STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of an abbreviated survey at the above named assisted living facility for complaint investigation(s) #159293, #159251, #160831 and #161647 conducted on 04-14-2021, 04-15-2021, 04-19-2021, 04-21-2021 and 04-22-2021.	S 000		
S3171 SS=G	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) 204 (i) The facility identified a census of 54 Residents. The sample included 1 Resident and 3 closed records Based on record review and interviews for one (#4) of four sampled, the Operator failed to ensure all health care services provided to residents by qualified staff in accordance with acceptable standards of practice. Resident #4 experienced a fall on 02-01-2021 at 8:42 pm. Resident #4 complained of severe pain to left hip/leg for over 2.5 hours before receiving emergency medical care. Resident suffered from a broken hip and required surgery. Findings included: - Record review for Resident #4 revealed an admit date of 09-12-2020 with diagnoses including Anemia, Chronic pain, and	S3171		

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

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Osteoarthritis.

The Functional Capacity Screen (FCS) dated 10-21-2020 recorded Resident #4 is independent with bathing, dressing, toileting, transfers, mobility and eating. Facility managed medications and treatments, Resident does not experience short-term memory loss, long term memory loss, memory recall or impaired decision making and listed falls/unsteadiness as a current or recent problem.

The Negotiated Service Agreement (NSA) dated 10-21-20 recorded Resident used 4-wheel roller walker for mobility.

The Health Care Service Plan (HCSP) dated 10-21-20 recorded staff to manage and administer medications, staff to provide stand by supervision with bathing, independent with dressing, grooming and ambulates with 4-wheel walker.

Medical record included a physician's order for Acetaminophen 650mg (two 325mg tablets) every 8 hours as needed for pain.

Review of video surveillance from 8:30pm 02-01-2021 to 12:30am 02-02-2021 from inside Resident apartment revealed the following:

8:42pm - Resident ambulating without walker adjusting clothing ...was seen walking between end of bed and chair, lost balance and fell to floor ...Resident verballing calling for help, stating "I think I broke my hip"

8:44pm - Certified Medication Aide (CMA) #D arrived at resident apartment ...immediately notified Licensed nurse #C of resident fall.

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Resident stated "It hurts so bad, I can't even move or get comfortable. I can't even move that hip at all".

8:48pm - Licensed Nurse #C entered apartment and asked resident what happened. Resident stated she fell and her hip hurts. Licensed nurse used walkie talkie and requested an Aide to come to stay with resident. Certified Nursing Assistant (CNA) #E arrived and Licensed Nurse #C left apartment stating was going to call ER (emergency room) to send resident to the hospital.

8:55pm - Licensed Nurse #C returned to apartment ...stated I notified Physician ... "Physician is aware of your pain and said it is not from your fall and to give you Ibuprofen." Video surveillance does not show vital signs being checked or physical assessment by Licensed nurse #C.

8:56pm - Licensed Nurse #C Administered medication to resident (according to medication administration record Ibuprofen) and then Licensed Nurse #C and CNA #E assisted resident up from floor and onto the seat of walker. Licensed nurse #C left apartment and CNA #E was observed pushing Resident on walker seat to bathroom and then assisting resident into bed. Resident seen and heard on video surveillance to continue to complain of pain to left leg/hip. Video surveillance does not show physical assessment by Licensed Nurse #C.

Resident seen and heard on video surveillance to continue to complain of pain to left leg/hip. At 10:30pm Licensed Nurse #C did facetime with Physician and Resident. Physician ordered Acetaminophen 500mg 2 tablets to be given and

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to obtain portable x-ray at facility.

10:45pm - Resident called out for help, CMA #F responded. Resident stated she needed to use the bathroom and was in pain and asked for pain medication. CMA #F notified Licensed Nurse #C via walkie talkie that Resident was in pain and Resident stated she could not get out of bed. Video surveillance does not show physical assessment by Licensed nurse #C. Licensed Nurse #C responded for CMA #F to assist Resident to bathroom using walker. Communication via walkie talkie was not clear and CMA #F left apartment to speak to nurse.

10:50pm - CMA #F returned to apartment ...placed a disposable pad on bed under Resident then left apartment, turning off the light and closing the door. No further assessment of Resident's complaint of pain was observed, no X-ray was obtained at facility, no further pain medication received by Resident.

11:30pm - EMS was called per Physician to transport Resident to hospital for treatment.

The Nurse's Note titled "Incident Details for Resident", recorded at 03:26am on 02-02-2021 included the following:

"At 2045 aide heard res calling for help. On opening the door, he saw res lying on the floor between the TV and her chair. Res stated, "I was trying to stand up from my chair, but my feet failed me." Res very confused, complained of pain but not specific, no visible injuries noted PERRLA, ROM done but res not able to bed L leg. Dr notified, Daughter did not want mother to go to hospital. Stat L hip, L thigh and pelvic x-rays orders received from Doctor, but Biotech needed

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more information about the resident insurance and this made the daughter to allow nurse to transfer res to OPR .... Licensed staff #C." Pulse 69, Respiration 20, Temperature 98.0 Blood Pressure 149/87 taken at 8:45pm"

Written statement from Certified Staff #D on 04-14-21 recorded, "On 02-01-2021 I was employed as a CMA at Glenwood Village Overland Park. I was taking a med to a resident when I heard (resident #4) screaming for help. I entered the apartment to see what she needed, and she had fallen. I then proceeded to call the nurse to access the situation."

On 04-14-2021 Requests for written statements from Certified staff #E, #F and Licensed Nurse #C resulted in no response.

On 04-14-2021 Administrator #A and Licensed Nurse #B confirmed video surveillance observations ...confirmed Licensed Nurse #C completed no further physical assessment of Resident #4 between 8:30pm and 11:30pm in accordance with accepted standards of practice.

For Resident #4, the operator failed to ensure all health care services to include licensed nurse assessment, provided by qualified staff in accordance with acceptable standards of practice. Resident #4 endured pain without further assessment for more than 2.5 hours.