STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046050	A. BUILDING: _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 with complaint investigations 111082 and 105866 at the above named assisted living facility conducted on 2-22-17 and 2-23-17.	S 000		
S3028 SS=E	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 61 residents. The sample included 4 residents (2 current residents and 2 closed record reviews). Based on record review and interview for 2 of 4 sampled residents, the administrator failed to ensure each allegation of abuse, neglect or exploitation shall be reported to the department within 24 hours. Findings included: - Record review for resident #1 revealed admission on 3-22-16 with diagnoses Dementia, Psychosis, Seasonal Allergic Rhinitis, Dry Eye Syndrome, Constipation, Anxiety, Restlessness, Agitation, History of Stroke, Vitamin D Deficiency, Vitamin B Deficiency, Type 2 Diabetes Mellitus, Gastroesophageal Reflux Disease, Depression and Delusional Disorder. The Functional Capacity Screen dated 5-27-16 recorded resident required physical assistance with bathing, dressing, toileting and walking/mobility; supervision of eating and unable to perform management of medication and treatments. Incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included falls, impaired vision and impaired decision-making. Uses wheelchair for mobility at times. The FCS was updated on 12-1-16 with change for eating (independent) and no use of assistive devices. The Negotiated Service Agreement/Health Care Service Plans (NSA/HCSP) dated 5-27-16 and 12-1-6 recorded the following services:	S3028		

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S3028	Continued From page 2	S3028		

Assistance with dressing and undressing
Assistance with toileting. Caregivers will provide pericare. (Note: HCSP dated 12-1-16 included toileting assistance before and after meals, before bedtime and every 2-3 hours during the night.)
Assistance to shower 1-2-times weekly.
Mobility escort to and from meals and activities.
Caregivers will administer medications as ordered.
Exit seeking at times and wears a personal watch for safety (Home Free System).
Verbal reminders and redirection when behavior is inappropriate.
Note: The NSA/HCSP for 5-27-16 and 12-1-16 lacked interventions to address the resident's fall risk.

Nursing Progress Notes stated the following:

12-11-16 (no time designated): "At approximately 6:00 pm this nurse was directed to resident's apartment by resident's (family member). Upon arrival, resident was seen lying on his/her back in doorway. Unable to state how he/she got to the floor..." Signed by Licensed Staff E.

12-12-16 (no time designated): "Resident had injury fall around 11:05 am. Resident struck head on bedroom door resulting in laceration to back of head...was sent to hospital for evaluation and treatment..." Signed by Licensed Staff F.

12-19-16 at 8:40 pm: "At approximately 7:30 pm, this writer was informed that resident was seen lying on the floor of his/her bedroom at the foot of bed..." Signed by unknown staff.

1-24-17 at 6:30 pm: "At approximately 2:50 pm, CNA (Certified Nurse Aide) called this nurse to

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resident's room where he/she was laying on his/her back next to bed on carpeted floor. his/her pants were soiled with urine and feces. So CNA and I helped him/her to the bathroom and sat him/her on the stool. He/She was unable to sit up straight and when he/she tried using his/her left arm, he/she cried out in pain and cracking sound audible in shoulder area on left side...ambulance called...transferred to hospital" Signed by Licensed Staff G.

Interview on 2-22-17 at 4:16 pm with Administrative Nurse B upon review of falls from 10-5-16 to 1-24-17 confirmed the above falls were unwitnessed and lacked documentation of resident's explanation of what happened to cause him/her to fall. Further confirmed these falls lacked documentation of report to the department.

For resident #1, the administrator failed to ensure allegations of abuse or neglect were reported to the department.

- Record review for resident #2 revealed admission on 4-16-16 with diagnoses Alzheimer's Disease and Hypertension.

The Functional Capacity Screen (FCS) dated 12-1-16 recorded resident required physical assistance with bathing, dressing, toileting and transfers; independent with walking/mobility and eating. Incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included falls, impaired vision and wandering. Uses walker.

The Negotiated Service Agreement/Health Care

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S3028	Continued From page 4 Service Plan (NSA/HCSP) dated 12-1-16 recorded the following services: Assistance with dressing and undressing Assistance with toileting. Caregivers will provide pericare; before and after meals, before bedtime and every 2-3-hours during night. Assistance to shower 1-2-times weekly. Mobility/Escort: uses front wheeled walker needs reminders to use walker and escort to and from meals and activities. Caregivers will administer medications as ordered. Resident will have a personal watch for safety...monitored 24/7 by Home Free System. Nursing Progress Notes revealed documentation of elopements as follows: 9-23-16 at 9:00 pm: "At approximately 8:00 pm, this LPN was notified by CNA (Certified Nurse Aide) that resident was outside attempting to get into a vehicle owned by an employee. CNA said resident became combative when trying to escort resident back inside. Resident escorted back inside main entrance...stated 'I want to leave and you can't stop me'..." Signed by Licensed Staff D. 2-9-17 at 5:00 pm: "Resident was found outside the building by the aide. Re-directed back. Head to toe assessment done, no injuries noted. Resident stated 'I want to go home'..." Signed by Licensed Staff I. (Note: On 1-1-17 at 11:40 pm, nurse documented that staff responded to door alarm and found resident outside. This incident was reported to the department. Facility failed to submit investigation report to the department within five working days.)	S3028		

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S3028	Continued From page 5 Interviews on 2-22-17 at 3:39 pm and 5:19 pm with Administrative Staff B confirmed the above documented incidents where resident was found outside of the facility. Stated there were two residents on the memory care unit that were considered elopement risks, this resident and another resident. Confirmed the facility failed to report the elopements on 9-23-16 and 2-9-17 for resident #2. For resident #2, the administrator failed to ensure each allegation of neglect was reported to the department within 24 hours; and for an allegation reported, failed to submit the report within five working days.	S3028		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 61 residents. The sample included 4 residents (2 current residents and 2 closed record reviews). Based on record review and interview for 1 (#1) of 4 sampled residents, the administrator failed to	S3155		

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ensure the licensed nurse provided or coordinated the provision of necessary health care services. Resident #1 experienced 11 falls from 10-5-16 to 1-24-17 and the licensed nurse failed to implement interventions to address this cognitively impaired resident's risk for falls. The fall on 12/12/16 resulted in a laceration to the back of the head that required staples and the fall on 1-24-17 resulted in a fractured left hip and left shoulder.

Findings included:

- Record review for resident #1 revealed admission on 3-22-16 with diagnoses that include Dementia, Psychosis, Anxiety, Restlessness, Agitation, Depression and Delusional Disorder.

The Functional Capacity Screen dated 5-27-16 recorded resident required physical assistance with dressing, toileting and walking/mobility; supervision of eating and unable to perform management of medication and treatments. Incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included falls, impaired vision and impaired decision-making. Uses wheelchair for mobility at times.

The FCS was updated on 12-1-16 with change for eating (independent) and no use of assistive devices.

The Negotiated Service Agreement/Health Care Service Plans (NSA/HCSP) dated 5-27-16 and 12-1-6 recorded the following services: Assistance with dressing and undressing Assistance with toileting. Caregivers will provide

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pericare. (Note: HCSP dated 12-1-16 included toileting assistance before and after meals, before bedtime and every 2-3 hours during the night.)
Mobility escort to and from meals and activities.
Exit seeking at times and wears a personal watch for safety (Home Free System).
Verbal reminders and redirection when behavior is inappropriate.

The NSA/HCSP for 5-27-16 and 12-1-16 lacked interventions to address the resident's fall risk.

Nursing Progress Notes stated the following:

10-5-16 at 2:00 pm: "At Approximately 1:25 pm, this LPN (Licensed Practical Nurse) observed resident sitting on dining room floor. Legs fully extended, back to the wall, head leaned against wall. This LPN called CNA (Certified Nurse Aide) to assist...abrasion noted from middle to lower back...resident stated 'I was trying to stand up and sit back down.'" Signed by Licensed Staff D.

11-16-16 at 6:55 am: "Resident was found on the floor ground at this time. Stated that he/she hit head on the floor and twisted his/her right wrist..." Signed by unknown licensed staff.

11-17-16 (no time designated): "This writer called to resident's room by aide who noticed that resident was on the bedroom /bathroom floor on right side. It was apparent that he/she slipped on floor mat and attempted to hold on to grab bar but the bar broke away from the wall. His/her right hip is sore but range of motion reveals no apparent acute issues..." Signed by unknown licensed staff.

12-11-16 (no time designated): "At approximately

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6:00 pm this nurse was directed to resident's apartment by resident's (family member). Upon arrival, resident was seen lying on his/her back in doorway. Unable to state how he/she got to the floor..." Signed by Licensed Staff E.

12-12-16 (no time designated): "Resident had injury fall around 11:05 am. Resident struck head on bedroom door resulting in laceration to back of head...was sent to hospital for evaluation and treatment..." Signed by Licensed Staff F. Note: record lacked documentation of hospital treatment with the laceration closed with staples.

12-19-16 at 8:40 pm: "At approximately 7:30 pm, this writer was informed that resident was seen lying on the floor of his/her bedroom at the foot of bed..." Signed by unknown staff.

12-21-16 at 7:00 pm: "Physical Therapist notified this LPN that resident was lying on floor in apartment. This LPN observed resident lying on right side between bed and television. Resident stated, 'I thought it was time to eat so I got up but fell'..." Signed by Licensed Staff D.

1-7-17 (no time designated): "At approximately 2:30 pm this afternoon, resident noted laying next to bed on right side. When asked what happened, resident states he/she fell trying to get to restroom. His/Her shoes were untied. When stood up and sat on bed, complained of right hip pain. He/She kept repeating 'my right hip is broken.'...x-ray to right hip showed no fracture or dislocation but mild Osteoarthritis..." Signed by unknown staff.

1-18-17 at 5:30 pm: "This LPN witnessed resident tangle foot in a (another) resident's wheelchair wheel, lose balance and land on top of

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(resident) in wheelchair and roll off onto floor...small rugburn area noted to left elbow..."

1-20-17 at 6:00 pm: "Late Entry for 1-18-17 at 1:15 pm. This nurse was summed by CNA to hallway, noted resident on the floor...lying on right side in fetal position. When asked what he/she was doing, replied, 'going to my room'..." Signed by Administrative Nurse B.

1-24-17 at 6:30 pm: "At approximately 2:50 pm, CNA called this nurse to resident's room where he/she was laying on his/her back next to bed on carpeted floor. His/her pants were soiled with urine and feces. So CNA and I helped him/her to the bathroom and sat him/her on the stool. He/She was unable to sit up straight and when he/she tried using his/her left arm, he/she cried out in pain and cracking sound audible in shoulder area on left side...ambulance called...transferred to hospital" Signed by Licensed Staff G.

1-24-17 at 7:00 pm: "Call placed to hospital for update on resident, reports he/she will be admitted for left hip fracture..." Signed by Administrative Nurse B.

1-26-17 at 12:15 pm: "Spoke with nurse at hospital reports resident had open reduction internal fixation of left hip and left shoulder and is doing well at this time..." Signed by Administrative Nurse B.

The resident experienced 11 falls from 10-5-16 to 1-24-17. The 11th fall resulted in a fractured left hip and left shoulder.

Interviews on 2-22-17 at 12:15 pm and 4:16 pm with Administrative Nurse B stated the resident

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S3155	Continued From page 10 was currently out of the facility in rehab for a fractured hip and shoulder. Upon review of record, confirmed the resident experienced 11 falls from 10-5-16 to 1-24-17. Further confirmed the FCS identified the resident to be at risk for falling and the NSA/HCSP lacked documentation of interventions to address the resident's fall risk. Confirmed he/she failed to document a root cause analysis in an effort to address the cause of the resident's falls. For resident #1, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of this cognitively impaired resident's risk for falls when the resident experienced 11 falls from 10-5-16 to 1-24-17. The fall on 12/12/16 results in a laceration to the back of the head that required staples and the fall on 1-24-17 resulted in a fractured left hip and left shoulder.	S3155		