

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>N046079</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/14/2015</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE OVERLAND PARK</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12000 LAMAR<br/>OVERLAND PARK, KS 66209</b> |
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| S 000              | INITIAL COMMENTS  | S 000         |   |                    |
| S3026<br>SS=D      | <p>26-41-101 (f) (1) Staff Treatment of Residents ANE</p> <p>(f)The administrator or operator shall ensure that all of the following requirements are met:<br/>(1) No resident shall be subjected to any of the following:<br/>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br/>(B) neglect; or<br/>(C) exploitation.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>The facility's census for the assisted living unit totaled 39 residents with 4 sampled. Based on observation, interview, and record review, the facility failed to provide services to ensure resident safety and well being for 1 of 4 residents (#2).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #2's Functional Capacity Screen (FCS) dated 8/8/14 documented the resident required assistance with management of medications and medical treatment.</li> </ul> <p>The Negotiated Service Agreement (NSA) dated 8/18/2014 documented the staff provide the resident with 7 or more medications daily. The resident preferred staff to awakened him/her between 7:30 A.M. and 8:30 A.M.</p> | S3026         |   |                    |

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

TITLE

(X6) DATE

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| S3026              | <p>Continued From page 1</p> <p>Record review of the the nurse's notes documented on 12/27/14 at 9:00 P.M. the resident was lethargic (abnormal drowsiness) with a blood pressure (b/p) of 175/74 and temperature of 101.4 degrees Fahrenheit (F). The resident was vomiting and had diarrhea, and was unable to take Tylenol (medication used for fever or pain) orally or rectally to reduce fever. The resident was coughing, had a runny nose with clear mucous, unable to sit up on his/her own, and stated he/she felt weak. The facility sent the resident to the emergency room for an evaluation.</p> <p>On 12/28/14 at approximately 12:30 A.M. the family brought the resident back from the hospital with orders for Tamiflu (oral medication for the flu) and Zofran (oral medication for nausea). The resident in bed sleeping, afebrile at this time, and color was improved. The family stated the resident received intravenous fluids and Zofran at the hospital.</p> <p>The nurse documented on 12/28/14 the staff checked the resident at 1:30 A.M., 2:40 A.M., 3:45 A.M., 4:50 A.M., and 5:40 A.M.</p> <p>The next nurse's note dated 12/28/14 at 1:30 P.M. (7 hours and 50 minutes after last documentation) documented the staff went to check on the resident after the resident's daughter called to check on the resident and staff found him/her sitting on the floor beside bed. The resident stated he/she was on his/her way to the bathroom, felt weak, lost balance, and ended up falling on the floor. The staff recorded the resident's blood pressure 170/70, and gave the resident their blood pressure medicine. The staff recorded the resident's temperature of 102 F, notified the nurse practitioner of the high blood</p> | S3026         |   |                    |

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| S3026              | <p>Continued From page 2</p> <p>pressure and elevated temperature. The nurse practitioner ordered Tylenol for the temperature, recheck the resident's temperature, and encourage him/her to drink fluids.</p> <p>On 12/29/14 at 8:00 A.M. the resident was in isolation (due to the flu) with documented blood pressure 139/71, and temperature of 99.3 F. The resident remained in his/her room, with no complaints of pain, nausea, or vomiting. The staff monitored the resident.</p> <p>The After Care Instructions from the resident's hospital visit on 12/27/14 documented the resident with seasonal flu, and to drink plenty of fluids in small, frequent amounts; continue current medications; and use Tylenol for pain or fever.</p> <p>On 1/9/15 at 7:50 A.M. the resident stood outside his/her room with a walker and looked down the hallway. The resident coughed several times as he/she walked to breakfast.</p> <p>On 1/9/15 at 3:00 P.M. administrative staff A revealed the resident had a pendant call button, was alert and oriented, and knew how to use the pendant call button. He/she said the resident went to the hospital for intravenous fluids the night before and missed 2 meals after his/her return which should concern the staff.</p> <p>On 1/9/14 at 3:40 P.M. licensed nursing staff J stated he/she direct care staff O was not told the resident was back from the hospital.</p> <p>On 1/9/15 at 3:45 P.M. licensed nursing staff I stated he/she came in late on 12/28/14, stopped and talked with the supervisor, and was told the resident was in the hospital. He/she came to the</p> | S3026         |   |                    |

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| S3026              | <p>Continued From page 3</p> <p>unit and was again told that 2 residents were in the hospital, did not know the resident was back until the daughter called to check on the resident, when they all went to his/her room and found him/her sitting on the floor next to his/her bed. His/her blood pressure was up, so he/she told the medication aide to get his/her medication and give it to him/her. He/she had no injuries from the fall but was incontinent of urine, so the staff cleaned him/her up, and got him/her some food and fluids.</p> <p>On 1/9/15 at 3:50 P.M. during a phone call with licensed nursing staff H reported the resident went to the hospital in the evening of 12/27/14 due to fever, elevated blood pressure, cough, weakness, lethargic, nausea, and vomiting. The family brought him/her back around 12:30 A.M. on 12/28/14 and the daughter took him/her to his/her room and put him/her to bed. Licensed nursing staff H reported he/she checked on the resident every hour during the night and the certified nurse's aide that was on the unit also checked on the resident. The last time licensed nursing staff H checked on the resident was around 5:45 A.M. Licensed nursing staff H reported off to direct care staff O at 6:15 A.M. and stated he/she told the oncoming staff the resident returned from the hospital.</p> <p>On 1/9/15 at 4:09 P.M. direct care staff O reported during morning report there was a lot of confusion with a staff person complaining of being sick and wanting to go home. During medication count, no one mentioned the resident returned, was told he/she went to the hospital because of the flu. The nursing staff would not go into the resident's room unless he/she was there, so since we thought he/she was in the hospital, we would not had a reason to go into the room.</p> | S3026         |   |                    |

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| S3026              | <p>Continued From page 4</p> <p>The resident's chart was not in the chart rack, so we thought the resident was still in the hospital. We found out the resident was back when his/her daughter called and wanted to know how he/she was. The staff went to the resident's room and found him/her sitting on the floor.</p> <p>The revised 6/10/2011 facility policy "Abuse, Neglect, And Exploitation Policy" documented the definition for neglect as the failure or omission by a caretaker to provide goods or services which were reasonably necessary to ensure safety and well being and to avoid physical or mental harm or illness.</p> <p>The facility failed monitor this resident who went to the hospital with reported with flu symptoms, high blood pressure, and weakness for 6 hours and 50 minutes. When staff did check on this resident, he/she was sitting on the floor in his/her room after a loss of balance and fell.</p> | S3026         |   |                    |