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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 a resurvey with complaint investigations #128394, #129221, #130092 at the above named residential health care facility conducted on 7-25-18, 7-26-18, 7-30-18, 8-1-18 and 8-2-18.	S 000		
S3026 SS=J	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: KAR 26-41-101(f)(1)(B) The facility reported a census of 37 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 1 (#304) of 3 sampled residents, the operator failed to ensure the cognitively impaired resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure this resident's safety and well-being and to avoid harm when Resident #304 reported he/she had a fall on 4-4-18 during the night. Night shift certified staff failed to report the resident's fall or complaint of pain. When day shift licensed staff assessed the resident and received an order for an immediate x-ray of resident's hip, the licensed staff failed to seek	S3026		

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

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immediate medical care for the resident after the initial assessment. The resident was not sent to the hospital for evaluation until 11 hours later at which time he/she was transported to the hospital and admitted with diagnosis of left hip fracture. These failures placed resident #304 in immediate jeopardy for harm, injury or death.

Findings included:

- Record review for resident #304 revealed admission on 5-6-16 with diagnoses Dementia, Meniere's Disease, Glaucoma, Asthma, and Anxiety.

The Functional Capacity Screening dated 2-5-18 for a significant change recorded resident required physical assistance with bathing, supervision of dressing, toileting and eating; and independent with transfers and walking/mobility. Cognition: problems with long term memory and memory/recall. Current problems/risks identified: Falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making, and wandering.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 2-5-18 recorded the following services:
Escort/Mobility: Personalized interventions included: "Ambulates independently with use of a walker. Requires cueing and supervision to get and from meals and activities due to memory impairment and vision deficits. Has a history of falls. Staff to monitor for dizziness related to Meniere's Disease and utilize prn (as needed) meclizine as ordered." May also use wheelchair as needed for increased weakness.
Cognitive/Psychosocial: " ...resident does wander at times, more during the early morning or late

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hours, staff to redirect as needed.
Behavior Management: "Has increased anxiety at times during the day. Requires redirection and reassurance from staff. Has difficulty remembering where room is at . ."

Resident Logs stated the following:
4-4-18 at 8:45 am: "Resident complained of pain to left side in hip and pelvic area. When sitting, no pain. When standing (pain rated) 10 of 10. Resident advised aides that he/she fell through night and aide (who) assisted him/her stated he/she would inform nurse. Nurse on shift has no recollection of that, contacted physician and he/she ordered x-ray stat (immediately). Contacted (x-ray company) ..." Signed by Licensed Staff D.
4-4-18 at 4:29 pm: "Contacted (x-ray company) in regards to x-ray order, spoke with representative who advised he/she has to contact technician, placed on hold, came back and advised will call with estimated time of arrival." Signed by Licensed Staff D.
4-4-18 at 6:30 pm: "Contacted (responsible party, advised that resident still complaining of pain at touch and will not stand. Advised that (x-ray company) still not arrive and if physician approve would he/she be okay with being sent out for x-ray. (Responsible party) voiced understanding and advised if absolutely necessary to send out ..." Signed by Licensed Staff D.
4-4-18 at 6:35 pm: "Physician okay with sending him/her out. Contacted (responsible party) and advised that we were sending (resident) out, (responsible party) voiced that was okay." Signed by Licensed Staff D.

The record lacked documentation of ongoing assessments of resident including pain assessment, refusal of meals and toileting.

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S3026	Continued From page 3 Review of Medication Administration Record for April 2018 revealed resident received acetaminophen 325 mg (milligrams), 2 tablets (650 mg). routinely on 4-4-18 at 7:58 am. The record lacked documentation of effectiveness of the medication or administration of any other medication for pain. Note: resident admitted to hospital with left hip fracture and had surgery to repair the fracture. Hospital Discharge Summary: Admission Date 4-4-18. Reason for Visit: Left Hip Fracture. Hospital Course: "The patient ...brought to the emergency department by emergency medical services from a nursing (facility) status post fall complaint of left hip pain ..." Observation of resident on 7-26-18 at 11:40 am revealed resident sitting in wheelchair in a common area. Oriented to person and place. Recognized and referred to another resident by name. Resident stated, "I can't walk, I'm not supposed to ...my hip hurts, I've broken my hip, it hurts whenever I do anything. Interview on 7-26-18 at 10:15 am with Administrative Staff A and Licensed Staff B stated Resident #304 had a fall with fracture around the first week of April that had been reported to the department and provided a copy of the report. The report stated: "At approximately 7:30 am on 4-4-18 CNA (Certified Nurse Aide) on day shift went to the resident for breakfast. At this time, resident reported that he/she was not feeling well and had pain. CNA reported this to charge nurse after leaving resident's room. Charge nurse assessed and resident was unable to report pain	S3026		

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on the pain scale due to cognitive impairment, but did not want to get up for breakfast which was out of character ...resident reported to charge nurse that during the night, he/she fell, but could not remember how, but has been in pain since. Charge nurse administered morning medications, did a full body assessment and called resident's primary care physician. Upon further assessment by charge and aide, resident was not able to put pressure on left leg when assisted to the bathroom by staff ...charge nurse unable to perform range of motion ...received order for STAT (immediate) x-ray of left hip due to constant pain. Charge nurse notified (family member) of incident and both agreed that if pain continued to increase before x-ray was performed, resident would be sent to hospital for further evaluation ...charge nurse follow up with x-ray company twice during the day with no ability to get a time of arrival for x-ray technician ...evening medications which included Tylenol for pain were given at this time. Due to (resident) not wanting to go for meals that day and continued complaints of pain, charge nurse called 911 to transport him/her to the hospital at approximately 6:35 pm ...(facility) received report from resident's legal representative that tests concluded that resident would have surgery the next day due to left hip fracture ...upon investigation ...it was noted that overnight aide (Certified Staff Q) assisted resident to complete activities of daily living. After these tasks were completed, Certified Staff Q stated that resident complained of pain but was able to assist with activities of daily living. After these tasks were completed, Certified Staff Q was abruptly called from the room to assist with another resident which caused him/her to be distracted and he/she did not report residents pain to the charge nurse at that time. Pain was reported by Certified Staff I on day shift at 7:40

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S3026	Continued From page 5 am ..." Certified Staff Q written statement provided by facility (date unknown): I last saw Resident #304 at 5:50 am when I went into his/her apartment and found him/her lying on his/her bed. At that time I assisted him/her to the restroom to get dressed. Resident expressed to me that he/she was feeling pain in his/her leg but was able to get to the restroom and participate in getting dressed. Resident also said that he/she had fallen through the night. I was skeptical that he/she could get self up from the floor after a fall and I knew that myself and co-workers had not helped him/her get up off the floor at any time during the night. As I was helping him/her, he/she presented like he/she was feeling some pain, but it did not seem extreme or excessive because he/she was participating in his/her care. I am aware of the policy to report such a complaint to the charge nurse, and I intended to do so. I was abruptly called from resident's apartment to assist with another resident and this distracted me from telling the charge nurse before the end of my shift ..." Administrative Staff A and Licensed Staff B confirmed the record lacked documentation of Licensed Staff D follow up calls to the x-ray company to determine when the x-ray would be completed, any notification of the resident's physician that the x-rays had not been done and the resident's continuing to complain of pain. Confirmed the resident was not sent to the hospital until 11 hours later despite resident's continuing complaints of pain. Stated the certified staff on night shift who failed to report the incident to the nurse was counseled. For resident #304, the operator failed to ensure	S3026		

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S3026	Continued From page 6 the cognitively impaired resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure this resident's safety and well-being and to avoid harm when resident #304 experienced a fall during the night with resulting pain and decreased mobility. Certified staff failed to report the incident to a nurse. When day shift licensed staff assessed the resident and received an order for a STAT x-ray of resident's hip, the licensed staff failed to seek immediate medical care for the resident when mobile x-ray failed to respond in a timely manner. The resident was not sent to the hospital for evaluation until 11 hours after the licensed nurse assess the resident. Resident #304 was admitted to the hospital with a diagnosis of left hip fracture. These failures placed resident #304 in immediate jeopardy for harm, injury or death. The jeopardy was removed on 4/4/18 when the resident was transferred to the hospital.	S3026		
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	S3028		

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S3028	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C) The facility reported a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 2 (#209, #415) of 3 sampled residents, the operator failed to ensure each allegation of abuse was be reported to the department within 24 hours, an investigation started when the operator received notification of the alleged violation and immediate measures taken to prevent further potential abuse while the investigation is in progress. Staff reported potential resident to resident sexual abuse on 4-25-18. The operator failed to report, thoroughly investigate and put measures in place to prevent further potential abuse. These failures placed resident #415 in immediate jeopardy for harm or injury. Findings included:	S3028		

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S3028	Continued From page 8 - Interview during entrance tour on 7-25-18 at 10:11 am with Administrative Staff A and Licensed Staff B stated there was a "rumor situation" in which a staff member had stated he/she heard from somebody else that they saw Resident #415 "undressed with another resident" and they were witnessed to have had a sexual interaction. Another staff had reported seeing a brief in Resident #209's room that belonged to Resident #415. Administrative Staff A and Licensed Staff B stated they "looked into it, asked questions and performed a full head to toe assessment" of Resident #415. Confirmed they did not report the allegation to the department when it was first brought up by staff in April. - Record review for resident #209 revealed admission on 11-1-17 with diagnoses Dementia, Type 2 Diabetes Mellitus, Hyperlipidemia, Hypertension, and Spinal Stenosis. The Functional Capacity Screening dated 12-31-17 recorded resident required supervision of toileting; and independent with dressing, transfers, and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included impaired vision and hearing. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 12-31-17 recorded staff assistance with toileting (reminders, verbal cueing and staff to ensure changing of briefs); ambulates independently; reluctant to accept care at times. Behavior Management: (has been observed trying to exit	S3028		

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building on several occasions, has moments of agitation.) The NSA/HCSP lacked interventions to address resident's attempts at helping other residents toilet, transfer and putting on clothing protectors in dining room.

- Record review for Resident #415 revealed admission on 7-4-17 with diagnoses Type 2 Diabetes Mellitus, Major Depressive Disorder, Chronic Kidney Disease, Hypertension, Muscle Weakness, Low Back Pain and Anxiety.

The Functional Capacity Screening dated 4-10-18 recorded resident independent with transfers, walking/mobility, eating; supervision of toileting; and physical assistance with dressing. Frequently incontinent of bladder. Cognition: problems with short term memory, long term memory and memory-recall. Current problems/risks included falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making and wandering.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-9-18 recorded staff assistance with dressing (requires 1 staff related to inability to stand independently during dressing task) and physical assistance with toileting (related to inability to stand independently). Staff assist of one for transfers. At times due to weakness, will need two staff for transfers. Uses wheelchair. Able to propel self around community. Has had multiple recent falls. Alert to self with confusion to date and time. Typically, easy to redirect. Can have moments when not sure where he/she is or where his/her room is. Staff to show pictures around room and help him/her realize he/she is in own apartment. Exit seeking, requires redirection from doors.

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S3028	Continued From page 10 Resident Log stated: 6-20-18 at 8:00 pm: "Nurse was told of a fall occurring with the resident. A resident wheeled (Resident #415) into another resident's room and tried to help him/her get up out of his/her wheelchair. Nurse assessed Resident #415 and there were no signs of bruising or injuries at this time ...Educated both resident on not getting out of wheelchair/helping people get up." Signed by Licensed Staff G. Administrative Staff A provided a written statement as follows: "On April 25, (Certified Staff L)...said 'he/she had heard" that Resident #415 and Resident #209 were unclothed in Resident #209's apartment. He/She could not remember who he/she had heard this from but to talk to Certified Staff M and Certified Staff N and Certified Staff O because they had information. I spoke to each of them as well as several other associates who worked over the past several days and the only information they could provide is they heard Certified Staff L saying that he/she had heard that information. I asked each of them directly if they saw anything with their own eyes, and none of them had...With such indirect information and no physical witness after speaking to every associate who had worked over the last day, we agreed that this was simply gossip and educated Certified Staff L as well as other associates on importance of proper reporting when there are resident concerns versus controlling rumors and gossip in the community...we were not concerned about the possibility of any kind of abuse or of any kind of sexual relationship happening between the two residents and for this reason we chose to monitor their interactions in the community and where	S3028		

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they spent time but did not believe it was necessary to report an allegation of abuse or investigate further. We also did not believe it would be necessary to alert responsible parties or to document in the medical record.

On April 27th Certified Staff P reported to me that he/she found a soiled brief in Resident #209's trash can that he/she believed to match the briefs that Resident #415 wears. Licensed Staff C and I investigated - we spoke to both Resident #415 and Resident #209 and neither of them reported anything that indicated they'd had any time together, or that they were engaged in any kind of romantic or sexual activity. We informed both Resident #415 and #209's responsible parties...Licensed Staff C assessed Resident #415's perineal region for any indications of sexual activity or molestation and found nothing noteworthy about the condition of the area...we did not believe it was necessary to report this concern to the State of Kansas because our initial investigation did not warrant any suspicion of abuse or of a sexual relationship. We did not believe that it was necessary to document this occurrence in the medical record."

Department records show facility reported 4-25-18 incident on 6-8-18 stating that the police department came to investigate on 6-5-18.

Facility report to the department received on 6-8-18 stated: "On 6-5-18 a police detective arrived to (facility) and asked to speak with the executive director about a reported incident involving resident #415 and Resident #209...the report does not match anything that has been reported within community. Administrative Staff A and Licensed Staff B reviewed shift reports, and questioned associates who had worked with

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either resident in the last several days and still found nothing reported...concluded that there was nothing further to investigate..."

The facility failed to report an allegation of abuse when it was initially heard on 4-25-18 and failed to document the investigation including obtaining written statements from all staff. The facility further failed to take immediate measures to protect Resident #415 and ensure prevention of further potential abuse while the investigation was in progress. After the visit from the police officer on 6-5-18, the facility again failed to report the allegation of abuse to the department within 24 hours.

Confidential Interview #2 written statement: "On or about 3 months ago I witnessed (#209) have (#415) in his/her room with his/her pants down. I told him/her that he/she cannot have him/her in his/her unit. After that I went straight to Licensed Staff C and reported what I saw and told the aide that was working that hall that day. Confidential Interview #2 stated Resident #209 "had Resident #415 standing up with his/her pants down." Resident #209 was dressed, wearing pajama pants and a tee shirt.

Confidential Interview #3 written statement: "(Resident #415) was sitting on (Resident #209) bed with his/her pants and brief at his/her ankles. Resident #209 had his/her hands at his/her waist band standing near the bed turning to look at the door as I walked in. I asked Resident #415 if he/she was okay, #415 said 'I want to go.' I got Resident #415 dressed and put in his/her wheelchair...it was reported to Licensed Staff B between December and February...I went to Resident #209's room in the morning. As I pulled new clothes out for #209 I saw a shirt of Resident

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#415's and a pair of jeans hanging in his/her closet. Reported to Administrative Staff A 2-3 weeks ago."

Confidential Interview #4 stated he/she has reported "numerous times" about Resident #209 and #415. "Any time I don't see Resident #415, I know he/she is in Resident #209's room the majority of the time." Stated he/she has observed and reported Resident #209 trying to transfer Resident #415 to the toilet. "He/She does that a lot, tries to help him/her." Stated he/she has seen Resident #415 in Resident #209's room with his/her pants half down. "I take care of him/her all the time, Resident #415 is not capable of pulling his/her pants down." Stated there was one incident in which Resident #415 was in Resident #209's room, "I took him/her to the bathroom and his/her brief was gone. The same type of brief was in Resident' #209's trash can. Resident #415 had on a tabbed brief that day. That's the day they checked him/her for sexual assault."

Confidential Interview #5 stated there were two times he/she had gone into Resident #209's room and Resident #415 was in the bathroom using the toilet. Stated Resident #415 used to live on that hall and he/she goes down there then resident #209 invites him/her into room. Stated Resident #415 has stated that Resident #209 will take his/her pants down and put him/her on the toilet. "I feel like Resident #209 is trying to help Resident #415, other times I'm not sure of the intentions."

Interview on 7-26-18 at 5:08 pm with Administrative Staff A stated after Certified Staff L made the comment during the stand-up meeting on 4-25-18 about seeing Resident #415 naked in

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Resident #209's room, "we pulled him/her aside went over proper reporting. Confirmed, "I did not report" the allegation to the department. Further stated when staff notified him/her of the dirty brief found in Resident #209's trash which they felt belonged to Resident #415, asked Licensed Staff C to look at resident's peri area for signs of abuse. Confirmed "we failed to properly document that, I failed to ensure proper documentation of the incident and assessment." Confirmed he/she did not think Resident #415 would be able to stand and remove own brief. Also did not think Resident #209 could remove the brief from the resident. Confirmed he/she failed to get written statements from all staff. In response to question regarding how have staff been educated to keep residents separated, Administrative Staff A stated, there's a "general understanding to keep them separate but no line divided in our community. We monitor but don't keep them completely separate."

Interviews with staff confirmed after the police visit on 6-5-2018 they had been told to monitor the residents. Resident #209 was sent to the behavior unit on 7-27-18 due to an aggressive incident with another resident.

For Residents #209 and #415, the operator failed to ensure an allegation of abuse was reported to the department within 24 hours, an investigation started and documented when the operator received notification of an alleged violation and failed to ensure immediate measures were taken to prevent further potential abuse while the investigation was in progress and ongoing. These failures placed resident #415 in immediate jeopardy for harm or injury.

The jeopardy was removed on 7-27-18 when

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S3028	Continued From page 15 resident #209 left the community. On 8-1-18, the operator provided the following plan: 1.We will immediately contact [the behavior unit] and request [#209] be put on Estrogen and / or other libido decreasing medications. 2.Prior to readmission to the community, HWD will contact DPOA requiring the following: - No family members / friends / visitors will give non prescribed medications or alcohol to #209. #209 will also not be given alcohol in community. - 24 hour 1:1 care will be required upon readmission to community. - 1:1 caregiver must be a non family member. 3.We encourage family members to visit #209 in community, but not take him out of the community during this evaluation period. 4.HWD will reassess in 2 weeks for behaviors and discuss with family 1:1, either continuing 24 hours or being titrated down based on assessment. 5.Upon return to the community, #209 will have ongoing assessments for any aggressive and sexual behaviors. HWD will evaluate at such time. If behaviors are exhibited, week to week assessment by HWD and medical professionals will continue until resident does not exhibit behaviors. 6.HWD will continue to evaluate weekly over the next 60 days for any aggressive and / or sexual behaviors. HWD will provide interventions based on assessment.	S3028		
S3155 SS=E	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	S3155		

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S3155	Continued From page 16 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 37 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 1 (#304) of 3 sampled residents and 1 (#500) of 1 closed record reviews, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of the residents and are in accordance with the functional capacity screening and the negotiated service agreement to address the resident's fall risk. Findings included: - Record review for resident #304 revealed admission on 5-6-16 with diagnoses Dementia, Meniere's Disease, Glaucoma, Asthma, and Anxiety. The Functional Capacity Screening dated 6-5-18 upon return from rehab recorded resident required physical assistance with bathing, dressing, and management of medications/treatments; supervision of toileting and eating; and independent with transfers and	S3155		

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walking/mobility. Cognition: problems with memory/recall and decision-making. Current problems/risks identified: Falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making, and wandering.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-5-18 recorded the following services:
Escort/Mobility: Resident uses a cane as a mobility aid. Resident uses a walker as a mobility aide. Personalized interventions included: "Ambulates independently with use of a manual wheelchair. Requires cueing and supervision to get and from meals and activities due to memory impairment and vision deficits. Has a history of falls. Staff to monitor for dizziness related to Meniere's Disease and utilize prn (as needed) meclizine as ordered."
Cognitive/Psychosocial: " ...resident does wander at times, more during the early morning or late hours, staff to redirect as needed.
Behavior Management: "Has increased anxiety at times during the day. Requires redirection and reassurance from staff. Has difficulty remembering where room is at as well as where he/she likes to sit at meal times."

The HCSP lacked documentation of personalized interventions to address resident's fall risk. The record lacked documentation of root cause analysis to identify possible causes of falls and personalized interventions to address the causes including instructions for anticipation of resident's needs.

Resident Logs stated the following:
Note: resident admitted to hospital on 4-4-18 with left hip fracture and had surgery to repair the fracture. Resident went to rehab afterwards and

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returned to the facility on 6-5-18.
6-5-18 at 6:15 pm: Resident returned to community via community transport. Mobility per wheelchair. Alert and oriented times one. Family present ...time of arrival 11:45 am. This evening resident with increased anxiety at dining table. 1:1 direction no help, repeating "no one is here to see us!" Resident cooperative with oral medication ...Signed by Licensed Staff E.
7-7-18 at 6:30 am: "Observed on floor by bed. Could move all extremities without any pain didn't really know what happened except stated was going to the bathroom, and also stated 'I didn't hit my head' ..." Signed by Licensed Staff E.
7-17-18 at 4:32 am: "At around 4:00 am, (staff member) was doing rounds and heard (resident) calling out for help. (Resident) was laying flat on back, shoes on fully dressed in pajamas. Dry and continent at the time. Unable to describe how it came to be that he/she was on the floor. Abrasions to both left and right elbows ...assisted back to bed. (Resident) was found laying parallel next to the bed." Signed by Licensed Staff F.

Observation of resident on 7-26-18 at 11:40 am revealed resident sitting in wheelchair in a common area. Oriented to person and place. Recognized and referred to another resident by name. Resident stated, "I can't walk, I'm not supposed to ...my hip hurts, I've broken my hip, it hurts whenever I do anything.

Interview on 7-25-18 at 3:35 pm with Licensed Staff B confirmed the record lacked documentation or personalized interventions to address resident's fall risk. Stated several of the items listed under Escort/Mobility are simply options which can be selected. Stated resident does not use a cane and primarily utilizes a wheelchair now. Confirmed the record lacked

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documentation of a root cause analysis of resident's falls in an effort to determine and address the cause of his/her falls.

For Resident #304, the operator failed to ensure the licensed nurse provided or coordinated the provision of health care services to address the resident's fall risk.

- Record review for Resident #500 revealed admission on 4-4-18 with diagnosis of Lewy Body Dementia, Hypertension, Depression, and Senile Dementia Probable Alzheimer's Type. Resident had history of falls with a pelvic fracture prior to admission.

The Functional Capacity Screening dated 4-5-18 for admission recorded resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility; supervision with eating and unable to perform management of medications/treatments. Occasionally incontinent of bladder. No problems with cognition. Current problems included: falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-4-18 recorded services for staff assistance with bathing (one staff, cueing); Staff to administer medications; texture modified diet; assist of one staff with dressing; self propels with wheelchair. Alert to self with some confusion to time and place. Has some difficulty with safety awareness and should be encouraged to attend programming as tolerated. Behavior Management: "Aside from safety awareness, does not currently display any behaviors." The NSA/HCSP lacked signature of

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S3155	Continued From page 20 responsible party. The HCSP lacked documentation of personalized interventions to address resident's fall risk. The record lacked documentation of root cause analysis to identify possible causes of falls and personalized interventions to address the causes including instructions for anticipation of resident's needs. Resident Log: 4-7-18 at 6:20 pm: "At approximately 6:15 pm, resident reported sitting on floor in club room with bottom on the floor and back up against the couch. When asked what happened, resident replied, I tried to sit on the couch and I missed and slid to the floor." Resident denies pain/discomfort. Upon assessment, scant blood noted on 1st and 2nd fingertips under fingernail. Denies hitting head..." Signed by Licensed Staff C. 4-8-18 at 1:15 pm: "...decreased safety awareness as evidence by multiple attempts to stand up from wheelchair. Some difficulty with redirection..." Signed by Licensed Staff C. 4-11-18 at 8:35 am: "Resident found in room sitting on basket according to aide...When entering room resident sitting on bed with skin tear to left forearm/elbow..." Signed by unknown licensed staff. 4-14-18 at 11:41 am: "At 10:55 am, resident inactivity room. Staff witnessed resident standing up from wheelchair and falling back resting in another's wheelchair. Resident did not fall to the floor. Alert and oriented times one...denied pain, full weight bearing with assist for balance...resident reaching out regarding hallucinations picking item up off the floor...(family member) made this nurse aware 3 falls in 12 days. This nurse informed (family member) staff	S3155		

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S3155	Continued From page 21 had been at side through the morning and while assisting another resident is when resident got up on his/her own." Signed by Licensed Staff E. (Note: Resident moved from facility on 4-16-18.) Interview on 7-31-18 at 1:20 pm with Licensed Staff B and Administrative Staff A stated resident was receiving physical therapy to help him/her ambulate with a walker. This was hard to do because of the dementia. Confirmed the resident was a high fall risk prior to admission. Further confirmed the NSA/HCSP lacked personalized interventions to address resident's fall risk other than to encourage resident to attend programming and reminders to stay seated. Confirmed no documentation of root cause analysis regarding possible causes of falls and interventions to anticipate and meet resident's needs. For Resident #500, the operator failed to ensure the licensed nurse provided or coordinated the provision of health care services to address resident's risk for falls.	S3155		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall	S3211		

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S3211	Continued From page 22 place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on observation and interview, the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the package of all over the counter medications. Findings included: - Observation of 2 medication carts in the medication room on 7-25-18 at 11:51 am revealed the following open bottles of over-the-counter medications which lacked documentation of a resident's full name: Aleve (pain reliever), Bayer Aspirin 81 mg (milligrams) Stool Softener Vitamin D3 5000 IU (International Units) Acetaminophen tablets (pain relief) 500 mg Fish Oil 1200 mg Aspirin 325 mg Vitamin C 500 mg Vitamin E 180 mg Vitamin B-12 500 mcg (micrograms) Vitamin D3 2000 IU Interview on 7-25-18 at 11:51 with Licensed Staff D confirmed the above medications lacked documentation of full name of residents.	S3211		

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S3211	Continued From page 23 Facility policy for Over the Counter Medications: All medications and treatments (including over-the-counter and sample medications) should be labeled with the necessary information to provide safe medication management administration/assistance. Policy Detail 3. Over the counter (OTC) and sample medications should be labeled in the following manner: a. Make a copy of the specific order from the medication administration record or medication observation record and rubber-band the label around the OTC and sample medications bottles/containers, or b. The resident's name only may be written on the OTC and sample medication bottles/containers along with the placement of a pharmacy sticker which refers back to the physician/healthcare provider order. The policy lacked requirement that a licensed pharmacist or licensed nurse shall place the full name of the resident on the package of over the counter medications. The operator failed to ensure that a licensed pharmacist or licensed nurse labeled the over-the-counter medications with the full name of the resident on the bottle/container.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall	S3215		

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S3215	Continued From page 24 store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on observation and interview for all residents and staff requiring tuberculosis skin testing, the operator failed to ensure licensed nurses and medication aides stored all medications and biologicals in accordance with each manufacturer's recommendations or those of the pharmacy	S3215		

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S3215	Continued From page 25 provider and with federal and state laws and regulations. Findings included: - Observation of medication room on 7-25-18 at 11:51 am revealed the following: medication refrigerator with 1 open one-third full bottle of TB (tuberculosis) skin testing solution, filled by pharmacy on 1-13-18 and dated as opened on 5-1-18. Interview on 7-25-18 at 11:51 am with Licensed Staff D stated the testing solution was last used 7-23-18. Confirmed the solution should be discarded 30 days after being opened and removed it from the refrigerator. Manufacturer's recommendations states: "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." For all residents and staff requiring TB skin testing, the operator failed to ensure licensed nurses and medication aides stored TB skin testing solution in accordance with the manufacturer's recommendations by discarding after 30 days.	S3215		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;	S3280		

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S3280	Continued From page 26 (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for all residents and staff, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with all residents and staff. Findings included: - Review of the facility emergency management plan on 7-25-18 around 1:30 pm with Administrative Staff A who provided documentation of quarterly review of the emergency management plan with staff and residents. Administrative Staff A stated the emergency management plan was reviewed on Family Night with resident's family members who attended. Provided a post-it note with list of family night dates: 8-10-17, 11-17-17, 2-13-18, 6-7-18. The documentation lacked an agenda,	S3280		

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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
S3280	Continued From page 27	S3280		

names/signatures of family/resident participants and documentation of quarterly review with staff.

Interview on 7-25-18 at 2:05 pm with Non-Certified Staff K stated in the event of a tornado, he/she knew all residents and staff were to go to A and D halls. Stated in the event of a power/water outage, explosion, bomb threat, flood or gas leak he/she had not been told what to do.

Interview on 7-25-18 at 2:07 pm with Certified Staff H stated he/she "hadn't been told anything" regarding emergency preparedness in the facility.

Interview on 7-25-18 at 2:08 pm with Certified Staff I stated in the event of a tornado, the "safe places are A and D halls". In response to question regarding what staff are supposed to do in the event of power/water outage, explosion/bomb threat or gas leak, stated "I don't know" and "I'm not sure."

Interview on 7-26-18 at 11:50 am with Certified Staff J stated all residents and staff were to go to A and D halls in the event of a tornado. Stated he/she did not know what to do in the event of a electrical/water outage, explosion or gas leak.

Interview on 7-25-18 around 1:30 pm with Administrative Staff A confirmed the facility lacked documentation of quarterly review of all components of the emergency management plan with all residents and staff.

Review of facility emergency management plan notebook revealed the front page stated Disaster Plan orientation to be done upon hire with employees and move-in with residents and to be reviewed quarterly. The second page of the

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 _____	08/02/2018

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S3280	Continued From page 28 notebook revealed a copy of the regulation for Disaster and Emergency Preparedness. The facility failed to follow its policy. For all residents and employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of all components of the facility's emergency management plan.	S3280		