

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #188309, #187374, #186682, #186290, #183387, #183269, #182275, #180748, #178659, #178619, #178622, #178550, #178082, and #178085 at the above named assisted living conducted on 06/11/24 - 06/13/24.	S 000		
S3028 SS=D	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 74 residents with seven residents included in the sample and five closed record reviews. Based on interview and record review the administrator failed to report an allegation of neglect to the department within 24 hours when Resident (R) 9 was found unresponsive with a blood glucose level of 22. Findings included: - Record review for R9 revealed an admission date of 12/28/21 with diagnoses of hemiplegia and muscle weakness The 12/29/23 "Functional Capacity Screen" (FCS) identified R9 required physical assistance with bathing, dressing, toileting, transfers, management of medications and treatments, and was incontinent of bladder. The 12/29/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide assistance for bathing, dressing, toileting, transfers, and management of medications; and she self-managed bladder incontinence. Management of treatments was not addressed on the "NSA." The 02/07/23 at 09:25 PM AM "Alert Charting Note" documented R9 was found unresponsive leaning toward her left side in a recliner. Blood glucose level was 22. The 02/10/23 at 10:57 AM "Return from Hospital Note" documented R9 arrived back to the facility	S3028		

Kansas Department on Aging

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S3028	Continued From page 2 from the hospital. Admitting diagnosis at hospital was hypoglycemia. Review of the hospital's "Discharge Order Report" for encounter dated 02/07/23 documented cause of condition was hypoglycemia. R9 reported she had been taking her morning medications as usual but there was another pill she did not usually take present with her usual medications. Within an hour of taking her medications she became sweaty and experience altered mental status. Review of R9's record revealed lack of evidence of documentation the incident was reported to the department within 24 hours. On 06/12/24 at 12:53 PM Administrative Nurse B confirmed R9 had been transferred to the hospital for hypoglycemia. R9 was not diabetic and the cause for her hypoglycemia was not found. On 06/12/24 at 01:34 PM Administrative Nurse B stated R9's reported to her R9 believed she had been administered the wrong medications. She confirmed R9's record lacked evidence of documentation of alleged medication error. Administrative Nurse B also confirmed the allegation was not reported to the department. On 06/12/24 at 02:04 PM Administrative Staff A confirmed R9 reported she had been administered the wrong medication. She confirmed an initial report to the department was not completed. The administrator failed to report an allegation of neglect to the department within 24 hours when R9 was found unresponsive with a blood glucose level of 22.	S3028		

Kansas Department on Aging

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S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (a) The facility reported a census of 74 residents. The sample included 7 "Residents" (R)'s and 5 focused record reviews. Based on record review and interview the Administrator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) for R's 2, 4, and 6. Findings included: - Record review for R2 revealed and admission date of 01/06/21 with diagnoses of diabetes mellitus, chronic obstructive pulmonary disease, hypertension, glaucoma, hearing loss, blindness	S3085		

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S3085	Continued From page 4 of one eye, congestive heart failure, insomnia, recurrent depression, and mild cognitive impairments. Review of R2's "Functional Capacity Screen" (FCS) dated 02/09/24 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility, and he required supervision with eating. He lacked the ability to manage his own medications, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with falls, impaired vision, impaired hearing, and impaired decision making. He used a wheelchair mobility device. Review of the facility provided document titled "Personal Service Plan" identified the facility would provide the following health services: facility staff to manage all medications and treatments ordered by the physician, and coordinate care with the outside hospice provider. One facility caregiver to assist with dressing bathing, and toileting. Interview on 06/13/24 at approximately 02:00 PM with administrative staff A and administrative Nurse C confirmed the facility document titled "Personal Service Plan" is the facility's version of the NSA. - Record review for R4 revealed an admission date of 11/28/22 with diagnoses of Enterococcus as the cause of diseases classified elsewhere, helicobacter pylori, moderate protein-calorie malnutrition, gastric intestinal metaplasia, acute kidney failure, and unspecified dementia.	S3085		

Kansas Department on Aging

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S3085	Continued From page 5 Review of R4's FCS dated 01/14/24 revealed R3 required supervision with bathing and dressing. He was independent with toileting, transferring and walking/mobility. He lacked the ability to manage his own medications, and had impaired short-term memory, impaired long-term memory, impaired memory recall, and impaired decision making. He was usually able to make himself understood and he usually understood others. He was marked with impaired decision making and used no mobility device. Review of the facility provided document titled "Personal Service Plan" identified the facility would provide the following health services: facility staff to administer his medications, assistance of one staff for showers, and assistance with urinary catheter care. Interview on 06/13/24 at approximately 02:00 PM with administrative staff A and administrative Nurse C confirmed the facility document titled "Personal Service Plan" is the facility's version of the NSA. - Record review for R6 revealed an admission date of 11/14/21 with diagnoses of Alzheimer's disease. Review of R6's FCS dated 05/28/24 revealed she required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. She lacked the ability to manage her own medications and was occasionally incontinent. She had impaired short-term memory, impaired long-term memory, impaired memory recalls and impaired decision making. She was sometimes able to make herself understood and she sometimes understood	S3085		

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S3085	Continued From page 6 others. She used a wheelchair mobility device. Review of the facility provided document titled "Personal Service Plan" identified the facility would provide the following health services: the facility would administer her medications, provide one staff member to physically assist her with dressing, bathing, and occasional assistance with toileting. One staff member to assist with R6's mobility by pushing her wheelchair. Interview on 06/13/24 at approximately 02:00 PM with administrative staff A and administrative Nurse C confirmed the facility document titled "Personal Service Plan" is the facility's version of the NSA. The Administrator failed to ensure the development of a written "Negotiated Service Agreement" (NSA) for R's 2, 4, and 6.	S3085		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 74 residents with seven residents included in the sample and five closed record reviews. Based on interview and	S3261		

Kansas Department on Aging

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S3261	Continued From page 7 record review the administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 3 died, when R10 had orders for an x-ray, and when R12 was transported to the hospital. Findings included: - Record review for R3 revealed an admission date of 02/09/23 with a diagnosis of dementia. The 03/22/24 "Functional Capacity Screen" (FCS) identified R3 was unable to perform bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments; he was frequently incontinent of bladder; had short-term and long-term memory, memory recall, and decision-making difficulties; was sometimes understandable and sometimes understood others during communication; and was marked for falls and impaired decision-making. The 03/21/24 "Negotiated Service Agreement" (NSA) identified facility staff would provide R3 assistance of one staff with bathing and toileting; assistance with dressing; staff propelled a reclining wheelchair for walking/mobility; staff provided management of medications and treatments, assistance with bladder incontinence; attention, verbal prompts, and reassurance for cognitive difficulties; and he had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe services provided for transfers, communication, and to prevent injury from falls. The 03/19/24 at 08:14 PM "Alert Charting Note"	S3261		

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S3261	Continued From page 8 documented R3 denied pain from a previous fall; scheduled topical cream for pain was applied to one shoulder; and he ate 25% of the evening meal. Review of R3's record revealed lack of evidence of documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action after the 03/19/24 at 08:14 PM "Alert Charting Note" which was the last nursing note documented. The "Discharged Residents List" provided by the facility during the survey revealed R3 was deceased on 03/27/24. On 06/13/24 at 10:34 AM Administrative Staff A confirmed R3 deceased on 03/27/24 and his record lacked evidence of documentation of incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action from 03/19/24 leading up to his death on 03/27/24. - Record review for R10 revealed an admission date of 02/28/22 with a diagnosis of diabetes mellitus type 2. The 09/11/23 "FCS" identified R10 was independent with all activities of daily living, management of medications and treatments, and had no cognitive or bladder continence difficulties. The 09/11/23 "NSA" identified R10 self-administered his own medications including insulin. The 05/31/24 at 02:12 PM "Alert Charting Note"	S3261		

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S3261	Continued From page 9 documented R10 complained of pain in left shoulder. Order for x-ray to left shoulder was received from the physician. The 05/31/24 at 04:02 PM "Alert Charting Note" documented an x-ray was scheduled for R10's left shoulder due to discomfort and soreness from a previous fall. Review of R10's record revealed lack of evidence of documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action after the 05/31/24 at 04:02 PM "Alert Charting Note" which was the last nursing note documented. On 06/13/24 at approximately 01:40 PM Administrative Nurse C confirmed R10's record lacked evidence of documentation of incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action following a physician's order to obtain an x-ray to his left shoulder. - Record review for R12 revealed an admission date of 02/04/22 with a diagnosis of dementia. The 03/08/23 "FCS" identified R12 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; was occasionally incontinent of bladder; had short-term and long-term memory, memory recall, and decision-making cognitive difficulties; was sometimes understandable and sometimes understood others during communication; and was marked for falls, impaired vision, and impaired decision-making.	S3261		

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S3261	Continued From page 10 The 03/27/23 "NSA" identified facility staff would provide R12 assistance with bathing, dressing, toileting, transfers, and propelled his wheelchair for walking/mobility; management of medications; assistance with bladder incontinence; oversight, guidance, and verbal prompts for cognitive difficulties; used a calm gentle voice and asked yes or no questions during communication; offered a later bedtime to prevent falls; and he had a DPOA for impaired decision-making. The "NSA" failed to describe the services provided for management of treatments and impaired vision. The 02/28/23 at 08:29 PM "Alert Charting Note" documented x-ray results for R12 reported to the nurse practitioner, R12's DPOA, and the administrative nurse. The 02/28/23 at 08:36 PM "Alert Charting Note" orders received from the nurse practitioner to transfer R12 to the hospital for evaluation. Review of R12's record revealed lack of evidence of documentation of all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action after the 02/28/23 at 08:36 PM "Alert Charting Note" to document date and time R12 was transferred to the hospital. On 06/12/24 at 05:00 PM Administrative Nurse C confirmed R12's record lacked evidence of documentation of incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when R12 was transferred to the hospital. The administrator failed to ensure licensed staff	S3261		

Kansas Department on Aging

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S3261	Continued From page 11 documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 3 died, when R10 had orders for an x-ray, and when R12 was transported to the hospital.	S3261		