Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046052	A. BUILDING: _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LEAWOOD STATE LINE	12724 STATELINE ROAD LEAWOOD, 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 citations are the result of a survey for re-licensure with attached complaints conducted on 8/26/20, 8/27/20, 8/28/20, 9/1/20 and 9/2/20 at the above named assisted living facility in Leawood, KS.	S 000		
S 140 SS=D	26-39-103 (i) Resident Right Privacy and Confidentiality (i) Privacy and confidentiality. The administrator or operator shall ensure that each resident is afforded the right to personal privacy and confidentiality of personal and clinical records. (1) The administrator or operator shall ensure that each resident is provided privacy during medical and nursing treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. (2) The administrator or operator shall ensure that the personal and clinical records of the resident are maintained in a confidential manner. (3) The administrator or operator shall ensure that a release signed by the resident or the resident's legal representative is obtained before records are released to anyone outside the adult care home, except in the case of transfer to another health care institution or as required by law. This STANDARD is not met as evidenced by: The facility reported a census of 27 residents. The sample included 3 residents. Based on record review, interview and observation for resident #102, the operator failed to ensure each resident was afforded the right to personal privacy when a certified staff member took a picture of	S 140		

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

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the resident on a privately owned cell phone which ended up being received, viewed and shared with a person outside of the facility and not related to the resident.

Findings included:

- Record review for Resident #102 revealed admission on 5-22-15 with diagnoses Dementia, Chronic Pain, Anxiety, and Major Depressive Disorder.

The Functional Capacity Screen dated 2-28-20 revealed resident required health care services, Current problems/risks identified included falls/unsteadiness, wandering and impaired decision making.

The Negotiated Service Agreement dated 2-28-20 recorded services for assistance with activities of daily living for bathing, dressing, toileting, management of medications and management of medical treatment. Fall interventions include placing personal items within reach, reducing environmental clutter and arrange furniture for adequate walkways, proper fitting non slip footwear.

Resident #102's record contained a signed Kansas Resident Rights form dated 5/22/2015 which stated resident has the right to personal privacy and confidentiality. Photographic authorization and release form states photographs or electronic images may be used for the purpose of marketing, illustration, advertising. publication and promotion of the company's products and/or services.

Record review revealed that on 8/2/20 the resident experienced facial bruising with swelling

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to left forehead. Investigation conducted by Staff Nurse #B revealed resident was in apartment in bed during night checks. At 0530 resident was not in apartment and was found sitting on a chair in A hallway with injuries. No other residents were observed in the area. Documentation in resident record reveal that apartment doors were locked from outside. When door is locked a key must be used to enter apartment from the outside, but door is not locked on the inside and resident can open door from inside and exit at any time. No other residents were noted to be in area of resident's apartment during the night. Further investigation of apartment environment revealed spots of blood on comforter and on a clean incontinent brief laying on floor between residents' bed and a short but long dresser with square corners.

Confidential Interview #1 provided a copy of the photo and confirmed that it was taken at the facility by a certified staff member working on 9/7/2020. Confirmed he/she received the photo after it had been sent to 2 other non-certified former employees. Further confirmed he/she was not related to this resident or in any way legally responsible for the resident.

Inspection of the photo properties revealed it was taken via a personal IOS device on 8/7/2020 at 7:22 AM.

Interview with staff nurse #B on 8/26/2020 at 11:30 AM upon inspection of the photo, confirmed that it was of a current resident #102 and the facial bruising was consistent to injuries the resident sustained on 8/2/2020.

Confidential Interview #3 on 9/1/2020 at 1:54 PM confirmed he/she took the digital photo of the

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S 140	Continued From page 3 resident on his/her personal phone and without the resident's consent. Further confirmed the digital photo was shared with two other former employees and confidential interview #1. Review of staff education documentation regarding Abuse, Neglect, Exploitation and Resident Rights revealed the certified staff member had received training on these topics. Facility policy regarding confidentiality of information stated "It is our policy to ensure that the operations, activities and affairs of Brookdale and our residents, patients and clients are kept confidential to the greatest possible extent. If, during their employment, associates acquire confidential information about Brookdale or its residents, patients and clients, not otherwise available to persons outside of Brookdale such information is to be handled with strict confidence and is not to be discussed with outsiders. Associates are also responsible for the internal security of such information Texting or other immediate form of electronic communication, including iMessage, Facebook Messenger, SnapChat and others of Protected Health Information (PHI) is strictly prohibited ...PHI is any personal identifiable resident, patient, or client data ..." For Resident # 102 the operator failed to ensure each resident was afforded the right to personal privacy when a certified staff member took a picture of the resident on a privately owned cell phone which ended up being received, viewed and shared with persons outside of the facility and not related to the resident.	S 140		

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S3245	Continued From page 4	S3245		
S3245 SS=F	26-41-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: The census equaled 27 the sample included 3 residents. Based on interviews and review of facility records for 1 licensed staff (#C) the administrator failed to ensure the employee record contained supporting documentation of current licensure from Kansas State Board of Nursing upon hire. Findings included: - Review of personnel records on 8/26/20 for 3 certified staff and 1 licensed staff revealed the following: Licensed staff #C (hire date 7-5-19). KSBN current license verification completed on 8-5-19. (30 days late) Licensed staff record lacked documentation of verification of current licensure through Kansas State Board of Nursing.	S3245		

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S3245	Continued From page 5 Interview on 8/26/20 at 2:10 pm with facility administrator #A confirm staff records lacked documentation of KSBN licensure upon hire. For all residents of the facility, the administrator failed to ensure the employee record contained supporting documentation from the nurse aide registry, KS Board of Nursing and criminal background checks upon hire.	S3245		