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	N046050	A. BUILDING: _____ B. WING _____	C 11/18/2021

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BICKFORD OF OVERLAND PARK	10665 BARKLEY OVERLAND PARK, KS 66212

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #167030, 167006, 166741, 166693, 166405, 165852 of the above named facility conducted on 11/15/2021, 11/16/2021, 11/17/2021, and 11/18/2021.	S 000		
S3026 SS=D	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: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 63 residents. The sample included 3 residents. Based on interview and record review the administrator failed to ensure 1 of 3 sampled resident's (# 5) was protected from neglect when staff failed to look at all messages on facility provided pagers which included alerts for monitoring door alarms. The failure of staff to look at all pages sent to the pagers allowed resident #5 to elope on 11/7/2021 and 11/8/2021. Findings included: - Record review of admission records for resident #5 revealed an admission date of	S3026		

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

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S3026	Continued From page 1	S3026		

3/12/2016, with diagnoses of dementia, macular degeneration, hypertension and osteoarthritis.

Review of the functional capacity screening dated 5/29/2021 for resident #5, identified she required physical assistance with bathing and supervision with dressing. She was independent with her mobility and used no walking assistive device. She had impaired short-term memory, long term memory, memory recall and decision making. She was marked with impaired vision, impaired hearing, wandering and impaired decision making.

Review of the negotiated service agreement dated 5/29/2021 revealed the facility would provide verbal reminders to resident at meal times and escort resident to dining room at the appropriate time. Facility staff to verbally cue/assist resident with dressing as needed. Resident requires multiple orientations to daily routine to stay on task. Resident get anxious at times and needs verbal cues to help her calm down. She also had increased anxiety after meal times. Resident wears a monitoring device for her safety and requires supervision outside the community.

Review of nursing progress notes revealed an entry on 11/7/2021 and signed with unreadable signature by a certified medication aide; "resident eloped on 11/7/2021 out of the branch and was on the sidewalk. An employee found her on the sidewalk and said a gust of wind came and resident fell on the sidewalk. Resident was helped up and brought back into the facility. Medication aid assist resident in vital signs and a glass of water".

The record lacked an entry by a licensed nurse,

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S3026	Continued From page 2	S3026		

notification of time of incident, and notification of durable power of attorney and physician. The record lacked an entry for the elopement on 11/8/2021.

Review of administrator C investigation documents revealed the following information: on 11/7/2021 the schedule showed 3 staff scheduled and only 2 staff showed for the shift, she stated that certified medication aide / assistant director B failed to report that the staff did not arrive for the scheduled shift. She reported that 1 staff member was passing medications and one staff member was cleaning the kitchen. It was reported the staff member passing medications looked at the computer and saw the door alarms and responded to the gate alarm, the other staff member followed. She stated that one staff member reported not having a pager on her. Staff member from the assisted living side saw the memory care main door alarm on her pager and tried calling the memory care, when she got no response she went to the door that was identified as breeched and found the resident on the sidewalk and brought her inside.

Review of the pager alert system showed there was a resident who activated the alarm system on the patio gate at the same time the resident accessed the main door alarm. The staff failed to look at all pages sent by the system to identify the doors that were breeched. Review off the alarm records revealed the resident was outside the building for approximately 1.5 minutes.

Review of administrator C investigation revealed the following information: on 11/8/2021 the system alerted staff that the egress alarm on the courtyard gate was breached at 8:09 am and unlocked at 8:11 am. Resident left the door at

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S3026	Continued From page 3 8:12 am. The system showed a family member of another resident came in the front door at 8:14 am and brought the resident in with him. The investigation showed that staff member K reported that she heard the alarm and did not stop taking resident meal orders. The staff failed to acknowledge and respond to the pager alert for doors breeched. Review of the alarm records revealed the resident was outside the building for approximately 1 minute. Review of the facility provided unwitnessed door alarm policy dated 4-2014 stated the following: "if a door alarm occurs and a staff member does not witness the events surrounding the alarm, staff must immediately check their pagers for the type of alarm that occurred, whether it was a general door alarm or whether a resident with a homefree watch caused the alarm", "The inside and outside area surrounding the door that caused the alarm must be visually searched immediately after an unwitnessed door alarm occurs", "if the door alarm was caused by a general door alarm, make sure that all employees know they must account for all residents. The staff neglected /failed to follow the door alarm policy, facility staff failed to check their pagers for all alarms and failed to stop and perform the search around the identified door. The administrator failed to ensure 1 of 3 sampled resident's (# 5) was protected from neglect when staff failed to look at all messages on facility provided pagers which included monitoring alerts for door alarms. The failure of staff to look at all pages sent to the pagers allowed resident #5 to elope on 11/7/2021 and 11/8/2021.	S3026		

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S3167	Continued From page 4	S3167		
S3167 SS=J	26-41-204 (f) Health Care Services (f) Each administrator or operator shall ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (f) The facility reported a census of 63 residents. The sample included 3 residents. The facility failed to ensure a licensed nurse was available for immediate direction for 1 of 3 sampled residents (#3), who developed an unexpected medical condition, which was not followed up on by a licensed nurse and the resident expired on 11/16/21. This failure placed resident #3 in immediate jeopardy. Findings included: Review of resident #3's "Admission Records" revealed an admission date of 10/15/20, with diagnoses of dementia, hyperlipidemia, breast cancer, indigestion, hypothyroidism, and vitamin D deficiency. The "Functional Capacity Screen" dated 10/15/21 identified resident #3 required physical assistance with bathing and dressing. She was independent with toileting, transferring, walking, and eating.	S3167		

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S3167	Continued From page 5	S3167		

She had impaired short-term memory, long term memory, memory recall and decision making. She used a rolling walker assistive device. She was identified with falls, wandering, and impaired decision making.

The "Negotiated Service Agreement" dated 06/16/21 for resident #3 stated the facility would provide reminders at mealtimes, escort to the dining room, and provide stand by assistance with verbal cueing for dressing, hygiene, and toileting tasks. The resident was independent with transfers and was able to ambulate about the facility independently with a rolling walker.

Observation on 11/16/21 at approximately 10:30 AM Physical Therapist A came to Administrator C's office and inquired about speaking with a nurse. Administrator C referred Physical Therapist A to contact Certified Medication Aide (CMA)/Assistant Director B to call the nurse on call.

Observation on 11/16/21 at approximately 12:00 PM Administrator C answered a phone call and stated she was not a nurse and to send the resident out. Administrator C then went to her desk, started making phone calls, and sending text messages explaining she was trying to reach a nurse. Certified Medication Aide/Assistant Director B reported there was an unresponsive resident with shallow breathing on the unit.

Observation on 11/16/21 at approximately 12:15 PM Administrator C escorted a police officer to the unit, where paramedics were already and explained to the police officer the resident was pronounced dead at approximately 12:08 PM.

Interview with Certified Medication Aide/Assistant

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S3167	Continued From page 6	S3167		

Director B 11/16/21 at 12:25 PM revealed she made the following phone calls:
At 10:41 AM call made to Licensed Nurse D, with no answer or message left.
At 11:57 AM call made to Licensed Nurse E, with no answer or message left.
At 11:58 AM call to physician's office, left message at this time.
At 12:00 PM call to Administrator C with instructions to send resident out.
At 12:03 PM call made to Emergency Medical Services (EMS).

On 11/16/21 at 12:25 PM Certified Medication Aide/Assistant Director B stated Physical Therapist A reported to her at approximately 10:40 AM that resident #3 was not feeling well, complaining of left lower abdominal pain. She stated she called Licensed Nurse D at 10:41 AM and did not get an answer or leave a message. She continued to state the resident was placed on checks every 15 minutes and that she did not call the nurse again because the resident had "no red flags", she stated the resident was not hunched over or crying in pain.

Interview on 11/16/21 at 1:00 PM with Physical Therapist A revealed she went into the resident room just after 10:00 AM for physical therapy. She stated resident #3 was complaining of severe abdominal pain in the left lower quadrant. She stated she assisted the resident to the bathroom and then transferred the resident to her recliner. She reported the resident's stomach was hard and distended. She then reported to Certified Medication Aide F the resident was not feeling well and was having severe abdominal pain. She stated she went to check on the resident at 11:20 AM and the resident stated she did not need anything. She reported she saw the resident on

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S3167	Continued From page 7	S3167		

11/15/21 and the resident had been complaining about lower left quadrant pain, and that resident #3's stomach was hard and distended.

Interview with Certified Medication Aide F revealed he did not administer any pain medication to resident #3 and he wasted ½ of the resident's medications, because she refused to take them. He did not confirm that he reported the physical therapist's concerns about resident #3's abdominal pain to the licensed nurse on call.

Interview with Occupational Therapist G revealed she saw resident #3 on 11/12/21 and while her vitals were being obtained the resident vomited approximately 300 cubic centimeters of green watery emesis. She stated resident #3's vitals were normal. She continued to state the resident complained of lower left quadrant pain on the 12th and stated, "it started about an hour ago". Occupational Therapist G stated she reported resident #3's vomiting to staff, but could not recall whom she reported it to. She continued to state she saw resident #3 on 11/15/21 and the resident was laying supine in her bed and she obtained the resident blood pressure, which was "80's/40's". She reported giving the resident a glass of water. She stated she sat the resident up on the side of the bed, and resident #3's balance was off. Occupational Therapist G stated she re-took resident #3's blood pressure and it was 110 over a number she could not remember. She stated resident #3 continued to complain about severe left lower abdominal pain. Occupational Therapist G stated she reported resident #3 not feeling well to Certified Nurse Aide H.

Interview with Certified Nurse Aide H revealed someone with therapy told her on 11/12/21 that resident #3 was not feeling well. She stated she

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wrote this on the communication sheet. She stated the resident did not feel well on 11/15/21 and she wrote it on her communication sheet. She stated she did not work with the resident and she did not recall resident #3's abdomen being swollen.

Interview with Licensed Nurse J revealed there had been no reports made to her about resident #3 not feeling well. She stated Certified Nurse Aide H said resident #3 did not get up for breakfast and the resident wanted to eat lunch in her room on 11/14/21. She stated, "someone talked to her on Friday about [resident #3] vomiting". She stated she told Certified Nurse Aide H to keep an eye on her. She continued to state there were no other reports of resident #3 vomiting. She stated she took the resident's vitals and a cup of coffee and the resident started cussing at her on Friday. Licensed Nurse J stated, "she didn't look like she was declining", and she did not chart the assessment in the resident record, because she had no concerns about the resident. She stated on 11/14/21 the resident did not to come out of her room. It was reported to her that the resident did not eat lunch on this day, and she did not chart it.

On 11/16/2021 at 1:45 pm call made to the department for immediate jeopardy review for lack of involvement of a licensed nurse to provide direction to certified staff when a resident developed an unexpected medical condition.

On 11/16/2021 at 2:00 pm facility notified of immediate jeopardy status for lack of licensed nurse involvement of a resident who developed an unexpected medical condition.

On 11/16/2021 at 4:17 pm facility provided plan

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S3167	Continued From page 9 submitted to department for acceptance. On 11/16/2020 at 4:20 pm department accepted plan and immediate jeopardy abated. The facility failed to ensure a licensed nurse was available for immediate direction for resident #3, who developed an unexpected medical condition, which was not followed up on by a licensed nurse and the resident expired on 11/16/21.	S3167		
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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 63 residents. The sample included 3 residents. Based on record review and interview the administrator failed to ensure the resident record included documentation of all incidents, symptoms and other indications of illness or injury which included the date, time of occurrence, actions taken and the results of the actions for 2 of the 3 sampled residents (#3 and 5). Findings included:	S3261		

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S3261	Continued From page 10	S3261		

- Review of sampled resident #3's record on 11/16/2021 revealed an admission date of 10/15/2020, with diagnoses of dementia, hyperlipidemia, breast cancer, indigestion, hypothyroidism, and vitamin D deficiency.

The functional capacity screening dated 10/15/2021 identified resident #3 required physical assistance with bathing and dressing. She was independent with toileting, transferring, walking and eating. She had impaired short-term memory, long term memory, memory recall and decision making. She used a rolling walker assistive device. She was marked with falls, wandering and impaired decision making.

The negotiated service agreement dated 6/16/2021 for resident #3 stated the facility would provide reminders at meal times and escort to the dining room and stand by assist with verbal cueing for dressing, hygiene and toileting task. Resident was independent with transfers and was able to ambulate about the facility independently with a rolling walker.

Record review of the resident progress notes revealed the last entry was made on 10/26/2021,

Interview with licensed nurse J revealed there had been no reports made to her about resident #3 not feeling well. She stated that certified nurse aide H said that resident #3 had not gotten up for breakfast and that the resident wanted to eat lunch in her room on 11/14/2021. She stated, "someone talked to her on Friday about resident #3 vomiting". She stated she told certified nurse aide H to keep an eye on her. She continued to state there were no other reports of resident #3 vomiting. She stated she took her vitals and a cup of coffee and the resident started cussing at her

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S3261	Continued From page 11	S3261		

on Friday. Licensed nurse J stated, "she didn't look like she was declining", and she did not document the assessment in the resident record, because she had no concerns about the resident. She stated on 11/14/2021 the resident did not to come out of her room. It was reported to her that the resident did not eat lunch on this day, and she did not document the events in the resident record.

The administrator failed to ensure the resident record included documentation of all incidents, symptoms and other indications of illness or injury which included the date, time of occurrence, actions taken and the results of the actions for resident #3.

- Record review for resident #5 revealed an admission date of 3/12/2016, with diagnoses of dementia, macular degeneration, hypertension and osteoarthritis.

Review of the functional capacity screening dated 5/29/2021 for resident #5, identified she required physical assistance with bathing and supervision with dressing. She was independent with her mobility and used no walking assistive device. She had impaired short-term memory, long term memory, memory recall and decision making. She was marked with impaired vision, impaired hearing, wandering and impaired decision making.

Review of the negotiated service agreement dated 5/29/2021 revealed the facility would provide verbal reminders to resident at meal times and escort resident to dining room at the appropriate time. Facility staff to verbally cue/assist resident with dressing as needed.

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S3261	Continued From page 12 Resident requires multiple orientations to daily routine to stay on task. Resident get anxious at times and needs verbal cues to help her calm down. She also had increased anxiety after meal times. Resident wears a monitoring device for her safety and requires supervision outside the community. Review of nursing progress notes revealed an entry on 11/7/2021 and signed with unreadable signature by a certified medication aide;" resident eloped on 11/7/2021 out of the branch and was on the sidewalk. An employee found her on the sidewalk and said a gust of wind came and resident fell on the sidewalk. Resident was helped up and brought back into the facility. Medication aide assist resident in vital signs and a glass of water". Interview with administrator C revealed the resident had and elopement on 11/7/2021 and 11/8/2021. She confirmed the resident record lacked an entry for the second elopement. The administrator failed to ensure the resident record included documentation of all incidents, symptoms and other indications of illness or injury which included the date, time of occurrence, actions taken and the results of the actions for resident #5. The administrator failed to ensure the resident record included documentation of all incidents, symptoms and other indications of illness or injury which included the date, time of occurrence, actions taken and the results of the actions for 2 of the 3 sampled residents (#3 and 5).	S3261		