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	N046087	A. BUILDING: _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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 represent the findings of an abbreviated survey at the above named residential healthcare facility conducted on 7-26-17, 7-27-17, 8-8-17 and 8-9-17.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 32 residents. The sample included 4 residents (2 current residents and 2 discharged residents). Based on observation, record review and interview for 1 (#202) of 4 sampled residents, the Operator/RN failed to ensure that no resident shall be subjected to verbal, mental or physical abuse when a cognitively impaired resident was roughly assisted down the hall to his/her room and yelled at by facility staff. Findings included: - Record review for resident #202 revealed admission on 9-15-16 with diagnoses Confusion, Dementia without Behavioral Disturbance, and	S3026		

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

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S3026	Continued From page 1 Gastroesophageal Reflux Disorder. The Functional Capacity Screen dated 4-19-17 recorded resident required supervision of bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications/treatments. Usually continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-19-17 recorded services for verbal cueing with bathing, set up clothing for dressing and medication assistance. Interview on 7-27-17 at 2:53 pm with Operator/RN and Licensed Staff B stated another resident's family member had reported that "last night, he/she heard a commotion in the hallway" and looked out of the room to see "2 girls man-handling" resident #202 (one on either side and each holding an arm, pulling/pushing the resident) down the hall toward his/her room and stated harshly "if you want to pee, you're going to pee in your own room". Stated the family members were "beside themselves" upon observing the treatment of Resident #202 by the 2 staff. Operator/RN stated both staff were immediately suspended pending investigation. Observation of Resident #202 on 7-26-17 and 7-27-17 revealed the resident to be pleasantly confused and easily redirectable. Staff able to hold out hand and resident will take it and follow if staff explain where they are going. Resident may become anxious if staff do not talk and explain in an unhurried manner. No bruising or injury to	S3026		

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S3026	Continued From page 2	S3026		

arms or body observed on 7-27-17 per resident's family member.

Confidential statement dated 7-26-17: "...as I was coming out of kitchen I looked over to the Bistro, I saw (Resident #202) pulled his/her pants down and wanting to sit on trash can nearby. I called staff who was close to the Bistro to take care of the resident..."

Confidential witness statement: Wednesday, 7-26-17 at approximately 6:15 pm. "My (family member) and I were visiting (my family member - resident at the facility) and heard a loud commotion in the hall. We saw resident #202 being man-handled into his/her room against his/her will. The worker...yelled for help from another ...aide. Loud harsh words were exchanged. 'Get in your room, you go pee in your own bathroom!' They both handled him/her aggressively and quickly headed back towards the main desk. (My family member) and I both ran to Resident #202 to see if he/she was ok or if he/she needed help. (Resident #202) was visibly shaken and said 'They do this to me all the time.'.."

Confidential witness statement for 7-26-17: "At about 6 pm I was told by (Certified Staff G) that (Resident #202) was using the bathroom in the bistro trash can. I ran over to the great room to check who it was and it was him/her. I sat down the items I had in my hand and went over to (Resident #202) and explained to him/her about where he/she needed to use the bathroom and I proceeded to guide him/her to his/her room. We made it to the chair/bench and he/she grabbed my hair. I turned around and yelled up the hall to (Certified Staff H) that I needed help. I then kept walking with (Resident #202) down the hall and

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S3026	Continued From page 3 Certified Staff H made it to us. We reached the door and I explained to (Resident #202) that this is your room this is where you need to use the bathroom. (Resident #202) at that time had continued to pee on him/herself..." The facility provided documentation of staff education/in-service for Abuse/Neglect/Exploitation on 7-27-17 and 7-28-17 which covered verbal abuse, emotional abuse, physical abuse, exploitation and neglect. For Resident #202, the Operator/RN failed to ensure that no resident shall be subjected to verbal, mental or physical abuse when a cognitively impaired resident was roughly assisted down the hall to his/her room and yelled at by facility staff.	S3026		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 32 residents. The sample included 4 residents (2 current residents and 2 discharged residents). Based on record review and interview for 1 (#203) of 4 sampled residents, the Operator/RN (Registered Nurse) failed to ensure designated staff shall ensured the resident's functional capacity at the	S3082		

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S3082	Continued From page 4	S3082		

time of the screening was accurately reflected on the resident's screening form.

Findings included:

- Record review for Resident #203 revealed admission on 6-27-17 with diagnoses Vascular Dementia with Behaviors, Wandering, Chronic Kidney Disease Stage II, Hypertension, Depression, Vitamin D Deficiency, Hyperlipidemia and Overactive Bladder.

The Functional Capacity Screen (FCS) dated 6-27-17 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term and long term memory, and memory/recall. Current problems identified included impaired vision and impaired hearing.

The FCS failed to identify "wandering" as a current problem/risk.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-27-17 recorded services for reminders to shower 3 times per week; and reminders to not wear the same clothes when dressing.

Physician Admission Orders dated signed and dated 6-26-17 stated "Primary Diagnosis: Vascular Dementia with Behaviors - Wandering."

Resident Record of "Observations" stated: "7-13-17 at 4:00 pm. Incident Notes: It was reported to me the concierge on 7-14-17 that (Resident #203) had eloped. He/She went out

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S3082	Continued From page 5 the back door and walked around to the front door and came back in by him/herself. The back door was alarming, (Certified Staff C) went out the back door to check for residents, he/she did not see anyone. Before he/she got to the front to report the alarm going off, Resident #203 had already come back in through the front door..." Physician Progress Note dated 7-14-17 stated: "Chief Complaint: Exit Seeking Behaviors, Dementia: Asked to see resident today for exit seeking behaviors. According to staff he/she exited building yesterday but thankfully came back in the front door...Resident is sitting in common area, alert, pleasantly confused...does not remember leaving yesterday." Interview on 7-26-17 at 3:00 pm with Operator/RN (Registered Nurse) and Licensed Staff B both confirmed Resident #203 was admitted with a diagnosis of Wandering and the FCS lacked identification of "Wandering" as a current problem/risk. Licensed Staff B confirmed he/she completed the form. For Resident #203, the Operator/RN failed to ensure designated staff ensured the resident's functional capacity at the time of the screening was accurately reflected on the resident's screening form.	S3082		
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 or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional	S3155		

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S3155	Continued From page 6 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 32 residents. The sample included 4 residents (2 current residents and 2 discharged residents). Based on observations, record review and interview for 2 (#203, #205) of 4 sampled residents, the Operator/RN (Registered Nurse) failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the cognitively impaired resident's risk for elopement. Findings included: - Record review for Resident #203 revealed admission on 6-27-17 with diagnoses Vascular Dementia with Behaviors, Wandering, Chronic Kidney Disease Stage II, Hypertension, Depression, Vitamin D Deficiency, Hyperlipidemia and Overactive Bladder. The Functional Capacity Screen (FCS) dated 6-27-17 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term and long term memory, and memory/recall. Current problems identified included impaired	S3155		

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S3155	Continued From page 7	S3155		

vision and impaired hearing. (Note: FCS failed to identify "wandering" as a current problem/risk).

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-27-17 recorded services for reminders to shower 3 times per week; and reminders to not wear the same clothes when dressing.

The NSA/HCSP lacked interventions to address wandering and elopement risk.

Facility "Elopement Risk Evaluation" form was blank/not completed.

Physician Admission Orders dated signed and dated 6-26-17 stated "Primary Diagnosis: Vascular Dementia with Behaviors - Wandering."

Resident Record of "Observations" stated: "7-13-17 at 4:00 pm. Incident Notes: It was reported to me the concierge on 7-14-17 that (Resident #203) had eloped. He/She went out the back door and walked around to the front door and came back in by him/herself. The back door was alarming, (Certified Staff C) went out the back door to check for residents, he/she did not see anyone. Before he/she got to the front to report the alarm going off, Resident #203 had already come back in through the front door..."

Physician Progress Note dated 7-14-17 stated: "Chief Complaint: Exit Seeking Behaviors, Dementia: Asked to see resident today for exit seeking behaviors. According to staff he/she exited building yesterday but thankfully came back in the front door...Resident is sitting in common area, alert, pleasantly confused...does not remember leaving yesterday."

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S3155	Continued From page 8 Observation of facility "back door" on 7-26-17 at 3:32 pm revealed keypadded exit in middle of a hallway with a 15 second egress push-bar. (hold bar in for 15 seconds, alarm will sound, after 15 seconds door opens). Door opened into a hallway with another door (no keypad) then a vestibule with another door (no keypad) which opened outside onto a paved sidewalk and driveway that encircled the building. Additionally, when entering facility at 10:00 am, the front door onto unit was locked and required a keypad code. If a visitor did not know the code, they were to pick up the phone on the wall to request assistance. The phone lacked a dial tone and failed to function. Interviews on 7-26-17 at 3:00 pm with Operator/RN (Registered Nurse) and Licensed Staff B both confirmed Resident #203 was admitted with a diagnosis of Wandering and the NSA/HCSP lacked interventions to address the resident's wandering and elopement risk. Further confirmed they failed to complete the Elopement Risk Evaluation form and provide instructions to staff for managing the behavior. Operator/RN stated when the push-bars are held down for 15 seconds on the exit doors, an alarm sounds at the door and also on the pagers, signaling staff to go check the door. On the day of the elopement, the concierges were "changing shifts" at the front desk and did not see the alarm on the computer screen nor hear the alarm sound. Stated the alarm system was checked afterwards and appeared to be working. Confirmed the facility lacked documentation of routine monitoring of the alarm system and lacked a policy/procedure for completing routine door/alarm monitoring. Stated he/she checked pager batteries daily but failed to document.	S3155		

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S3155	Continued From page 9 Interview on 7-26-17 at 5:19 pm with Concierge E confirmed he/she was working the day resident eloped and witnessed resident come in through front door. Stated he/she "heard 3 tugs on the door, the bells and whistles didn't go off (from someone opening the door without entering the keypad code). The door opened and resident came inside. Stated he/she didn't think the system worked like it was supposed to, when the back door opened, it lit up on the computer screen, but the alarm didn't sound at the front desk. For Resident #203, the Operator/RN failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the cognitively impaired resident's risk for wandering and elopement. - Record review for Resident #205 revealed admission on 6-2-17 with diagnoses Adjustment Disorder with Anxiety, Delirium, Vascular Dementia with Behaviors, Hypertension, Cerebrovascular Disease and Lymphedema. The Functional Capacity Screen (FCS) dated 6-2-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; supervision of eating; and unable to perform management of medications/treatments. Usually continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified included: impaired hearing, impaired vision, and socially inappropriate disruptive behavior.	S3155		

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S3155	Continued From page 10 The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-2-17 recorded services for physical assistance with bathing, dressing, transfers. The NSA/HCSP lacked documentation of services for toileting, walking/mobility per wheelchair, staff administration of medication, use of bilateral lower extremity lymphedema wraps and interventions to address resident's behaviors. Physician Admission Orders dated/signed 6-2-17 recorded order for "Lymphedema wraps bilateral lower extremities and described the following signs and symptoms: aggression, confusion, delusions, hallucinations, short and long term memory loss, impulsive,...able to transfer times 1 assist, wheelchair for ambulation and safety." History and Physical dated 6-8-17 stated: "...new resident in memory care. Staff reports (resident) has been combative, yells out at staff and residents and has hit another resident in the face." Physician Progress Note dated 6-16-17: "Staff request to see (resident) for increased anxiety, agitation, restlessness. Resident yelling, trying to get up and walk, nonsensical..." Staff Observation notes: 6-6-17 at 2:00 pm: "(Staff) took (resident #205) to the bathroom and he/she began cussing at them, he/she had an incontinence episode and while they were attempting to change him/her, (resident #205) began hitting them both...then grabbed the back toilet cover and threw it to the ground shattering it. I was called in and assisted...he/she was calling everyone names, and continued	S3155		

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S3155	Continued From page 11 hitting at everyone. We finally got him/her cleaned up and back in his/her wheelchair..." Signed by Operator/RN (Registered Nurse). 6-13-17 at 7:00 am: "Resident cursing and hitting staff. He/She threw a glass of cranberry juice..." Signed by Certified Staff F. Documentation of staff "Observations" through 7-6-17 recorded multiple episodes of resident's agitation and combativeness with cares including toileting and resistance to taking medications, vital signs and application of lymphedema wraps. Interviews on 7-27-17 at 3:13 pm with Operator/RN and Licensed Staff B confirmed the NSA/HCSP lacked documentation of services for staff assistance with toileting, use of wheelchair (staff to propel), staff administration of medication, use of bilateral lower extremity lymphedema wraps and interventions to address resident's behaviors. For resident #205, the Operator/RN failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services to address the cognitively impaired resident's behaviors. The licensed nurse further failed to ensure the NSA/HCSP provided instructions to staff for management of medication administration, application of lymphedema wraps, use of a wheelchair and toileting.	S3155		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including	S3261		

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S3261	Continued From page 12 the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 32 residents. The sample included 4 residents (2 current residents and 2 discharged residents). Based on observation, record review and interview for 1 (#205) of 4 sampled residents, the Operator/RN (Registered Nurse) failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for Resident #205 revealed admission on 6-2-17 with diagnoses Adjustment Disorder with Anxiety, Delirium, Vascular Dementia with behaviors, Hypertension, Cerebrovascular Disease and Lymphedema. Physician Admission Orders dated/signed 6-2-17 recorded order for "Lymphedema wraps bilateral lower extremities. The Functional Capacity Screen (FCS) dated 6-2-17 recorded resident required health care services. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 6-2-17 recorded services for physical assistance with bathing, dressing, and transfers.	S3261		

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S3261	Continued From page 13 Observation on 7-27-17 at 2:35 pm of resident #205's room revealed furniture, decor and clothing still in room except for a bed. Review of staff "Observations" notes revealed the record lacked documentation of resident's date and time of arrival to facility including an admission assessment. The "Observations" notes on 7-20-17 at 9:38 am stated "Resident was discharged from the system. Deactivating Resident." Signed by Licensed Staff B. Interview on 7-27-17 at 2:40 pm with Operator/RN and Licensed Staff B stated Resident #205 went to "geri-psych (geriatric psychiatric facility) for behaviors, hitting and biting...was there a week then family took him/her home." Stated resident was not considered to be a current resident at the facility, but resident's furniture remained in room except for the bed. Confirmed the record lacked documentation of resident's admission (date/time of arrival and nursing assessment); ongoing documentation of condition of resident's bilateral lower extremities for which lymphedema wraps were ordered; and documentation of a nursing assessment prior to resident leaving the facility to be admitted to geri-psych including the date, time and how resident left. For Resident #205, the Operator/RN failed to ensure documentation of all symptoms and other indications of illness including the date, time of occurrence, action taken and results of the action.	S3261		
S3320 SS=F	28-39-254 CONSTRUCTION	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	08/09/2017

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S3320	Continued From page 14 (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-29-254(a) The facility reported a census of 32 residents. The sample included 4 residents (2 current residents and 2 discharged residents). Based on observation and interview for all cognitively impaired residents, the Operator/RN (Registered Nurse) failed to maintain the facility to protect the health and safety of these residents and the public. Findings included:	S3320		

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S3320	Continued From page 15 - Observation on 7-26-17 upon arrival to facility revealed when entering facility at 10:00 am, the front door onto unit was locked and required a keypad code. If a visitor did not know the code, they were to pick up the phone on the wall to request assistance. The phone lacked a dial tone and failed to function. - Observations on 7-26-17 beginning at 10:12 am during tour of facility revealed the following: Medication room with an automatic soap dispenser which failed to work. Men's public restroom with an automatic soap dispenser which failed to work. Laundry room with soiled and clean entrances. Both entrances unlocked. Soiled entrance opened into small room which contained a gallon of Eco-San Liquid Sanitizer sitting on the floor underneath sink, Open bottle of Ecolab Oasis 137 Orange Force cleaner with no top. A box which contained two large unopened containers of Ultra Sour cleaner and two large containers of Oasis Glass Force cleaner connected to a dispenser. The automatic soap dispenser at the hand washing sink room failed to work. Sitting room next to front lobby with urine odor. Three upholstered chairs and sofa with urine odors. The sofa also contained a cushion with dried feces on it. The resident roster identified 32 of 32 residents in this memory care facility with impaired cognition. Interviews on 7-26-17 during tour beginning at 10:12 am until 11:00 am with Operator/RN (Registered Nurse) confirmed the above unsecured items and locked the laundry room	S3320		

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S3320	Continued From page 16 doors. Further confirmed the urine odors and condition of furniture in the sitting room and turned the cushion over on the sofa which was soiled with fecal matter. Interview on 7-26-17 at 10:38 am with Housekeeping Staff D confirmed the condition of the sofa and stated he/she would clean it. Observation of sofa on 7-26-17 at 5:15 pm revealed the sofa still had a urine odor and the cushion remained soiled with fecal matter. Confirmed by Operator/RN. For all cognitively impaired residents, the Operator/RN failed to maintain the facility to protect the health and safety of these residents and the public.	S3320		