STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	12000 LAMAR OVERLAND PARK, KS 66209

(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 complaint investigations #KS00160696, KS00160737, and KS00160738. The 2567 was sent electronically on 3/30/21	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/30/2021

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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by:
The facility identified a census of 62. The sample included five residents. Based on record review and interviews, the facility failed to ensure Resident (R) 1's choice to have female care givers was honored when a male Certified Nurse Aide (CNA) put R1 into bed, and removed her pants and incontinent brief.

Findings included:

- R1's electronic medical record (EMR), under the "Diagnosis" tab, listed diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and difficulty in walking.

The "Admission Minimum Data Set (MDS)" dated 12/08/2020 recorded R1's Brief Interview for Mental Status (BIMS) was not assessed. R1 required extensive assistance from one staff member with dressing and extensive assistance from two staff members for bed mobility and transfers.

The "Activities of Daily Living (ADL) Function Care Area Assessment," Dated 12/02/2020 recorded R1 could verbalize needs and preferences and required supervision to extensive care of one to two staff members for ADLs.

The "Care Plan" dated 12/02/2020 documented R1 had self-care performance deficit related to decreased mobility. An intervention dated 12/02/2020 directed staff to allow R1 sufficient time for dressing and undressing but lacked preference for female care givers.

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The "Tasks" tab, dated 12/16/2020, documented R1 was to have female care staff only .

In the "Incident Investigation Report" on the incident that occurred on 02/27/2021 R1 reported that Certified Nurse Aid (CNA) M came into her room to get her ready for bed. R1 reported that she had asked CNA M to leave her clothes on. CNA M then picked R1 up, threw her into bed, and pulled R1's pants and underwear off. After that occurred R1 reported CNA M then left the room.

In an email, dated 03/01/2021, CNA M typed that that he had done what the old report directed. CNA M stated that R1 refused to put a brief on, so CNA M placed a disposable chuck underneath R1 and left the room. CNA M typed that he was the only CNA working that hall with the nurse .

In the signed "Witness Statement" dated 03/04/2021, Licensed Nurse (LN) G wrote R1 stated that Certified Nurse Aid (CNA) M did not use the Etac (sit to stand patient transfer/turning device) to transfer R1 but "grabbed her" and put her into the bed.

On 03/22/2021 at 1:30 PM CNA N stated that if a resident only wanted female care givers that the staff would trade assignments or made sure that only female staff answered that call light to provide cares.

On 03/22/2021 at 1:35 PM License Nurse (LN) I stated if a resident only wanted female care givers then it was noted at report and staff made sure to pass that information out to the other nursing staff. She further stated that if needed staff would trade assignments around to care for

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F 561	Continued From page 3 that resident as the resident had requested . The facility policy "Resident Rights" revised 10/2019 documented associated would adhere to and respect resident's rights as applicable to state and federal regulation. It further directed that every effort to assist each resident in exercising his/her rights to assure that the resident was always treated with respect, kindness, and dignity. The facility failed to ensure R1 had female care givers as requested per her resident rights. The deficient practice placed R1 at risk for impaired dignity.	F 561		
F 689 SS=D	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 identified a census of 62. The sample included five residents reviewed for transfers. Based on record review and interviews, the facility failed to ensure Resident (R) 1 was free from accidents and hazards when staff failed to use two people with the Etac (sit to stand patient transfer/turning device), as directed in R1's plan of care, for a transfer when staff picked the resident up to transfer her into bed. This deficient practice placed R1 at risk for injury.	F 689		

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F 689	Continued From page 4	F 689		

Findings included:

- R1's electronic medical record (EMR), under the "Diagnosis" tab, listed diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and difficulty in walking.

The "Admission Minimum Data Set (MDS)" dated 12/08/2020 recorded R1's Brief Interview for Mental Status (BIMS) was not assessed. R1 required extensive assistance from two staff members for bed mobility and transfers.

The "Activities of Daily Living (ADL) Function Care Area Assessment," Dated 12/02/2020 recorded R1 could use upper extremities to assist with transfers but needed two staff members to assist with transfers.

The "Care Plan," dated 12/02/2020 documented R1 had self-care performance deficit related to decreased mobility. An intervention dated 12/02/2020 directed staff R1 required the Etac for transfers but lacked indication for the number of staff required to use the Etac.

The "Tasks" tab in the EMR, dated 02/09/2021, documented R1 required two staff assistance with transfers on the Etac.

In the "Incident Investigation Report" on the incident that occurred on 02/27/2021 R1 reported that Certified Nurse Aid (CNA) M came into her room to get her ready for bed. R1 reported that she had asked CNA M to leave her clothes on. CNA M then picked R1 up, "threw her" into bed, and pulled R1's pants and underwear off. After

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that occurred, R1 reported CNA M then left the room.

A "Social Services Progress Note" dated 02/28/2021 documented Social Services X had spoken to R1 about "the incident that occurred the night prior." The note recorded R1 reported she wanted to go home, but the note lacked any description of the event .

In an email, dated 03/01/2021, CNA M typed that that he had done what the old report directed. CNA M stated that R1 refused to put a brief on, so CNA M placed a disposable chuck underneath R1 and left the room. CNA M typed that he was the only CNA working that hall with the nurse .

In the signed "Witness Statement" dated 03/04/2021, Licensed Nurse (LN) G wrote R1 stated that Certified Nurse Aid (CNA) M did not use the Etac to transfer her but "grabbed her" and put her into the bed.

In the signed "Witness Statement" dated 03/04/2021, LN H wrote R1 stated CNA M came into R1's room to get R1 ready for bed. CNA M "picked [R1] up and threw her on the bed."

On 03/22/2021 at 1:00 PM Administrative Nurse E stated that the Etac is a disk that sits on the floor and has a handlebar that comes up for the resident to hold onto. She stated it required two staff members to use it.

On 03/22/2021 at 1:30 PM CNA N stated that to use the Etac it always took two staff members. She revealed that it was the charge nurse's responsibility to inform staff how to transfer the residents and it could be looked up in the

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computer as well. CNA N stated that agency staff received training prior to arriving to the facility and at times had been paired with a current staff member.

On 03/22/2021 at 1:35 PM LN I stated that the Etac takes two staff members to use and that staff is notified of transfer status during report. LN I said the therapy department was also good about communicating how the residents transfer. She further revealed that all staff could see how a resident transfer in the Kardex (the electronic point of care). Agency staff were trained prior to arriving and they had access to the Kardex as well.

The facility policy "Safe Lifting and Movement of Residents" revised 07/2018 documented the community used appropriate techniques and devices to lift and move residents.

The facility failed to ensure staff used the required equipment (Etac), as directed by the care plan, and required number of staff, indicated in the tasks to transfer R1 to bed. The deficient practice placed R1 at risk for injury.