STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046102	A. BUILDING: _____ B. WING _____	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHERIDAN AT OVERLAND PARK	10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210

(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 citations are the result of an abbreviated survey conducted at the above named assisted living facility in Overland Park, KS on 5/29/18 and 5/30/18	S 000		
S3026 SS=G	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: KAR 26-41-101 (f)(1)(B) The facility reported a census of 72 residents. The sample included 4 residents. Based on observation, record review and interview for 1 of 4 residents sampled (#30) the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to provide services reasonable and necessary to ensure this resident's safety and well-being and to avoid harm when facility staff failed to administer medications resident #30, as ordered by a physician, following a hospitalization for aspiration pneumonitis, acute hypoxic respiratory failure and severe sepsis resulting in readmission 4 days later for the same condition. Findings included:	S3026		

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

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S3026	Continued From page 1 - Record review for resident #30 recorded admission date of 1/31/18 with diagnoses of: chronic obstructive pulmonary disease (COPD), anemia, history of cerebrovascular accident, hypothyroidism, depression, anxiety, osteoarthritis, vitamin B deficiency and vitamin D deficiency. Functional Capacity Screen (FCS) dated 3/1/18 recorded resident required assistance with management of medications (management of treatments is blank). Resident has no cognition or communication problems. Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 3/1/18 recorded: physical assistance needed. A caregiver prepares medications for administration and assists the resident to take medications. Breathing treatments: resident requires breathing treatments and staff monitoring and assistance of an appropriately skilled professional or appropriately trained staff member. Oxygen: resident does not require oxygen. March 2018 MAR/TAR (medication administration/ treatment administration record) recorded 15 different oral medications administered by facility staff including: bupropion XL (depression) 15 mg (milligrams) on tablet one time daily; atorvastatin (cholesterol) 10mg by mouth one time a day at bedtime and treatments including: ipratropium/albuterol inhalation solution (COPD) via nebulizer 3 times a day as needed for SOA (shortness of air) and Spiriva handihaler (COPD) 18mcg (micrograms) inhale contents of 1 capsule via handihaler one time a day.	S3026		

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S3026	Continued From page 2	S3026		

Facility charting notes (nurses notes) dated 3/23/18 at 1:05pm recorded: "Resident reported not feeling well and said he/she had vomited, had an upset stomach and had not had a bowel movement for a couple days. I spoke with CNA's (certified nurses aides) who have not witnessed BM (bowel movement). Bowel sounds active. This writer spoke with CMA (certified medication aide). CMA did administer Zofran (nausea) and Miralax (laxative) as ordered PRN (as needed). Effective. This writer called [family member] and reported medication administration. He/she was thankful ..." signed by licensed nurse #B. Resident record lacked nurses note nursing assessment and monitoring of resident including vital signs and lung status after episode of vomiting on 3/23/18 at 1:05pm. and lacked for documentation of transfer to the emergency room and admission to the hospital on 3/23/18.

Interview on 5/29/18 at 2:40pm with licensed nurse #B confirmed record lacked entry for 3/23/18 hospital admission. He/she stated it might be on paper, no documentation was presented.

Next note recorded on 3/27/18 at 3:31pm: "Resident returned to community with [family member] at approximately 1:15pm today. Denies pain, alert and oriented times 3. ROM WNL (range of motion within normal limits), ambulating with walker, noted bruise to right hand and small bruising to antecubital areas from lab draws and IV's (intravenous). Denies SOA (shortness of air), dizziness or labored breathing at this time. Resident is to have Duoneb (nebulizer treatment) QID (4 times a day) now, not PRN (as needed). Resident has a couple new orders, these have been faxed to [pharmacy]. Placed on the list and requested to be seen by [physician name] per

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S3026	Continued From page 3	S3026		

[family member]. "Signed by licensed nurse #C.

Hospital history and physical recorded the following:
Date of admission: 3/23/18; chief complaint: hypoxia; history of present illness: "[resident] was brought to the emergency department today by his her [child] with concern for acute hypoxia. Apparently, the [family member] tells me that he/she spent the day with [resident]yesterday and he/she was feeling quite well with no cough, shortness of breath or signs of acute illness. The patient is able to tell me that this morning he/she woke up and suddenly felt nauseated and had 1 episode of nausea with vomiting. Since that episode, he/she apparently has had increased coughing and has seemed short of breath. When the patient's [child] arrived to see him/her today, he/she did not seem to be feeling well. He/she seems fatigued and quite short of breath, so he/she checked his/her oxygen saturation with a monitor that he/she carries with him/her and found his/her oxygen saturation to be low in the 70s and his/her heart rate to be high. At this point, the patient was brought to the emergency department for further evaluation ..."

Hospital discharge orders/ summary dated 3/27/18 at 11:11am recorded resident was seen in the emergency department and admitted on 3/23/18. Diagnoses of: acute hypoxic respiratory failure, severe sepsis, aspiration pneumonitis, COPD, HTN, history CVA, dementia and hypothyroidism. Aspiration seems to be due to episode of emesis. Resident received 6LPM Oxygen via nasal cannula on 3/23/18 in the emergency department. It included signed orders for the following new medications:

Ipratropium/ albuterol inhalation solution 3 ml

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(milliliters) (bronchodilator to treat COPD) nebulization 4 times a day
Amoxicillin/ clavulanate potassium (Augmentin, antibiotic) 875 mg (milligram) 1 each tablet oral twice a day
Prednisone (steroid) 10mg tablet oral as directed: 4 tabs for 4 days, 3 tabs for 4 days, 2 tabs for 4 days and 1 tab for 4 days.
Review of the March MAR/TAR for 2018 recorded Ipratropium/albuterol 3ml nebulizer ordered on 3/27/18 4 times a day was administered by staff on 3/27 at 6pm, 3/28 at 12am, 6am, noon and 6pm. On 3/29 at 6am and 6pm (refused at 12am and noon) and on 3/30 at 6am (refused at 12am and 6pm). A new entry started on 3/30/18 recorded ipratropium/ albuterol inhalation solution 3 ml (milliliters) via nebulizer administered at 9am, 1pm and 5pm on 3/31/18.

The MAR recorded the prednisone ordered on 3/27/18 to be administered on a tapering dose was not started until 3/31/18 at 9am and the first dose of amoxicillin/clavulanate potassium also ordered on 3/27/18 was not administered until 3/31/18 at 9 a.m.

The nurses notes lacked documentation of an assessment of the resident and documentation of the resident's return to the hospital on 3/31/18.

History and physical from hospital admission date 3/31/18 recorded: "History of present illness: [resident] was recently discharged from the hospital on 3/27/18 of this year. The patient was admitted and treated for acute hypoxic respiratory failure secondary to pneumonia, severe sepsis present on admission, acute exacerbation of COPD, pneumonia, possible aspiration pneumonia or strep pneumonia, chronic cognitive impairment, hypothyroidism and hypertension.

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S3026	Continued From page 5 The patient was discharged on his/her home medication plus he/she was discharged on tapering prednisone and PO Augmentin for 7 days. Patient was also discharged with continuing his/her nebulizer treatments 4 times a day. The patient was discharged back to (facility name) an assisted living facility, but the scripts the patient was discharged with were never filled .... The patient reports today with no improvement of symptoms and due to not being treated by the facility he/she was discharged to. Physical exam: pulse oximetry 90 percent on nonrebreather at 15 liters (oxygen)". Interview on 5/29/18 at 2:40pm with licensed nurse #B, stated the pharmacy was faxed the new orders, they did not fill them, he/she believed he/she contacted them on the 28th and was told he/she did not say it was needed from "back up" so it was not sent immediately. He/she confirmed medications were not started until the 31st. Licensed nurse #B confirmed he/she does not have any documentation of contact with the pharmacy requesting the missing medications or documentation of follow up when they were not delivered. Phone interview on 5/29/18 at 1:45pm with resident's [family member] stated pharmacy told him/her they tried to contact the facility several times regarding the discharge medications. He/she stated resident has had significant cognitive decline since the hospitalizations. Pharmacy record of contact with the facility regarding resident's medications revealed the following: 3/27/18 at 3:40pm "Looks like this is a list of	S3026		

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discharge orders has resident D/Cd (discharged from facility? Or readmit?"
3/27/18 at 4:59pm "no answer."
3/27/18 at 5:18pm "LVM with Ref # (reference number)- NO HOLD?"
3/27/18 at 5:25pm "NO HOLD?"
3/28/18 at 6:08am "Per nurse [licensed nurse #D] patient returned yesterday afternoon asked him/her to send over valid orders"
3/28/18 4:30pm "nothing received yet"
3/28/18 4:49pm "Transferred, no answer"
3/28/18 4:55pm "okay to no hold?"
3/28/18 at 5:02pm "no hold"
3/29/18 at 6:29am "no answer try back later"
3/29/18 at 8:45am "left VM (voice message) with ref #, will try back later"
3/29/18 at 12:08pm "per [certified staff #E] he/she will tell nurses to send valid orders"

Documentation of pharmacy contact with facility is recorded over top of a copy of resident's discharge medication orders. Fax date/time from facility reads 3/27/18 at 2:26:31pm CDT (central time).

Pharmacy ordering instructions (posted on bulletin board outside licensed nurse #B office) recorded the following: "Urgent requests: If the order is faxed after 2pm or on the weekend and is needed prior to the next scheduled delivery, please contact the pharmacy for medication to be sent from back-up"

Nurses notes dated 4/4/18 at 5:04pm recorded "Resident returned today approximately 3pm ..... full assessment completed see MD (medical doctor) note in chart. New meds (medications) ordered from hospital. Hard script given to resident's [family member] and [family member] returned with meds ...." Signed by licensed nurse

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S3026	Continued From page 7 #B. Record lacked FCS and NSA/HCSP updates for both readmissions on 3/27/18 and 4/4/18. Interview on 5/29/18 at 3:35pm with licensed nurse confirmed current NSA/HCSP dated 4/16/18 lacked signatures (blank). He/she confirmed record lacked FCS and NSA/HCSP for resident readmissions to facility. For resident #30, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to provide services reasonable and necessary to ensure this resident's safety and well-being and to avoid harm when facility staff failed to administer medications resident #30, as ordered by a physician, following a hospitalization for aspiration pneumonitis, acute hypoxic respiratory failure and severe sepsis resulting in readmission 4 days later for the same condition.	S3026		