

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/01/2022
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 W 127TH ST OVERLAND PARK, KS 66213		
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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint #'s 168911, 168946, 168042, 168044, 165909, 165911, 163458, 163468, 162143, 161271, and 158342 attached, for the above named facility conducted on 1/25/2022, 1/26/2022, 1/27/2022 and 2/1/2022.	S 000		
S3026 SS=K	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (A) The facility reported a census of 50 residents. The sample included 14 female Residents (R). Based on observation, interview, and record review the facility failed to protect 14 female residents from alleged sexual abuse when Certified Nurse Aide (CNA) A found cognitively impaired R112 wearing only an incontinent brief and Certified Medication Aide (CMA) D in the resident's bathroom with his pants down and washing his peri-area on 01/20/22 at approximately 08:00 PM. CNA A failed to immediately report the incident to the administrator. The failure to report allowed CMA	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 D to remain on duty in the #3 House where 14 cognitively impaired female residents resided for three hours until approximately 11:00 PM when CNA A and CMA D left the facility. CNA A failed to notify her supervisor of the sexual abuse allegation until approximately 07:01 AM on 01/21/22. This deficient practice placed all 14 female residents in House #3 in immediate jeopardy. Findings Included: - Record review for resident R112 revealed an admission date of 09/13/21 with diagnoses of dementia. The "Admission Functional Capacity Screen" (FCS) dated 09/13/21 identified the resident with impaired long-term memory, impaired memory recall, and impaired decision making. She required supervision with bathing and walking. She lacked the ability to manage her own medications and used no mobility device. The combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) dated 09/13/21 included the following services/directions to be provided to the resident by the facility: Staff would make frequent checks on the resident throughout each shift when not in site of staff, especially while in her apartment. Staff would know the resident may need assistance to zip/unzip, button /unbutton, tie/untie, and/or reminders to prioritize tasks. Team members would provide the resident with set-up, verbal cues, and visual prompts to complete the task of bathing. Team members would keep the resident engaged and active throughout the day, as tolerated to	S3026		

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S3026	Continued From page 2 reduce boredom that may result in wandering. Review of the "Nursing Notes"/" Progress Notes" revealed the following entries on 01/21/22 signed by Licensed Nurse C: On 01/21/22 at 08:40 AM revealed at 07:00 AM a CNA notified the writer R112 might have been sexually assaulted the night before. The note further stated the witness statement was complete and the nurse practitioner, durable power of attorney (DPOA), local police department, and state agency were notified. On 01/21/22 at 10:00 AM the resident left the community with her DPOA and the police to go to the hospital for an evaluation. On 01/21/22 at 02:44 PM revealed the resident arrived back to the facility with her DPOA and no paperwork from the hospital. The facility instructed staff that only females would provide cares for the resident. Review of the facility provided "Incident Report" dated 01/21/22 revealed the following statement at the end of the report, "crime scene investigator and detective removed all bedding, trash and took pictures from [R112] room as evidence director of nursing [Licensed Nurse (LN) C] received a call from forensic nurse to gather additional information, resident has a labial tear." Review of CNA A's signed "Witness Statement" dated 1/20/2022 revealed CNA A went to answer another resident's call light and decided to check on R112 at approximately 08:00 PM on 01/20/22 because R112 constantly got out of bed at night and would get dressed. CNA A further stated when she walked into R112's room she was	S3026		

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S3026	Continued From page 3 laying on her bed with her pull up on, but with no pants in place. CNA A heard R112's tap water running and thought maybe she forgot to turn it off. CNA A found CMA D holding his genitalia with his pants down and appeared to be washing the area. R112 appeared to be sleeping at the time but. The statement continued to state R112 did get out of her room and sat in the living room for a while and then went back to sleep upon CMA D's request [after the alleged incident occurred]. CNA A later walked into R112's room and found a soiled brief in her trash can along with wet paper towels. Review of the facility provided, undated, "Witness Statement" from CNA E confirmed CNA A did not report to her any allegation of sexual abuse regarding R112. The statement also revealed CMA D arrived back at the facility "a little after midnight", to pick up his cell phone that was locked in the medication cart. CNA E did not reveal if CMA D went into any resident rooms at this time. Review of LN C's signed "Witness Statement" dated 01/21/22 revealed LN C was notified at 07:01 AM from an unidentified CNA that an assault possibly occurred the previous night, involving an employee and a resident. LN C stated she interviewed the resident who confirmed she was "assaulted". R112 reported to LN C "a man stuck his penis in me". LN C charted a physical assessment. At 7:31 AM licensed nurse C called the executive director, 911, and the DPOA to report the allegation. Review of CNA A personnel record revealed a hire date of 11/11/2021. The personnel record contained a facility acknowledgment of training signed by CNA A, the training included training on	S3026		

Kansas Department on Aging

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S3026	Continued From page 4 Kansas abuse/neglect/exploitation policy. On 01/25/22 at 01:10 PM an interview with CNA A revealed at approximately 08:00 PM she went to answer a call light of another resident and decided to check on R112, because she has a habit of getting out of bed and getting dressed. She stated she walked into R112's room and saw R112 on her bed in a pull up incontinent brief and nothing else, and she appeared to be asleep. She continued to state she heard water running in the bathroom and opened the door to turn the water off and found CMA D standing at the sink with his genitalia in his hand and he appeared to be washing it off. CNA A stated she turned and left the room. CNA A stated after CMA D came out of R112's room he sat at the staff workstation. CNA A reported that CMA D left the workstation only one time, when R112 came and sat in the resident living room and CMA D escorted her back to her room (after the alleged incident). CNA A stated she was too scared to try and retrieve a supervisor's phone number, which was located in front of CMA D. CNA A explained the facility phone list was near where CMA D sat. CNA A stated CMA D completed his shift and left the facility at 11:00 PM. CNA A stated she waited until CMA D left the facility before she left the facility and she did not report/call anyone to report the alleged sexual assault after CMA D left the facility. On 01/26/22 at 08:35 AM an interview with Operator B revealed CNA A came back to the facility the morning of 01/21/22 to work the 07:00 AM shift and reported to LN C the alleged sexual assault on R112, she stated that LN C and CNA A came to her office early the morning of 01/21/22 to report the incident. Operator B reported she spoke with CNA E and she confirmed she was	S3026		

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S3026	Continued From page 5 not told of the alleged sexual assault of R 112 during the shift change report provided by CNA A and CMA D. On 01/26/22 an interview with LN C revealed CNA A went to LN C's office the morning of 01/21/22 at 07:01 AM and stated she needed to report something to the licensed nurse. She stated CNA A came directly to her office upon entering the facility to report the alleged sexual assault. Operator B stated that the facility provides training and the staff is trained to call and report any allegation of abuse neglect and exploitation per the facility policy. Review of the undated facility policy titled Abuse, Neglect, and Exploitation Prohibition Policy included the following: under example of physical abuse the policy list "sexual molestation," it continues to state Sexual Abuse: includes but is not limited to sexual assault. Review of the undated facility Abuse Neglect and Exploitation Prohibition Procedure revealed the following: Section D. Identification of Abuse, Neglect, or Exploitation, #5 "any staff member must report to his/her immediate supervisor, department head or the executive director any suspected abuse, neglect, or exploitation. Committing resident physical abuse, mistreatment or neglect shall be considered unprofessional conduct in the practice of his or her profession and will result in immediate action up to and including termination." Section E. Investigation of Allegations; #1 "each allegation of abuse, neglect, or exploitation shall be immediately reported to the executive director	S3026		

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S3026	Continued From page 6 or operator as soon as staff is made aware of the allegation ... " The facility failed to protect 14 female residents from alleged sexual abuse when CNA A found cognitively impaired R112 wearing only an incontinent brief and CMA D in the resident's bathroom with his pants down washing his peri-area on 01/20/22 at approximately 08:00 PM. CNA A failed to immediately report the incident to the administrator. CMA D was allowed to remain on duty in the #3 House where 14 cognitively impaired female residents resided until approximately 11:00 PM when CNA A and CMA D left the facility. CNA A failed to notify her supervisor of the sexual abuse allegation until approximately 07:01 AM on 1/21/22. This deficient practice placed all 14 female residents in House #3 in immediate jeopardy and R112 was denied a prompt medical exam and treatment for a labial tear that was discovered by the forensic nurse upon the medical examination. The immediate jeopardy was removed on 01/21/22 at 07:01 AM by implementation of the following: 1. CNA A reported the allegation of sexual assault to LN C, notified 911 on 01/21/22 at 07:20 AM, and CMA D was placed in police custody on 01/21/22 by 11:45 AM. 2. On 01/25/22 at 03:00 PM the facility provided a mandatory staff in-service covering the abuse policy and regulations on recognizing/reporting abuse, neglect and exploitation. After implementation of corrective actions, the deficient practice remained at a scope and severity of "G."	S3026			

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S3215	Continued From page 7	S3215		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h) (4)	S3215		

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S3215	Continued From page 8 The facility reported a census of 50 residents. The sample included 4 Residents (R) and 4 closed record reviews. Based on observation and interview the operator failed to ensure licensed nurses could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration regarding insulin pen for resident #116. Findings included: - On 1/25/2022 at 12:00PM, the certified medication aide unlocked the locked medication cart. Observation revealed an open and in-use insulin pen of Lantus and Humalog with R 116 name on the pens. Neither of the pens had a date recorded of when the pens were opened for use. Interview on 1/25/2022 at 12:00PM with licensed nurse C revealed the nurses administer the insulin, and the pens lacked the date of when they were opened for use. Humalog Kwik pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. Lantus SoloStar Pen manufacture recommended to store opened insulin at room temperature for up to 28 days and discard even if insulin remained. The administrator failed to ensure licensed nurses could not administer medication beyond the manufacturer's or pharmacy provider's recommended date of expiration regarding insulin pens for R 116.	S3215		