

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 20705 W 151ST STREET OLATHE, KS 66061		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 689 SS=D	The following citations represent the findings of complaint investigation #KS00167815. The 2567 was sent electronically on 01/06/22. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included three residents reviewed for falls. Based on record review, interview, and observation, the facility failed to ensure proper positioning of Resident (R)1's Broda Chair (specialized wheelchair with the ability to tilt and recline) as directed by R1's plan of care when facility staff failed to ensure the chair was reclined after R1 finished eating her breakfast, which resulted in her falling forward and hitting the built in dresser beside her recliner. This deficient practice placed R1 at increased risk for injury due to accidents/falls. Findings included: - R1's electronic medical record (EMR), under the "Diagnosis" tab recorded diagnoses of difficulty in walking, muscle weakness, abnormal pain, lack of coordination, dementia (progressive	F 689			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/06/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 mental disorder characterized by failing memory, confusion), restless leg syndrome, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues). The "Significant Change Minimum Data Set" (MDS) dated 04/30/21 documented R1 had short and long term memory problems per staff interview. The MDS recorded R1's activities of daily living (ADL) as total dependence of one staff member for bed mobility, locomotion on and off unit, dressing, eating, toilet use and personal hygiene. R1 had total dependence on two staff members for transfers. R1 had delusions. The MDS lacked information related to fall history. The "Cognitive Loss Care Area Assessment" (CAA) dated 04/30/21 documented R1 experienced severe cognitive impairment due to dementia and Parkinson's. The "Falls CAA" dated 04/30/21 documented R1 fell in her room. R1 was in her Broda Chair and the back was not reclined. Staff found R1 on the floor, and R1 had a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to her head. The "Quarterly MDS" dated 10/15/21 documented R1 had short- and long-term memory problems per staff interview. R1 required total assistance on one staff member for bed mobility, locomotion on and off the unit, and dressing. R1 required extensive assistance of one staff member for eating, toilet use, and personal hygiene. R1	F 689			

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F 689	Continued From page 2 required total assistance of two staff members for transfers. R1 had delusions and behavioral symptoms not directed towards others four to six days out of the look back period. The fall history lacked documentation. The "Fall Risk Care Plan" initiated 07/17/16 was updated 03/30/21 directed staff to ensure R1's Broda chair was in a reclined position when R1 sat in the chair. A "Risk Management" note dated 12/07/21 at 10:15 AM documented R1 was found sitting on the end of her Broda chair with her head against her recliner. A head to toe assessment was performed, and range of motion to all extremities was completed without pain or discomfort noted. Neurological checks were initiated. R1 had a hematoma to the top of her scalp and was not taken to the hospital. The note documented the physician and responsible party were notified at 03:33 PM. The "Communication with Resident/Family Note" dated 12/22/21 at 12:49 PM documented Social Services X called and left a voicemail to receive a return call regarding the "bump" on R1's head from the fall two weeks ago and what actions should be taken to treat the area. The "Communication with Resident/Family Note" dated 12/29/21 at 05:24 PM documented R1's responsible party was notified that a physician could treat the hematoma on R1's forehead on Wednesday, 01/05/22. On 12/30/21 at 12:39 PM R1 sat in her Broda chair in the sitting room off the hallway. R1's Broda Chair was tilted back. The resident had a	F 689			

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F 689	Continued From page 3 hematoma on the left side of her forehead in her hairline. R1 appeared comfortable. On 12/30/21 at 12:35 PM Administrative Nurse D stated that R1 didn't need to go out to the emergency room after the fall on 12/07/21, and that the doctor just wanted to monitor the hematoma in the facility. Administrative Nurse D further stated the doctors progress notes recorded the physician's decision. On 12/30/21 at 12:49 PM Certified Nurse Aide (CNA) M stated she was assigned to work the hall on 12/07/21 and confirmed she found R1 in her room, after the fall. CNA M stated R1 had just finished eating breakfast and the kitchen took R1's tray out of the room. R1 was still positioned in an upright position in the Broda chair. CNA M stated R1 somehow pulled herself forward in her Broda chair and then tipped forward hitting the stationary dresser right next to the recliner. CNA M demonstrated how R1 was observed in R1's room. CNA M stood to the seven o'clock position from the recliner, with the recliner being in the twelve o'clock position. CNA M demonstrated R1 had reached out with her hands and pulled on the recliner arm and tipped forward hitting the left side of R1's head on the stationary dresser that the recliner sat next to. CNA M revealed that R1 had anxiety and at times grabbed for things and asked for her mom. CNA M further revealed that R1's Broda chair should have been reclined. On 12/30/21 at 1:15 PM Administrative Nurse D stated that she could not recall the fall event or how the hematoma had occurred. The facility's "Falls Preventions and Management-Rehab/Skilled, Therapy & Rehab"	F 689			

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F 689	Continued From page 4 policy revised 09/17/21 documented the purpose was to prevent further injury. An Accident referred to any unexpected or unintentional incident, which may result in injury. The policy directed staff to identify the cause of the problem so that the best solutions can be identified and put into place. The facility failed to prevent R1 from falling when staff removed the breakfast tray and failed to recline R1's Broda chair. The fall resulted in R1 pulling herself forward and hitting her head on the stationary dresser which resulted in a hematoma.	F 689			