

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
NAME OF PROVIDER OR SUPPLIER BROOKDALE COLLEGE SQUARE		STREET ADDRESS, CITY, STATE, ZIP CODE 11000 OAKMONT AVENUE OVERLAND PARK, KS 66210		
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S 000	INITIAL COMMENTS The following citations represent the findings of a survey for re-licensure with attached complaints #42554, #49735, #51873, #55100 and #61881 conducted on 5/5/21, 5/6/21, 5/10/21, 5/11/21 and 5/12/21 at the above-named assisted living facility in Overland Park, KS.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

TITLE

(X6) DATE

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (3) The facility reported a census of 44 residents. The sample included three residents and three focused review residents. Based on interviews, and record reviews for one sampled resident identified as an alleged perpetrator of inappropriate sexual behavior (#111), and for three focused reviews identified as potential recipients of resident's behavior (#110, #109, and #108), the operator failed to immediately implement specific corrective measures to prevent further potential sexual abuse, failed to report an allegation of abuse within 24 hours to the department as required, and failed to immediately begin an investigation of an incident to rule out abuse. Findings included: - Record review revealed #111 admitted to facility 02/11/2021 with diagnoses of Dementia with behavioral disturbance, Hyperlipidemia, Hypertension, and Type 2 Diabetes. Resident's medical record contained a Progress Note from a physician's office visit dated 12/30/2020: "patient is being inappropriate and flirty with the nurses, trying to touch them inappropriately and has been getting naked and running around the facility almost every other day. This has worsened the last 4 weeks. This happens any time day or night" Resident's medical record contained documentation from a facility referral service dated 02/09/2021: "early to mid-stages dementia	S3028			

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S3028	Continued From page 2 - likes to be naked, has wandered into apartments and got in bed with a woman. He feels bad afterward like he has been bad. Very pleasant otherwise...these behaviors are relatively recent developments." The Functional Capacity Screen (FCS) dated 02/11/2021 assessed resident #111 independent with walking/mobility and transfers, occasionally incontinent of bladder, with impaired short and long-term memory, impaired memory/recall and decision-making. Current identified problems/risks included socially inappropriate/disruptive behavior, wandering and impaired decision-making. Alert charting (nurses notes) for resident #111 documented the following: 2/16/21 - "Resident noted to wander and attempt to touch ladies in an inappropriate manner. Resident redirected by staff away from female residents ...New order noted for Trazadone (antidepressant) 25 milligrams (mg) every night for insomnia. New order for Estrace (female hormone) 1mg every day for sexual aggression. 2/17/21 - "This resident was noted to be sitting close to a female resident (#110) and ... started sliding his hand into the chest of the female resident. I asked him what he was doing, and he quickly stood up straight and responded, "I am not doing anything" and he moved away from this resident ... later assisted to his room ... won't stay in there ... Started exploring other neighborhoods ... this writer notified other staff to be on the lookout for him. Will continue to monitor." The record lacked evidence of corrective action besides medication orders to address these specific inappropriate behaviors.	S3028		

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S3028	Continued From page 3 The record lacked evidence an investigation initiated to rule out abuse. The record lacked evidence a report of potential abuse made to the Department within 24 hours of occurrence as required. 3/24/21 - "Resident noted to continue with sexual aggression in trying to touch female residents inappropriately. Called ARNP new order noted" (Trazadone 25 mg by mouth morning and evening for sexual aggression.) 4/8/21 - "...On 4-8-21 at approximately 8:10am the CNA (Certified Nursing Assistant) noted resident #111 standing at resident #109 bedside (female alert to self with confusion of time and place) ...#111 was standing over #109 just starting to bend down towards #109 (asleep)... #109's night gown had been unbuttoned and breasts were exposed ... (incontinent) brief open and vagina exposed...Staff called #111's name ... proceeded to lift his hands in the air ... Staff redirected #111 from the room ..." The record indicated medication orders and 15-minute checks as corrective measures. The record lacked evidence an investigation initiated to rule out abuse. The record lacked evidence a report of potential abuse made to the Department within 24 hours of occurrence as required. 4/16/21 - "Resident noted to come walking down the hallway without his pants or underwear. Staff redirected him to his room for assistance dressing." 4/20/21 - "Resident was noted to have strayed out of his neighborhood and from his room to another neighborhood with no pants or diaper on. Redirected back to his room and assisted to bed	S3028			

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S3028	Continued From page 4 ..." 4/22/21 - "This writer later went to check on him around 7:45pm ... missing from room ... noted coming from another neighborhood with no walker ... redirected back to room ..." 4/27/21 - " ...after being assisted to bed, he quietly got out of his bed and out of the neighborhood and went to a different neighborhood while wearing brief only ... staff heard somebody saying 'get out' and when they went in there he was in the room standing by the bed where the other resident was in bed. He was redirected back to his room." The record lacked evidence of corrective action to address these specific inappropriate behaviors. The record lacked evidence an investigation initiated to rule out abuse. The record lacked evidence a report of potential abuse made to the Department within 24 hours of occurrence as required. 4/30/21 - " ... "Resident impulsively had his hands on another female resident and was redirection x 2 was successful." 4/30/21 ... "Staff reported resident walked up to a female resident #108 in the dining room ... sitting in her wheel chair at the table ... (#111) placed his hands inside her shirt cupping his hands around her breast ... Staff told (#111) to walk away from her and have a seat x 3 before he walked to his table ..." The record indicated 1:1 supervision as corrective measure initiated, and request to physician for geriatric-psych referral and evaluation. The record lacked evidence an investigation initiated to rule out abuse.	S3028			

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S3028	Continued From page 5 The record lacked evidence a report of potential abuse made to the Department within 24 hours of occurrence as required. On 5/5/21 at 9:30am Administrative Nurse #B confirmed facility received resident records for #111 from previous facility of residence on 02/09/21 (prior to admission). Nurse #B confirmed that record included documentation of potential sexual abuse involving resident #111... confirmed reports of potential sexual abuse involving resident #111 (at this facility on 4/08/21 and 4/30/21) were not made to department within 24 hours of occurrence. Nurses' notes of 4/08/21 recorded: "Administrative Nurse #B told #111 he should not be touching other residents in that manner ... #B notified Physician and received orders to increase Trazadone to 50 mg (milligrams) BID (twice a day) for Sexual aggression and placed resident #111 on 15-minute checks for 24 hours ..." Nurses' notes of 4/30/21 recorded: "Dr notified with new order noted for Geriatric-Psych consult ... interviewed #111 and when asked why he did that (touched #108's breasts), responded with "I don't know" ... assessment completed on #108 with no redness or bruising noted ... #111 started on 1:1 supervision ... #111 was accepted at Behavioral Health Hospital for evaluation and treatment." Record review revealed #B emailed the Department on 04/10/21 (more than 24 hours) about the 4/08/21 incident involving #109 and started an investigation. Record review revealed no investigation or report to Department about the 4/27/21 incident involving resident in an unidentified resident	S3028		

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S3028	Continued From page 6 room. Record review revealed the facility emailed the Department on 5/06/21 (more than 24 hours) about the 4/30/21 incident involving #108 and started an investigation. On 5/07/21 at 11:00am, notarized statement from CNA (certified nursing assistant) #C recorded: (On 4-30-21) "Came back from the kitchen with breakfast cart, saw resident (#111) touching another female resident (#108) with his hands inside her top. Resident was re-directed to another area. Nurse notified." On 5/07/21 at 11:10am, notarized statement from activity staff #D recorded: (On 4/08/21) "I saw #109 door open. When I go at door I saw #111 standing next to the bed. #109 pajama top was un button and tabs of brief was open. #111 was fully dressed and was not touching #109, at the moment I walked in was leaning over her with hands extended out. I re-directed #111 out of the room and notified the nurse. On 5/07/21 at 12:00pm, notarized statement from operator #A recorded: "In the matter of the return of #111 to the community: We will assist the resident family in finding appropriate placement in an all-male memory care. If unable to find placement prior to discharge from current Geriatric Psych stay, resident will have one to one service until another placement is found. By review, facility policy titled "Abuse, Neglect & Exploitation Policy- KS-1" included: Definitions: (a)(2) Any sexual act with a resident when the resident does not consent or when the other person knows or should know that the resident is incapable of resisting or declining consent to the sexual act due to mental	S3028		

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S3028	Continued From page 7 deficiency or disease or due to fear of retribution or hardship and External reporting (6)(c)(1): If a determination is made that there is reasonable cause to believe an incident constitutes abuse, neglect or exploitation, the Executive Director or designee should report such information or cause a report of such information to be made to Kansas Department of Aging as soon as practicable. For #111, #110, #109, and #108, the operator failed (for all incidents) to immediately implement specific corrective measures to prevent further potential sexual abuse, failed to report an allegation of potential abuse within 24 hours to the department as required, and failed to immediately begin an investigation of an incident to rule out abuse.	S3028		
S3155 SS=J	26-41-204 (a) Health Care Services (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a)	S3155		

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S3155	Continued From page 8 The facility reported a census of 44 residents. The sample included three residents and three focused review residents. Based on interviews and record reviews, for one sampled resident identified as an alleged perpetrator of inappropriate sexual behavior (#111), and for three focused reviews identified as potential recipients of resident's inappropriate sexual behavior (#110, #109, and #108), the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the identified needs of each resident in accordance with the functional capacity screen (FCS) and negotiated service agreement (NSA). Resident #111 admitted to facility with documented history of inappropriate sexual behaviors towards females. The facility failed to develop interventions and health care services to address these specific identified needs and failed to develop corrective interventions when behaviors occurred. Resident #111 displayed inappropriate behaviors towards at least three female residents. The failure to provide and coordinate services to meet identified needs placed residents #111, #110, #109, and #108 in immediate jeopardy for injury and/or harm. Findings included: - Record review revealed #111 admitted to facility 02/11/2021 with diagnoses of Dementia with behavioral disturbance, Hyperlipidemia, Hypertension, and Type 2 Diabetes. Resident's medical record contained a Progress Note from a physician's office visit dated 12/30/2020: "patient is being inappropriate and	S3155		

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S3155	Continued From page 9 flirty with the nurses, trying to touch them inappropriately and has been getting naked and running around the facility almost every other day. This has worsened the last 4 weeks. This happens any time day or night" Resident's medical record contained documentation from a facility referral service dated 02/09/2021: "early to mid-stages dementia - likes to be naked, has wandered into apartments and got in bed with a woman. He feels bad afterward like he has been bad. Very pleasant otherwise...these behaviors are relatively recent developments." The Functional Capacity Screen (FCS) dated 02/11/2021 assessed resident #111 independent with walking/mobility and transfers, occasionally incontinent of bladder, with impaired short and long-term memory, impaired memory/recall and decision-making. Current identified problems/risks included socially inappropriate/disruptive behavior, wandering and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 02/11/2021 recorded "Resident is noted to wander the hallways at various times of the day. Resident is noted at times to be invasive in others personal space. Staff will redirect when he is invasive." The NSA/HCSP failed to identify resident's inappropriate sexual behaviors and failed to include interventions to specifically address those behaviors. Alert charting (Nurses Notes) for resident #111 documented the following:	S3155		

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S3155	Continued From page 10 2/16/21 - "Resident noted to wander and attempt to touch ladies in an inappropriate manner ... redirected by staff away from female residents ... New order noted for Trazadone (antidepressant) 25 milligrams (mg) every night for insomnia. New order for Estrace (female hormone) 1mg every day for sexual aggression." (NSA/HCP lacked revision of interventions to address reported inappropriate behaviors). 2/17/21 - "This resident was noted to be sitting close to a female resident (#110) ... started sliding his hand into the chest of the female resident ... asked him what he was doing, and he quickly stood up straight and responded, "I am not doing anything" and he moved away from #110 ... later assisted to his room, but he won't stay ... Started exploring other neighborhoods ... this writer notified other staff to be on the lookout for him. Will continue to monitor". (NSA/HCP lacked revision of interventions to address reported inappropriate behaviors). 2/18/21 - "Staff keeping an eye on him and he is aware, so this is keeping him from misbehaving. Will continue to monitor". 3/9/21 - "New orders to start Estrace 2mg. Give 2mg in the morning for sexual aggression" (notes lacked a description of how or why this order issued). 3/24/21 - "Resident noted to continue with sexual aggression in trying to touch female residents inappropriately. Called ARNP new order noted" (Trazadone 25 mg by mouth morning and evening for sexual aggression). (New NSA/HCP of 3/11/21 included medication change, lacked revision of interventions to address reported inappropriate behaviors).	S3155		

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S3155	Continued From page 11 4/8/21 - " ...On 4-8-21 at approximately 8:10am the CNA (Certified Nursing Assistant) noted resident #111 standing at resident #109 bedside (female alert to self with confusion of time and place) ...#111 was standing over #109 just starting to bend down towards #109 (asleep)... #109's night gown had been unbuttoned and breasts were exposed ... (incontinent) brief open and vagina exposed...Staff called #111's name ... proceeded to lift his hands in the air ... Staff redirected #111 from the room ..." (New NSA/HCP of 3/11/21 included medication change; included an additional "4/08/21" note entered after a 4/11/21 entry, that directed every 15 minute checks, redirection when invasive in others space, notify nurse if redirect doesn't help). 4/16/21 - "Resident noted to come walking down the hallway without his pants or underwear. Staff redirected him to his room for assistance dressing." 4/20/21 - "Resident was noted to have strayed out of his neighborhood and from his room to another neighborhood with no pants or diaper on. Redirected back to his room and assisted to bed ..." 4/22/21 - "This writer later went to check on him around 7:45pm ... missing from room ... noted coming from another neighborhood with no walker ... redirected back to room ..." 4/27/21 - " ...after being assisted to bed, he quietly got out of his bed and out of the neighborhood and went to a different neighborhood while wearing brief only ... staff heard somebody saying 'get out' and when they	S3155		

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S3155	Continued From page 12 went in there he was in the room standing by the bed where the other resident was in bed. He was redirected back to his room." 4/30/21 - " ... "Resident impulsively had his hands on another female resident and redirection x 2 was successful". 4/30/21 ... "Staff reported resident walked up to a female resident #108 in the dining room ... sitting in her wheel chair at the table ... (#111) placed his hands inside her shirt cupping his hands around her breast ... Staff told (#111) to walk away from her and have a seat x 3 before he walked to his table ..." (New 3/11/21 NSA/HCP lacked revision of interventions to address reported inappropriate behaviors). On 5/05/21 at 9:30am Administrative Nurse #B confirmed facility received resident records for #111 from previous facility of residence on 02/09/21 (prior to admission). Nurse #B confirmed that record included documentation of potential sexual abuse involving resident #111... confirmed reports of potential sexual abuse involving resident #111 (at this facility) were not made to department within 24 hours of occurrence. Nurses' notes of 4/08/21 recorded: "Administrative Nurse #B told #111 he should not be touching other residents in that manner ... and #B notified Physician and received orders to increase Trazadone to 50 mg (milligrams) BID (twice a day) for Sexual aggression and placed resident #111 on 15-minute checks for 24 hours ..." Nurses' notes of 4/30/21 recorded: "Dr notified	S3155			

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S3155	Continued From page 13 with new order noted for Geriatric-Psych consult ... interviewed #111 and when asked why he did that (touched #108's breasts), responded with "I don't know" ... assessment completed on #108 with no redness or bruising noted ... #111 started on 1:1 supervision ... #111 was accepted at Behavioral Health Hospital for evaluation and treatment." Record review revealed on 04/10/2021 #B emailed the Department about the 4/08/21 incident involving #109 and started an investigation. Record review revealed on 5/06/21 the facility emailed the Department about the 4/30/21 incident involving #108 and started an investigation. On 5/07/21 at 11:00am, notarized statement from CNA (certified nursing assistant) #C recorded: (On 4-30-21) "Came back from the kitchen with breakfast cart, saw resident (#111) touching another female resident (#108) with his hands inside her top. Resident was re-directed to another area. Nurse notified." On 5/07/21 at 11:10am, notarized statement from activity staff #D recorded: (On 4/08/21) "I saw #109 door open. When I go at door I saw #111 standing next to the bed. #109 pajama top was un button and tabs of brief was open. #111 was fully dressed and was not touching #109, at the moment I walked in was leaning over her with hands extended out. I re-directed #111 out of the room and notified the nurse. On 5/07/21 at 12:00pm, notarized statement from operator #A recorded: "In the matter of the return of #111 to the community: We will assist the resident family in finding appropriate placement in	S3155		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
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S3155	Continued From page 14 an all-male memory care. If unable to find placement prior to discharge from current Geriatric Psych stay, resident will have one to one service until another placement is found. By review, facility policy titled "Abuse, Neglect & Exploitation Policy- KS-1" included: Definitions: (a)(2) Any sexual act with a resident when the resident does not consent or when the other person knows or should know that the resident is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship and External reporting (6)(c)(1): If a determination is made that there is reasonable cause to believe an incident constitutes abuse, neglect or exploitation, the Executive Director or designee should report such information or cause a report of such information to be made to Kansas Department of Aging as soon as practicable. The operator's failure to ensure the licensed nurse provided and coordinated health care services to address specific identified needs of a resident admitted with a history of inappropriate sexual behaviors, placed residents #111, #110, #109, and #108 in immediate jeopardy when #111 displayed inappropriate behaviors towards at least three female residents. The immediate jeopardy was removed on 4/30/21 at 12:52pm, when #111 discharged from this facility to a geriatric-psych behavior health facility.	S3155		