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 _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LEAWOOD STATE LINE	12724 STATELINE ROAD LEAWOOD, KS 66209

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey with investigations #137760, #137738, #137761, #134743, and #133359 at the above named residential health care facility conducted on 1-30-19 and 1-31-19.	S 000		
S3028 SS=J	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)(B) The facility reported a census of 35 residents. The sample included 3 residents. Based on record review and interview for 3 (#1, #2, #3) of 3 sampled residents, the operator failed to report to the department within 24 hours and further failed to ensure immediate measures taken to prevent further potential abuse while an investigation was in progress. Staff reported potential resident to resident sexual abuse involving Resident #1 on 1-27-19 at 11:45 am. The operator failed put measures in place to prevent further potential abuse. This failure placed resident #2 in immediate jeopardy for harm or injury. Findings included: - Interview on 1-30-19 at 9:40 am with Administrative Staff A and Administrative Nurse B stated we "reported something from Sunday evening with a (resident) who was sexually inappropriate with some (other) residents." Administrative Staff A and Administrative Nurse B provided the following written documentation of the events which occurred on 1-27-19: (Note: the following reports were sent to the department on 1-29-19) (Resident #3) ...is alert to self with confusion to place and time. (Resident #3) ambulates independently without the use of an assistive device ...(Resident #1) is alert to self with confusion to place and time. (Resident #1 requires the assistance of one staff member for all dressing and grooming tasks and uses a wheelchair to propel self independently around the community ...On 1-27-19 at approximately	S3028		

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S3028	Continued From page 2 11:45 am, (Licensed Staff C heard (Resident #1) shouting for help. Resident #1 often does this intermittently as a way to get staff attention. When Licensed Staff C heart (Resident #1), he/she reported to his/her room to check on him/she but noted that he/she was not there. (Licensed Staff C) heard Resident #1 again and upon entry to another resident's room, observed Resident #1 sitting on a bed crying fully clothes with Resident #3 nearby, who was also fully clothed. Resident #3 walked out of the room and Licensed Staff C assessed and comforted Resident #1. Licensed Staff C asked Resident #1 if resident touched him/her and Resident #1 stated "No, I don't know, I just want to get out of here." Licensed Staff C assisted Resident #1 to his/her wheelchair and wheeled him/her out of the room into the hallway to take him/her to the dining room for lunch. While taking him/her to the dining room, Resident #1 said, 'He/she wanted to have sex.' Licensed Staff C stopped and asked him/her if Resident #3 said that to him/her and Resident #1 said he/she didn't remember what Resident #3 said, but knew Resident #3 wanted to have sex. Licensed Staff C took resident #1 to his/her table in the dining room where he/she stayed with the certified staff for lunch. Administrative Nurse B, physician, family, and Administrative Staff A notified of incident. Resident #1 was added by Licensed Staff C to alert charting where nursing will monitor for changes in mood, sleep, appetite and behaviors. Licensed Staff C notified staff to do rounds on Resident #3 at increased intervals and report any behaviors. " ...At approximately 5:00 pm on 1-28-19 (later confirmed to be a typo by Administrative Staff A. Incident occurred on 1-27-19), Licensed Staff C	S3028		

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S3028	Continued From page 3 was notified by Certified Staff D that while Resident #3's family was visiting and looking for him/her around the community, he/she was observed in another resident's room on his/her hallway by Certified Staff D. Upon entry to this apartment, Certified Staff D reported that when he/she walked in he/she observed Resident #3 standing without pants on, and Resident #2 on the bed without pants on. Certified Staff D verbalized for Resident #3 to stop and he/she immediately began to put his/her clothes on and left the room. Staff was assigned to stay with Resident #3 immediately until 1:1 staff reported to the community to sit with him/her for increased observation. Licensed Staff C assessed Resident #2 and asked him/her if he/she was hurt. He/she said no. Licensed Staff C asked Resident #2 if Resident #3 had taken him/her out of his/her wheelchair and put him/her in that bed, Resident #2 said yes. Licensed Staff C asked Resident #2 if Resident #3 had taken his/her clothes off, Resident #2 said yes. Licensed Staff C asked Resident #2 if Resident #3 had touched him/her anywhere, Resident #2 said yes, with his/her hand. Licensed Staff C asked if Resident #3 had touched him/her with his/her (genitalia) and Resident #2 said no. Licensed Staff C immediately called Administrative Nurse B, Administrative Staff A and the police to notify and report the incident ..." - Record review for Resident #1 revealed admission on 7-4-17 with diagnoses: Unspecified sequelae of nontraumatic intracerebral hemorrhage, dysphagia, type 2 diabetes mellitus, major depressive disorder, muscle weakness, gastro-esophageal reflux disease, chronic kidney disease, hyperlipidemia, hypertension and low back pain.	S3028		

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S3028	Continued From page 4 The Functional Capacity Screen dated 10-9-18 recorded resident required physical assistance with bathing dressing, toileting, transfer and walking/mobility; supervision of eating; unable to perform management of medications and treatments. Incontinent of bladder. Cognition: problems with long term memory and memory/recall. Current problems/risks included falls, wandering and impaired decision-making. Uses a wheelchair. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-9-18 recorded staff to administer medications and monitor blood sugars, to receive regular diet (per managed risk agreement) and thickened liquids. Facility staff to assist with bathing, dressing, and toileting. Requires 1 staff for transfers and resident self-propels wheelchair around the facility. Exhibits exit seeking behaviors, staff to redirect. Resident is alert to self with confusion to time and place. Nursing Progress Notes for Resident #1 stated: 1-27-18 at 7:23 pm: "At approximately 11:45 am this nurse was in the nurses station and heard resident call "help" and this nurse went to his/her room but he/she wasn't in room/ I heard him/her call help again and this nurse called out, 'where are you ...' and the resident yelled 'In here' which came from the room I was walking past, another resident's rom. When I opened the door, resident was seated on the bed fully clothed and crying and a male resident was standing there fully clothed nest to the bed and resident's wheelchair. I asked (Resident #3) to leave the room and then consoled Resident #1 and asked him/her what happened and if he/she had touched him/her to which he/she responded 'no, I don't know, I just	S3028		

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want to go out of here.' I assessed Resident #1 for any signs that he/she had been touched or injured, his/her clothes were intact, non-rumpled, dry, there were no visible signs of injury or marks on his/her skin. I assisted Resident #1 to his/her wheelchair and wheeled him/her out of room into the hallway to take him/her to the dining room for lunch. While taking him/her to the dining room, Resident #1 said, 'he/she wanted to have sex'. I stopped and asked him/her if he/she said that to him/her and he/she said he/she didn't remember what Resident #3 said but he/she knew Resident #3 wanted to have sex. I took Resident #1 to his/her table in the dining room where he/she stayed with the (certified staff) for lunch. Administrative Staff A and Administrative Nurse B notified. Will monitor for any distress." Signed by Licensed Staff C.

Observation of resident on 1-30-19 revealed him/her to be friendly and pleasantly confused. Propels self around facility talking frequently, looking for family members and wanting to leave.

- Record review for Resident #2 revealed admission on 7-5-13 with diagnoses: Dementia with Behavioral Disturbance, Major Depressive Disorder, Alzheimer's Disease, Dry Eye Syndrome, Cardia Pacemaker, Peripheral Vascular Disease and Anemia.

The Functional Capacity Screen dated 10-27-18 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; supervision with eating; unable to perform management of medications and treatments. Incontinent of bladder. Cognition: problems with long- and short-term memory and decision-making. Current problems included:

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wandering. Uses wheelchair.

The Negotiated Service Agreement/Health Care Service Plan dated 10-27-18 recorded staff to administer medications. Facility staff to assist with bathing, dressing, and toileting. Requires 1 staff for transfers and resident self-propels wheelchair around the facility. Resident is alert to self and able to make needs known.

Nursing Progress Notes for Resident #2 stated: 1-27-19 at 9:30 pm: "At 5:00 pm this evening, Certified Staff D called this nurse on the radio and said he/she was looking for (Resident #3), that his/her family was here and they and he/she had not been able to find him/her within 10 minutes of looking. I advised him/her that I would start searching rooms on hall where I was and he/she was searching rooms on hall where he/she was. About 1-2 minutes later, Certified Staff D called over the radio urgently requesting this nurse to come to a room as soon as possible. This nurse ran to room and when I opened the door, Certified Staff D was there telling (Resident #3) to put his/her pants on, (Resident #3) was naked from the waist down and (Resident #2) was laying in the bed naked from the waist down with his/her brief, pants and shoes piled at the end of the bed. Certified Staff D told this nurse that when he/she opened the door, Resident #2 was in the bed naked from the waist down and Resident #3 was naked from the waist down and was leaning over in motion to straddle Resident #2 when he/she interrupted him/her. I told Certified Staff D to take Resident #3 out of the room and I stayed in the room with Resident #2. I asked Resident #2 if he/she was hurt, he/she said no. I asked if Resident #3 had taken him/her out of wheelchair and put him/her in that bed, Resident #2 said yes. I asked Resident #2 if Resident #3 had taken

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S3028	Continued From page 7 his/her clothes off, he/she said yes. I asked Resident #2 if Resident #3 had touched him/her anywhere, he/she said yes. I asked Resident #2 if Resident #3 touched his/her (genitalia) with his/her hand, his/her (genitalia) or any part of his/her body and Resident #2 said yes, with his/her hand. I asked if Resident #3 had touched him/her with his/her (genitalia) and Resident #2 said no. I called Administrative Nurse B, Administrative Staff A and the police. While waiting for the police, I assessed Resident #2 from head to toe for any injury or any evidence that he/she had been assaulted, none noted ..." Signed by Licensed Staff C. Observation on 1-30-19 of resident, sitting in wheelchair in dining room. Quiet. Answers slowly when asked simple questions, stated he/she was "fine." Staff report resident will not initiate conversation but will respond when spoken to and is able to make needs known. - Record review for Resident #3 revealed admission on 1-2-19 with diagnoses: Alzheimer's Disease, Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease, Hyperlipidemia, Hypertension, Gastroesophageal Reflux Disease and Unspecified Sequelae of Cerebrovascular Disease. The Functional Capacity Screen dated 1-4-19 recorded resident required physical assistance with bathing and management of medications and treatments; supervision of dressing, toileting, transfers, walking/mobility, eating; and independent with eating. Continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and	S3028		

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decision-making. Current problems/risks included falls/unsteadiness, wandering and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan dated 1-2-19 recorded staff to administer medications and perform blood sugar monitoring. Facility staff to assist with bathing, dressing (cueing/set up), and toileting (cue and escort). Resident wanders, sleeps at intervals and has been up at night ...is exit seeking, has difficulty staying in one place.

Addendum to NSA dated 1-28-19 stated:
How needs have changed: Resident displayed sexual behavior.
Changes in services: 1:1 in place to monitor behaviors and report to charge nurse as needed; Busy box to give resident purposeful activities as needed; Onesie ordered to deter sexual behavior. (one-piece garment that zips in the back); Primary care provider contacted regarding medication adjustment; staff educated to monitor and report behaviors as needed.
Note: the addendum signed by Administrative Staff B. The addendum lacked signature of resident's responsible party.

Nursing Progress notes for Resident #3 stated:
1-27-19 at 10:00 pm: "At 5:00 pm this evening, Certified Staff D called this nurse on the radio and said he/she was looking for (Resident #3), that his/her family was here and they and he/she had not been able to find (Resident #3) within 10 minutes of looking. I advised him/her that I would start searching rooms where I was and he/she was searching rooms where he/she was. About 1-2-minutes later, Certified Staff D called over the radio urgently requesting this nurse to come as soon as possible. This nurse ran to room and

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when I opened the door, Certified Staff D was there telling (Resident #3) to put his/her pants on. Resident #3 was naked from the waist down and Resident #2 was laying in the bed naked from the waist down with his/her brief, pants and shoes piled at the end of the bed. Certified Staff D tole this nurse that when he/she opened ed the door, Resident #2 was in the bed naked from the waist down and Resident #3 was naked from the waist down and was leaning over in motion to straddle Resident #2 when he/she interrupted him/her ...While waiting for the police to arrive, I place Resident #3 on 1:1 with a CNA (certified nurse aide) until a 1:1 sitter could come to the facility. Two of the resident's family members were here in the facility, they had been called by another family member that had been here during the incident and had left ...I advised them of the situation. The family members were also present in Resident #3's room with this nurse and the police officers and Resident #3 while they asked him/her questions. Resident #3 was unable to respond to any questions appropriately as is his/her baseline since he/she has been in the facility. This nurse assessed Resident #3 and there were no noted changes to his/her behaviors or mood." Signed by Licensed Staff C.

Observation of resident on 1-30-19 during group activities revealed him/her to be smiling, alert, friendly, likes to joke with staff. Ambulatory without assistive devices. Agency staff member arrived at 11:00 am to sit with resident. Was able to engage resident in painting activity with sitter.

Interview on 1-30-19 around 11:00 am with Administrative Staff A stated sitters comes from a local agency. The agency provides sitters (companions) for the resident 7 days a week.

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Stated facility staff monitored the resident the first 2 hours after the incident on 1-27-19 at 5:00 pm. Then the agency provided a sitter for 48 hours continuously. The agency sitter "left at 8 pm yesterday 1-29-19" and facility staff monitored resident overnight. Starting Wednesday (1-30-19) agency provided a sitter 11 am to 8 pm. Stated they had contacted resident's physician regarding medications but that they physician had not provided any new medications at this time. Further stated the "onesies" have been ordered but have not yet arrived so are also not in use at this time.

Interview on 1-30-19 at 12:35 pm with Certified Staff D confirmed he/she had worked on 1-30-19 from 7 am to 7 pm and observed the incident at 5:00 pm. Denied witnessing the incident at 11:45 am and stated the nurse informed him/her of the 11:45 incident "briefly" but failed to give instructions to monitor Resident #3. Stated he/she did not know the incident at 11:45 am was sexual in nature, "I knew they took one of the resident's out of a room that he was with, but I didn't know he/she was trying to have sex with him/her". Stated Resident #3 is always trying to be helpful the other residents, will push someone's wheelchair. Confirmed he/she did 1:1 monitoring of the resident from 5 pm until 7 pm.

Interview on 1-30-19 at 1:06 pm with Certified Staff E stated he/she did not observe the incident at 11:45 am but heard over the walkie that Resident #3 was found in another resident's room with Resident #1 on the bed and Resident #1 was screaming for help. Stated he/she was instructed by Licensed Staff C to keep and eye on Resident #3, to make sure to watch because Resident #3 hadn't been here that long. Stated his/her shift ended at 2:00 pm and he/she did not report off to

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anyone when he/she left.

Interview on 1-30-19 at 4:14 pm with Certified Staff F confirmed he/she was instructed to "check (Resident #3) every hour to see how he/she's doing after the incident at 5:00 pm with Resident #2, but otherwise had not heard about the incident that occurred at 11:45 am with Resident #1.

Interview on 1-30-19 at 4:20 pm with Licensed Staff C confirmed his/her documentation of the events in the resident's records. Stated he/she had spoken face to face with Certified Staff D in the dining room and another CNA but could not remember who the second staff member was. Confirmed he/she could not remember talking directly to any other staff regarding monitoring of the residents. Stated after the incident at 11:45 am, he/she asked staff to monitor and make sure Resident #1 was doing ok and confirmed he/she did not ask facility staff to closely monitor Resident #3 as he/she was difficult to watch because he/she is "all over the building all of the time. He/She walks the halls, paces back and forth ..." Licensed Staff C reported that he/she saw Resident #3 "periodically during my shift" but that they focused more on Resident #1. Stated he/she did not know the last time he/she had observed Resident #3 prior to the incident with Resident #2 at 5:00 pm. Confirmed he/she failed to take immediate actions regarding Resident #3 to protect the other residents in the facility. Stated he/she performed a "survey of discomfort" as instructed by Administrative Staff A to determine a possible cause of the change in behavior.

Interview on 1-31-19 at 2:15 pm with representative from the local agency providing 1:1 sitter/companion for resident #3 stated they

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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
S3028	Continued From page 12 started providing a sitter at 8:00 pm on Sunday, 1-27-19 and continuously until Tuesday 1-29-19 at 6:00 pm. On Wednesday, 1-30-19, a sitter was provided from 11:00 am until 8:00 pm. Stated this morning, the facility called and requested 1:1 sitter for 24 hours. The facility failed to report an allegations of abuse within 24 hours. The facility further failed to take immediate measures to protect other residents including Resident #2 and ensure prevention of further potential abuse while the investigation was in progress. For Residents #1 and #2, the operator failed to ensure an allegation of abuse was reported to the department within 24 hours, and failed to ensure immediate measures were taken to prevent further potential abuse while the investigation was in progress and ongoing. These failures placed other residents including Resident #2 in immediate jeopardy for harm or injury. The jeopardy was removed on 1-31-19 when staff began 1:1 monitoring of Resident #3.when facility reinstated 24 hour 1:1 care.	S3028		