

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

PRINTED: 10/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175557</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/12/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AZRIA HEALTH OLATHE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>201 E FLAMING ROAD</b><br><b>OLATHE, KS 66061</b>                            |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| F 000                                                          | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F 000                                                                      |                                                                                                                          |                            |                                                                    |
| F 689<br>SS=G                                                  | <p>The following citations represent the findings of complaint investigations #KS00166216 and #KS00166227.</p> <p>The 2567 was sent to the facility on 10/18/21.</p> <p>Free of Accident Hazards/Supervision/Devices<br/>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.<br/>The facility must ensure that -<br/>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br/>This REQUIREMENT is not met as evidenced by:<br/>The facility reported a census of 113 residents. The sample included three residents at risk for falls. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 received adequate care and supervision to prevent a fall. On 10/07/21 at approximately 11:00 AM, while being supervised and assisted by a facility staff member, R1 fell from a wheelchair onto the pavement in a parking lot, at an offsite location (drug store) when the facility staff member diverted her attention from R1's safety to her cell phone. R1 sustained skin tears, abrasions, and a laceration (cut) which required evaluation and treatment which included sutures (stitches) at a local hospital before returning to the facility.</p> <p>Findings included:</p> | F 689                                                                      | Past noncompliance: no plan of correction required.                                                                      |                            |                                                                    |

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

TITLE

(X6) DATE

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                                                          | <p>Continued From page 1</p> <p>- R1's Electronic Medical Record (EMR), under the "Diagnosis" tab, listed diagnoses of: osteomyelitis of vertebra (bones that form the spine), lumbar region (an inflammation in the lower back) of bone or bone marrow, usually due to infection), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), and a need for assistance with personal care.</p> <p>The "Five Day Minimum Data Set" (MDS) dated 09/26/21 documented the resident had a Brief Interview for Mental Status score of 13 which indicated R1's cognition was intact. The MDS documented R1 required extensive to total assistance of one to two staff members with most activities of daily living (ADLs). The assessment recorded R1 had functional limitations in range of motion to his lower extremities and ambulated by use of a wheelchair with one-person extensive assistance.</p> <p>The 08/26/21 "ADL Care Area Assessment" (CAA) recorded staff and therapy were available and provided services to ensure R1's daily needs were met and reported and documented any changes.</p> <p>The 08/26/21 "Falls CAA" recorded R1 was at risk for falls due to decreased mobility, weakness, and lumbar pain. The CAA directed staff to work with R1 on strengthening and balance.</p> <p>The facility's "Fall Risk Assessment" dated 08/23/21 documented a score of 10 or greater placed a resident at high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                          | <p>Continued From page 2</p> <p>R1's "Care Plan" for ADLs initiated on 08/24/21 and revised on 09/24/21 directed staff to consult physical therapy per order, ensure R1's call light was available, and evaluate R1's ability to perform ADLs. The "Care Plan" lacked documentation to address the R1's level of assistance needed, how the resident transferred, ambulated, and/or R1's ability to complete any ADLs on his own.</p> <p>R1's "Care Plan" for falls initiated 08/24/21 directed staff to evaluate R1's fall risk on admission and as needed. If a fall occurred, alert the provider and initiate frequent neurological checks and a bleeding evaluation per facility protocol.</p> <p>The 10/07/21 revised "Care Plan" documented R1's fall with injury, transportation staff's re-education, a review of job descriptions, and safety techniques. On 10/08/21 R1's "Care Plan" noted a wheelchair maintenance evaluation and directed staff to determine R1's ability to transfer.</p> <p>The "Facility Investigation" documented on 10/07/21 at about 11:00 AM revealed staff transported R1 by a contracted medical transport company to a local drug store/pharmacy for a vaccine. Designated Facility Transporter (DFT) M accompanied R1. While exiting the store, DFT M was in the process of calling transportation, when R1's wheelchair rolled and went over resulting in R1 falling out of the chair and onto the pavement.</p> <p>In a "Witness Statement" DFT M documented R1 and DFT M were going out of the store. DFT M was on the phone with the facility to give to the facility the address of DFT M and R1's location.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                          | <p>Continued From page 3</p> <p>DFT M put the left side wheelchair brake on and then turned to look at the building address. When DFT M turned around, she heard R1 saying "wait, wait" and observed R1 on the concrete parking lot. When R1 fell, he was face down, and DFT M went to R1 and asked him if he was alright, then called 911.</p> <p>In a "Witness Statement" Medical Company Driver (MCD) N documented he was in the parking lot and saw DFT M come out of the store. SFT M was on her cell phone. DFT M looked up at the building and as she did so, MCD N witnessed R1 roll off the sidewalk in his wheelchair and then fall out of the wheelchair. When MCD N picked up the wheelchair, the brakes worked. MCD N then secured R1 in the transportation van before leaving the premises.</p> <p>The "Nurse Progress Notes" dated 10/7/2021 at 7:06 PM recorded at 11:30 AM transport staff reported the resident was sent to the hospital following a fall. MCD N stated that R1 fell out of the wheelchair onto the pavement after leaving a vaccine appointment at a local drug store. R1 had several superficial injuries noted, including a laceration to the face above R1's right eyebrow with three sutures in place. The 3rd, 4th, and 5th toes on R1's left foot had open areas which were bleeding and R1's right great toe was also bleeding. R1 had bloody abrasions to the left and right elbow, left forearm, and two lacerations to his left knee. R1 denied pain, and staff notified R1's family and physician. Staff cleansed all open areas and applied treatments. Staff started neurological checks when R1 returned to the facility at approximately 5:30 PM.</p> <p>Observation on 10/12/21 at 10:59 AM revealed</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                          | <p>Continued From page 4</p> <p>R1 laid in bed with bilateral arm bruising, an adhesive pad dressing on bilateral elbows, and a cut to his right forehead/eyebrow. Both feet were wrapped in gauze.</p> <p>Interviewed on 10/12/21 at 10:59 AM R1 confirmed the skin tears and a "mashed" left foot were a result of a fall. R1 pointed to his right temple and stated, "I also received three stitches." R1 stated while being assisted out of the local drug store by the facility driver, R1's wheelchair went over the curb and he fell face first to the ground. R1 could not confirm whether staff locked his wheelchair brakes. R1 stated, "that is where the story becomes convoluted, [DFT M] was behind me, so I cannot tell you, all I know is that my wheelchair went over the curb. We were not facing the ramp to go toward the van."</p> <p>Interviewed on 10/12/21 at 12:34 PM R1 felt the accident could have been prevented. R1 stated the facility transporter should not have been transporting R1 while distracted. R1 added, "I don't know what was going on behind me, all I know is we were not lined up with the ramp, you know how at [local drug stores] they have the ramp by the stores' corner entrance? Well, we were lined up with the curb and I yelled, Stop! Stop! and then I was on the ground."</p> <p>Interviewed on 10/12/21 at 12:00 PM Administrative Staff A stated after they reported the incident, they suspended DFT M at 12:30 PM on 10/7/21 pending the investigation. DFT M received instruction and reeducation on appropriate times to use a phone and resident safety.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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| F 689                                                          | <p>Continued From page 5</p> <p>On 10/12/21 at 03:30 PM DFT M was unavailable for interview.</p> <p>The facility's "Driver-Job Description" updated 2/21/21 documented in keeping with the organization's goal of improving the lives of residents they serve, the driver plays a critical role in providing transportation for residents to and from the facility in accordance with current federal, state and local standards governing the facility, to ensure that the highest degree of quality care is maintained at all times.</p> <p>The undated "Training Outline Checklist for Resident Transport Drivers" for loading and unloading documented to make sure wheelchair brakes worked and were safe.</p> <p>The facility's "Cell Phones" policy revised 01/20/21 documented personal cell phones and electronic devices were only permitted in patient care areas for authorized business purposes. This same policy also recorded personal cell phones should not be carried or worn during working hours.</p> <p>The facility failed to provide adequate supervision and appropriate interventions to prevent an accident with injury, when during wheelchair transport, a distracted staff member allowed R1's unsecured wheelchair to drift over a curb. As a result, R1 fell from the wheelchair sustained skin tears, abrasions, a laceration and a need for emergency treatment. The facility investigated and implemented corrective action which included training and check list competency for involved staff which was completed on 10/07/21 therefore the deficient practice was cited as past noncompliance.</p> | F 689                                                                      |                                                                                                                          |                            |                                                                    |

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