documented that R67 had an unwitnessed fall, was found lying on the floor, and had a bleeding abrasion to her forehead. R67 was not able to say what happened. R67 was left using the bathroom. Staff went to check on R67 and found her lying on the floor, bleeding on the forehead. The walker was in the bathroom, R67 had a pull-up on, and her pants were down to her feet. The "Fall Investigation" dated 04/23/25 documented that R67 had an unwitnessed fall with injury in the bathroom. R67 was unattended in her bathroom. The root cause was that R67 was ready to get up after toileting and fell, as R67s cognition level was unsafe to do the task alone. The intervention was not to leave R67 unattended in her bathroom. This intervention was not added to the care plan. On 05/01/25, R67 had a room change from the rehabilitation unit to a special care unit. The "Progress Note" dated 05/04/25 at 06:30 AM, documented R67 sitting on the floor at the end of her bed wearing a brief and a sleep shirt. She had bare feet and the call light was clipped to the bedrail. R67 stated she was trying to get to the	F 657			

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F 657	Continued From page 37 bathroom. The intervention was to add 05:30 AM toileting to her care plan. This intervention was not added to the care plan. The intervention of taking R67 to the bathroom at midnight, 04:30 AM, and 05:30 AM was not initiated on the care plan until 06/09/25. On 06/10/25 at 07:40 AM, R67 sat in the commons area in a recliner with her feet elevated and staff sitting next to her. R67 alert and wearing glasses. Staff provided oral medications, and she was able to take the medication without difficulty. On 06/11/25 at 11:02 AM, Certified Nurse Aide (CNA) N reported that R67 had fallen while in the rehabilitation unit. CNA N stated she would look at the care plan book and the computerized charting system for interventions related to falls and fall prevention. On 06/11/25 at 11:36 AM, Licensed Nurse (LN) I reported that due to staff changes, the management staff was uncertain who was responsible for making or adding changes to the care plan. LN I reported that the admitting charge nurse was responsible for baseline care plans, and the therapist also provided direction for staff. LN I stated that all fall-preventing interventions should be added to the care plan as appropriate. On 06/11/25 at 12:03 PM, Administrative Nurse D stated that fall management and intervention have been an area the facility has been lacking in, due to staff changes. Administrative Nurse D stated that the fall intervention should be added to the resident's care plan. The facility's "Fall Management and Prevention"	F 657			

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F 657	Continued From page 38 policy, dated 02/08/25, documented that each resident living at the facility will be provided with services and care to ensure that the resident's environment remains as free from accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. The development and implementation of appropriate fall risk interventions. Individual fall prevention care plan interventions will be developed and will be included in the resident's care plan. - Resident (R) 70's Electronic Medical Record (EMR) recorded diagnoses of non-pressure chronic ulcer of skin, ill-defined heart disease, chronic kidney disease, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), morbid obesity (excessive body fat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R70's "Admission Minimum Data Set" (MDS), dated 04/15/25, documented R70 had intact cognition, and was dependent on staff for toileting and lower body dressing, sit-to-standing, chair/bed-to-chair transfers, and toilet transfers. R70 was frequently incontinent of urine and bowel. The MDS further documented that R70 received a scheduled pain medication regimen and as-needed pain medication, and frequently had pain. R70 had two unhealed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), two arterial (referring to blood vessels that carry blood away from the	F 657			

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F 657	Continued From page 39 heart) ulcers, and macerated associated skin damage (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, or feces (or wounds for extended periods) upon admission. R70 had pressure-reducing devices for the bed and chair, pressure ulcer care, application of ointment other than to feet, and applications of nonsurgical dressings. The MDS documented R70 received insulin (a hormone that lowers the level of glucose in the blood), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), and opioid (medication used to treat pain), along with physical and occupational therapy services. The "Urinary Incontinence Care Area Assessment" (CAA), dated 04/16/25, documented R70 had bladder incontinence and further risk for skin breakdown, and R70 required staff assistance with toileting needs and therapy to improve independence. The "Fall CAA" did not trigger. R70's "Care Plan" dated 05/21/24, documented R70 had a fall without injury. The care plan initiated on 05/12/24 directed staff not to leave R70 alone on a bedpan, and on 05/18/25 directed staff not to wake R70 up as she became confused and delusional. R70's "Care Plan" dated 04/23/25, documented R70 at increased risk of falls and had actual falls. The care plan directed staff to check the environment for fall risk factors and institute corrective actions. R70's floors should be uncluttered, ensure that lighting is adequate, and	F 657			

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F 657	Continued From page 40 lights are functioning, including nightlights, and keep frequently used items in easy reach. The "Progress Note" dated 05/04/25 at 01:17 AM, documented staff heard R70 screaming from her room. R70 was sitting on the edge of her bed, gripping the side rail, lying on her back with her bottom beginning to slip off the bed. R70 was not on the floor nor fell off the bed. Three staff able to get R70 pulled back onto the bed safely. R70 was confused, tearful, and panicking. R70 stated she was dreaming and thought she was going to get up and go to breakfast. The bed was lowered. Staff checked R70 every half hour for safety at that time. The facility failed to provide a fall investigation for the near-miss fall. The interventions were not added to the plan of care. The "Progress Note" dated 05/18/25 at 06:34 AM documented staff assisted R70 to get ready at 06:16 AM, and after getting her shirt on, R70 declined to get out of bed. Staff left the room after lowering the bed. At approximately 06:30 AM, R70's family member called the nurse's cell phone and reported witnessing via in-room camera, R70 slid out of bed slowly on the floor, then turned over and was on her knees, and then ended up sitting on the floor. The nurse and staff assisted R70 off the floor using a mechanical lift. R70's family requested that staff not wake her for care at night and not before 07:30 to 08:00 AM. The family wanted staff to check on her to make sure she was safe and offer care if she was already awake. The staff were educated on the request. The "Fall Investigation" dated 05/18/25	F 657			

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F 657	Continued From page 41 documented R70 awakened early AM and denied wanting to get up. R70 has a camera in the room, and staff were notified that she was on the floor. At times, it was decided that she would stay in bed past 08:00 AM and not to wake R70 up as she became confused and delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue). She slid out of bed onto her knees after staff woke her up at 06:16 AM to get her dressed. This intervention was not added to the care plan until 05/21/25. The "Progress Note" dated 05/26/25 at 02:45 PM, documented nursing staff went to R70's room due to R70 falling out of the stand-up lift while getting up from the toilet. Two staff present at the time of the fall reported R70 appeared to have let go of the lift and fallen. R70 reported she may have passed out for a second, but was unsure. R70 had pain and would not allow staff to move her. Staff placed a call to 911 and R70 went to the hospital. The "Fall Investigation" dated 05/25/25, documented to check R70's blood pressure if she felt dizzy when she stood, and she fell out of the sit-to-stand lift when getting up from toileting. The investigation lacked any further comments to an investigation. The "Progress Note" dated 05/26/25 at 07:55 PM, documented R70 returned from the hospital, and x-rays and CT scan were all negative. R70 had a sling on the right arm, but no new orders. The Care Plan lacked documentation related to obtaining R70's blood pressure or a new intervention reflected on the care plan.	F 657			

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F 657	Continued From page 42 On 06/09/25 at 03:45 PM, Certified Nurse Aide (CNA) O and CNA P assisted R70 to the wheelchair utilizing the sit-to-stand lift. Staff instructed the resident to keep her hands on the handles. CNA O and CNA P gave step-by-step instructions to R70 as they prepared to transfer the resident to the wheelchair. R70 was fastened into the mechanical lift and transferred to the wheelchair without difficulty. CNA O and CNA P both reported knowing about the fall but were not aware of any new interventions. On 06/11/25 at 11:25 AM, Licensed Nurse (LN) I reported following the fall from the mechanical lift, the intervention was to take R70's orthostatic blood pressure, but the resident refused. LN I stated they would continue to try to get the orthostatic blood pressure if R70 allowed, but not sure if this had been communicated in the care plan or electronic charting system. On 06/11/25 at 12:03 PM, Administrative Nurse D stated that fall management and intervention have been an area the facility has been lacking in, due to staff changes. Administrative Nurse D stated that the fall intervention should be added to the resident's care plan. Administrative Nurse D stated the investigation lacked a root cause. The facility's "Fall Management and Prevention" policy, dated 02/08/25, documented that each resident living at the facility would be provided with services and care to ensure that the resident's environment remained as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents. The development and implementation of appropriate fall risk interventions. Individual fall prevention care plan	F 657			

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F 657	Continued From page 43	F 657			
F 689 SS=D	interventions will be developed and will be included in the resident's care plan. 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. The sample included 18 residents, of which six were reviewed for falls. Based on observation, record review, and interview, the facility failed to identify and implement interventions to prevent falls for Resident (R) 28, R67, and R70. This placed the resident at risk for ongoing falls and injuries. Findings included: - R28's Electronic Medical Record (EMR) documented diagnoses of displaced fracture (broken bone) of the greater trochanter (hip joint area) of the right femur (thigh bone), malignant (cancer) neoplasm (tumor) of the mouth and mandible (lower jawbone), laceration (cut) without foreign body of right forearm, and spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities). The "Admission Minimum Data Set" (MDS), dated 05/22/25, documented that R28 had intact cognition, no delirium (sudden severe confusion,	F 689			

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F 689	Continued From page 44 disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R28 had a functional range of motion impairment of one side lower extremity and required supervision or touching assistance with toileting, upper and lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and walking ten to 50 feet. The MDS further documented a walker and a wheelchair used for mobility. R28 had occasional incontinence of urine and frequent incontinence of bowel, and had almost constant pain which occasionally affected sleep. The MDS further documented R28 had a fall in the prior month and six months before admission with a fracture related to a fall. R28 had speech, occupational, and physical therapy services. The "Fall Care Area Assessment" (CAA), dated 05/29/25, documented R28 had a recent fall with a fracture, and was at risk for falling, staff assistance to complete all activities of daily living and care as needed. The CAA further documented R28 had therapy to improve strength and endurance. R28's "Care Plan" dated 06/01/25 documented that R28 was at risk for falls due to weakness, poor balance, and medication use. The Care Plan directed staff to encourage mobility programs, check the environment for fall risk factors, and institute corrective actions; the floor should be uncluttered, and ensure that clothing does not cause tripping. The Care Plan documented a non-injury fall on 06/01/25, and R28 was often encouraged to ask for help and would get up without asking for help. The Care Plan directed the staff that the walker would be there to remind	F 689			

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F 689	Continued From page 45 him to use it and to keep the walker in front of him. The "Progress Note" dated 06/01/25 at 06:23 PM, documented R28 sitting on the floor with his back up against the bed, with a pillow behind him, had shoes on, with pants and brief down and stool on the floor around him. The Progress Note further documented the walker and wheelchair were in the corner out of reach, and the call light was not on. R28 was educated to keep the floor free of clutter and would leave the walker in reach and encourage use. The "Fall Investigation" dated 06/01/25, documented that R28 was found on the floor of his room and incontinent of bowel. R28 appeared to have been attempting to use the bathroom without the walker. The intervention was to keep the floor free of clutter. The "Progress Note" dated 06/02/25 at 02:45 PM, documented R28 was on the floor of his room, wearing shoes, the walker and wheelchair were out of reach, and had a skin tear to the left elbow. R28 told staff he was going to the bathroom to refill the toilet paper roll. The Progress Note further documented that R28 was educated to use his call light and would continue with therapy for balance and strength. The "Fall Investigation" dated 06/02/25, documented that R28 was found on the floor of his room, and was attempting to refill the toilet paper roll in the bathroom without the use of the walker. The investigation note further documented that the walker was not within R28's reach. The intervention was documented to keep the walker within reach of the resident. The Fall	F 689			

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F 689	Continued From page 46 Investigation lacked a new intervention to prevent further falls and did not implement the intervention of keeping the walker within reach of the resident. On 06/09/25 at 03:03 PM, R28 was sitting on the edge of the bed, with a gait belt around his waist. The walker was against the wall and not within reach of the resident. On 06/11/25 at 11:11 AM, Certified Nurse Aide (CNA) M reported to keep R28 safe and free of falls, staff continually checked on R28, reminded R28 to call for assistance, make sure the gait belt was on along with shoes, and to keep the walker close to him. On 06/11/25 at 11:22 AM, Licensed Nurse (LN) I stated the walker should remain within reach of the resident as directed to prevent falls. On 06/11/25 at 12:17 PM, Administrative Nurse D verified that the staff should follow fall prevention interventions to prevent further falls of R28. Administrative Nurse D stated fall management, investigations, and intervention have been an area the facility has been lacking in, due to staff changes. The facility's "Fall Management and Prevention Policy" dated 02/08/25, documented that each resident living at this facility will be provided with services and care to ensure that the resident's environment remains as free from accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors of falling at the time of admission, quarterly, for a significant	F 689			

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F 689	Continued From page 47 change of assessment, upon return from a health care facility, and after every fall in the facility. - Resident (R) 67's Electronic Medical Record (EMR) documented diagnoses of weakness, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late-onset, dementia (a progressive mental disorder characterized by failing memory and confusion), mood disturbance, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R67's "Admission Minimum Data Set" (MDS), dated 03/19/25, documented severe cognitive impairment, no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception) or exhibited behaviors. R67 had no functional range of motion impairment and used a walker and wheelchair for mobility. R67 required partial/moderate assistance with toileting hygiene, lower body dressing, putting on and taking off footwear and supervision, and touching assistance with personal hygiene, rolling in bed, lying to sitting, transfers, and walking ten to 50 feet. The MDS further documented R67 was frequently incontinent of urine, and had frequent pain which occasionally interfered with day-to-day activities. R67 had a fall in the month prior to admission, and two falls within six months. The "Fall Care Area Assessment", dated 03/20/25 documented R67 had impaired mobility, and weakness, and was at risk of falling, staff assisted R67 will all activities of daily living and care as needed.	F 689			

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F 689	Continued From page 48 R67's "Fall Care Plan" initiated 04/22/25, documented R67 was a high fall risk related to confusion, left hip pain, glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and a history of falling. The care plan directed staff to keep frequently used items within easy reach, needed supervision/touching assistance with transfer, lower body dressing and walked up to 50 feet with supervision. The "Progress Note" dated 04/01/25 at 04:35 AM, documented at 03:45 AM R67 was in her room, on the floor trying to go to the bathroom. The call light was not utilized and R67 reported landing on her bottom. R67 had non-skid socks on, but a walker was not utilized. Upon request, the facility failed to provide a fall investigation for the unwitnessed fall on 04/01/25. The "Progress Note" dated 04/03/25 at 04:50 AM documented R67 found on the floor in the bathroom. Urine covered the floor, as R67 had urinated while attempting to self-transfer to the bathroom. R67 bed was locked and in the lowest position, the call light was not activated, no socks or shoes on, poorly lit room, no ambulatory aide, and the staff were not aware she was getting up to the bathroom. The "Fall Investigation" dated 04/03/25, documented that R67 had an unwitnessed non-injury fall in her bathroom. R67 was confused per baseline. The floor was wet since she was incontinent of urine during self-transfer in the bathroom. The call light intervention was to remind R67 to use the call light and wait for staff.	F 689			

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F 689	Continued From page 49 The root cause was that R67 needed to use the bathroom and attempted to transfer self. No new fall intervention was added to the care plan. The "Progress Note" dated 04/11/25 at 01:12 AM, documented the location was the resident's room, baseline confusion, laceration, and hematoma to the back of the head. The Progress Note lacked a description of the event that led to the laceration and hematoma. The "Fall Investigation" dated 04/11/25, documented at 12:45 AM, R67 had an unwitnessed fall with injury in her room. R67 was found by nursing staff on the floor by her bed. R67 had a noticeable hematoma to her left lateral posterior head with a laceration at the top of her head. R67 was confused at her baseline and was attempting to ambulate without assistance. The fall investigation further documented interventions of placing a pancake light and took R67 to the toilet at midnight and 04:00 AM. The determined root cause was the need to use the bathroom. The care plan lacked initiation of intervention. The "Progress Note" dated 04/23/25 at 10:54 AM documented that R67 had an unwitnessed fall, was found lying on the floor, and had a bleeding abrasion to her forehead. R67 was not able to say what happened. R67 was left using the bathroom. Staff went to check on R67 and found her lying on the floor, bleeding to the forehead. The walker was in the bathroom, R67 had a pull-up on, and her pants were down to her feet. The "Fall Investigation" dated 04/23/25 documented that R67 had an unwitnessed fall with injury in the bathroom. R67 was unattended in her bathroom. The root cause was that R67	F 689			

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F 689	Continued From page 50 was ready to get up after toileting and fell, as cognition level is unsafe to do tasks alone. The intervention was not to leave R67 unattended in her bathroom. This intervention was not added to the care plan. On 05/01/25, R67 had a room change from the rehabilitation unit to a special care unit. The "Progress Note" dated 05/04/25 at 06:30 AM, documented R67 sitting on the floor at the end of her bed wearing a brief, sleep shirt, she had bare feet, and the call light was clipped to the bedrail. R67 stated she was trying to get to the bathroom. The intervention was to add 05:30 AM toileting to her care plan. This intervention was not added to the care plan. On 06/10/25 at 07:40 AM, R67 was sitting in the commons area in a recliner with her feet elevated and staff sitting next to her. R67 alert and wearing glasses. Staff provided oral medications, and she was able to take the medication without difficulty. On 06/11/25 at 11:02 AM, Certified Nurse Aide (CNA) N reported that R67 had fallen while in the rehabilitation unit. CNA N stated she would look at the care plan book and the computerized charting system for interventions related to falls and fall prevention. On 06/11/25 at 11:36 AM, Licensed Nurse (LN) I reported that due to staff changes, the management staff was uncertain who was responsible for making or adding changes to the care plan. LN I reported that the admitting charge nurse was responsible for baseline care plans, and the therapist also provided direction for staff. LN I stated that all fall-preventing interventions	F 689			

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F 689	Continued From page 51 should be added to the care plan as appropriate. On 06/11/25 at 12:03 PM, Administrative Nurse D stated that fall management and intervention have been an area the facility has been lacking in, due to staff changes. Administrative Nurse D stated that the fall intervention should be added to the resident's care plan. The facility's "Fall Management and Prevention Policy" dated 02/08/25, documented that each resident living at this facility will be provided with services and care to ensure that the resident's environment remains as free from accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors of falling at the time of admission, quarterly, for significant change assessment, upon return from a health care facility, and after every fall in the facility. - Resident (R) 70's Electronic Medical Record (EMR) recorded diagnoses of non-pressure chronic ulcer of skin, ill-defined heart disease, chronic kidney disease, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), morbid obesity (excessive body fat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R70's "Admission Minimum Data Set" (MDS), dated 04/15/25, documented R70 had intact cognition, and was dependent on staff for toileting and lower body dressing, sitting to standing chair/bed-to-chair transfers, and toilet transfers.	F 689			

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F 689	Continued From page 52 R70 was frequently incontinent of urine and bowel. The MDS further documented that R70 received a scheduled pain medication regimen and as-needed pain medication, and frequently had pain. R70 had two unhealed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), two arterial (referring to blood vessels that carry blood away from the heart) ulcers, and macerated associated skin damage (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, or feces (or wounds for extended periods) upon admission. R70 had pressure-reducing devices for the bed and chair, pressure ulcer care, application of ointment other than to feet, and applications of nonsurgical dressings. The MDS documented R70 received insulin (a hormone that lowers the level of glucose in the blood), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), and opioid (medication used to treat pain), along with physical and occupational therapy services. The "Urinary Incontinence Care Area Assessment" (CAA), dated 04/16/25, documented R70 had bladder incontinence and further risk for skin breakdown, and R70 required staff assistance with toileting needs and therapy to improve independence. The "Fall CAA" did not trigger. R70's "Care Plan" dated 04/23/25, documented R70 at increased risk of falls and had actual falls. The care plan directed staff to check the	F 689			

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F 689	Continued From page 53 environment for fall risk factors and institute corrective actions. R70's floors should be uncluttered, ensure that lighting is adequate, and lights are functional, including nightlights, and keep frequently used items within easy reach. R70's "Care Plan" dated 05/21/24, documented R70 had a fall without injury. The care plan initiated on 05/12/24 directed staff not to leave R70 alone on a bedpan, and on 05/18/25 directed staff to not wake R70 up as she became confused and delusional. The "Progress Note" dated 05/04/25 at 01:17 AM, documented staff heard R70 screaming from her room. R70 was sitting on the edge of her bed, gripping the side rail, lying on her back with her bottom beginning to slip off the bed. R70 was not on the floor nor fell off the bed. Three staff able to get R70 pulled back onto the bed safely. R70 confused, tearful, and panicking. R70 stated she was dreaming and thought she was going to get up and go to breakfast. The bed was lowered. Staff checked R70 every half hour for safety at that time. The facility failed to provide a fall investigation for the near-miss fall. The interventions were not added to the plan of care. The "Progress Note" dated 05/18/25 at 06:34 AM documented staff assisting R70 to get ready at 06:16 AM, and after getting her shirt on, she declined to get out of bed. Staff left the room after lowering the bed. At approximately 06:30 AM, R70's family member called the nurse's cell phone and reported witnessing via in-room camera R70 sliding out of bed slowly on the floor then turned over and was on her knees, and then	F 689			

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F 689	Continued From page 54 ended up sitting on the floor. The nurse and staff assisted R70 off the floor using a mechanical lift. R70's family requested that staff not wake her for care at night and not before 07:30 to 08:00 AM. The family wanted staff to check on her to make sure she was safe and offer care if she was already awake. The staff were educated on the request. The "Fall Investigation" dated 05/18/25 documented R70 awakened early AM and denied wanting to get up. R70 has a camera in the room, and staff were notified that she was on the floor. At times, it was decided that she would stay in bed past 08:00 AM and to not wake R70 up as she became confused and delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue). She slid out of bed onto her knees after staff woke her up at 06:16 AM to get her dressed. This intervention was not added to the care plan until 05/21/25. The "Progress Note" dated 05/26/25 at 02:45 PM, documented nursing staff went to R70's room due to R70 falling out of the stand-up lift while getting up from the toilet. Two staff present at the time of the fall reported R70 appeared to have let go of the lift and fallen. R70 reported she may have passed out for a second but was unsure. R70 had pain and would not allow staff to move her. Called placed to 911 and went to the hospital. The "Fall Investigation" dated 05/25/25, documented to check R70's blood pressure if she felt dizzy when she stood, and she fell out of the sit-to-stand lift when getting up from toileting. The investigation lacked any further comments to an investigation.	F 689			

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F 689	Continued From page 55 The "Progress Note" dated 05/26/25 at 07:55 PM, documented R70 returned from the hospital, and x-rays and CT scan were all negative. R70 had a sling to the right arm, no new orders On 06/09/25 at 03:45 PM, Certified Nurse Aide (CNA) O and CNA P assisted R70 to the wheelchair utilizing the sit-to-stand lift. Staff instructed the resident to keep her hands on the handles. CNA O and CNA P gave step-by-step instructions to R70 as they prepared to transfer the resident to the wheelchair. R70 was fastened into the mechanical lift and transferred to the wheelchair without difficulty. CNA O and CNA P both reported knowing about the fall but were not aware of any new interventions. On 06/11/25 at 11:25 AM, Licensed Nurse (LN) I reported following the fall from the mechanical lift, the intervention was to take R70's orthostatic blood pressure, but the resident refused. LN I stated they would continue to try to get the orthostatic blood pressure if R70 allowed, but not sure if this had been communicated in the care plan or electronic charting system. On 06/11/25 at 12:03 PM, Administrative Nurse D stated that fall management and intervention have been an area the facility has been lacking in, due to staff changes. Administrative Nurse D stated that the fall intervention should be added to the resident's care plan. Administrative Nurse D stated the investigation lacked a root cause. The facility's "Fall Management and Prevention Policy" dated 02/08/25, documented that each resident living at this facility will be provided with services and care to ensure that the resident's environment remains as free from accident	F 689			

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F 689	Continued From page 56 hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors of falling at the time of admission, quarterly, for significant change assessment, upon return from a health care facility, and after every fall in the facility.	F 689			
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The	F 761			

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F 761	Continued From page 57 sample included 18 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 31 and R42's insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when expired. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On 06/09/25 at 08:05 AM, observation of the facility's Meadowlark Hall medication room revealed the following: R31's Basaglar (long-acting insulin) flex pen was not labeled with an opened date or an expired date. R42's Novolog (fast-acting insulin) flex pen was labeled with an expiration date of 06/02/25. On 06/09/25 at 08:15 AM, Administrative Nurse D verified the nurses should label and date the insulin flex pens with the date opened and discard the expired insulin flex pens. Medlineplus.gov directs open, unrefrigerated Basaglar and Novolog can be used within 28 days; after that time, they must be discarded. The facility's "Labeling of Medications" policy, dated 06/17/24, documented medications are labeled in accordance with facility requirements and Kansas and Federal laws. All drug contains would be labeled, and drug labels must be clear, consistent, legible, and in compliance with state and federal requirements. The policy documented upon opening insulin pens; the licensed nurse would write the date opened along with the resident's name on the pen itself. The policy	F 761			

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F 761	Continued From page 58 documented medication containers having soiled, damaged, incorrect, illegible, or makeshift labels were returned to the issuing pharmacy for relabeling or to be destroyed in accordance with the medication destruction policy. - On 06/09/25 at 08:10 AM, during the initial tour of the rehabilitation unit medication room, Resident 70's Humalog) (Short-acting insulin and Lantus (long-acting insulin) pens stored in a tote drawer lacked open and expiration dates. Licensed Nurse (LN) I verified that the insulin (a hormone that lowers the level of glucose in the blood) pens should have open and expiration dates, and generally, the pens expire 28 days after being put in use. LN I recorded it on the pens. The facility's "Labeling Medications" policy, dated 06/17/24, documented that medications are labeled by facility requirements and Kansas, and Federal laws. All drug containers will be labeled, and drug labels must be clear, consistent, legible, and comply with state and federal requirements. Upon opening of insulin pens, the licensed nurse will write the date opened along with the resident's name on the pen itself.	F 761			
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			

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F 880	Continued From page 59 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 §483.71 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	F 880			

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F 880	Continued From page 60 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 18 residents. Based on observation, record review, and interview, the facility failed to adhere to infection control for enhanced barrier precautions (EBP - an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities) for Resident (R) 57 who had a coccyx wound (pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). This placed the resident at risk for possible exposure to infection. Findings included: - On 06/10/25 at 07:50 AM, observation revealed License Nurse (LN) G entered the bathroom of R5, who was sitting on the toilet. LN G donned	F 880			

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F 880	Continued From page 61 gloves but no gown and assisted R57 to stand with the assistance of the grab bar. Continued observation revealed LN G cleansed R57's coccyx wound with normal saline applied zinc oxide to the wound area then applied an Opti foam dressing. Continued observation revealed LN G discarded her gloves in the trash can in the room. LN G assisted the resident in pulling up his attends and sweatpants and assisted him in walking to the recliner. Observation revealed the resident did not have any PPE available in the room or instructions for the use of PPE when providing cares for the resident with the pressure ulcer wound. On 06/10/25 at 12:55 PM, LN G verified she wore gloves to change the R57's coccyx wound dressing and she had not been instructed by administrative staff to wear PPE with the resident's wound care. LN G verified there was no PPE available in the resident's room and no EBP guidelines available for R57. On 06/11/25 at 10:30 AM, Administrative Nurse D stated the staff should wear PPE for EBP when providing cares for R57. Then Administrative Nurse D verified they lacked PPE equipment or a sign on the door that indicated the staff should wear PPE when providing R57's wound care. Administrative Nurse D verified she would post the necessary signage on the resident's door and have the PPE available for staff to wear. The facility's "Enhanced Barrier Precautions" policy, dated 02/28/25, documented it was the policy of the facility to have all staff and external consultants that perform high-contact resident care were responsible for following EBP policies and procedures. EBP precautions were	F 880			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER BREWSTER HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SW 29TH ST TOPEKA, KS 66611		
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F 880	Continued From page 62 implemented based on an evaluation of the resident's risk of acquiring a Multidrug-resistant organism (MDRO) infection, such as an indwelling medical device or wound present as described by this policy or the resident's history of known colonization or infection with a targeted MDRO. Residents with any of the one risk factors would require EBP precautions: indwelling medical devices, wounds, colonization, or infection with targeted MDRO's or any MDRO of epidemiologic concern specific to the facility. If EBP is indicated the facility would notify the following: resident, resident representative, Infection Preventionist, Management Team, Unit Nurse, and therapy, if applicable. EBP signage would be placed outside of the resident's room such as the door or wall that clearly indicates the high-contact resident care activities that require the use of gowns and gloves. The facility would ensure accessibility of alcohol-based hand sanitizer, gowns, and gloves for use during high-contact resident care activities done in a resident's room, and in select common areas such as bathrooms and therapy services requiring high-contact care.	F 880			