STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087116	A. BUILDING: _____ B. WING _____	R-C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRECIOUS GEMS HOMES AT POLO DR	5502 POLO DRIVE WICHITA, KS 67208

(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 the revisit survey for notice of assessment 21-37 conducted on 04-29-21 and 05-03-21.	{S 000}		
{S5205} SS=J	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (a) The facility reported a census of 8 residents. Based on observation, interview and record review the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This deficient practice placed the 8 dependent residents in immediate jeopardy for harm, injury or death (#11, #12, #13, #14, #15, #16, #17 & #18) Findings included: - On 04-29-21 at 5:15 AM observation revealed 4 staff on duty at the facility (direct care staff A, B, C & D). Direct care staff A reported there were 8 residents in the facility. She reported 2 residents were already up and in their wheelchairs. Observation revealed 6 of the 8 residents remained in bed with their eyes closed.	{S5205}		

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

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{S5205}	Continued From page 1 On 04-29-21 at 5:19 AM the surveyor requested for the 4 staff on duty to conduct an evacuation of all residents to a secure area (the outside as the home plus lacked any fire doors or other fire suppression mechanisms). The evacuation began at 5:20 AM on 04-29-21with the surveyor utilizing a stopwatch. Direct care staff A, B and D went towards resident #13's room (at the end of the west hall). Along the way the staff called out to resident #12, already in the powerchair, to propel herself to the outside for the fire drill. The 3 staff entered resident #13's room said they were doing a fire drill and the resident said ok. The resident wanted to use her slide board to get into her powerchair but then said it was ok to use the fitted bed sheet. Staff used the fitted bed sheet to lift the resident off the bed with 1 staff on the left side of the resident, 1 staff at the shoulders on the right side and 1 staff at the resident's feet. The staff had difficulty lifting the resident from the bed, taking a few steps towards the wheelchair and the resident's body went downward before staff were able to stabilize and complete the transfers. The stopwatch registered 1 minute and 53 seconds when the 3 staff placed the resident into her power wheelchair. Direct care staff B & C stayed with resident #13 trying to better position her into the powerchair while direct care staff D went to start with resident #14. When staff B & C exited resident #13's room to go to resident #14's room they told resident #13 to use her powerchair and exit to the outside area for the drill. Time on the stopwatch was 1 minute and 55 seconds when direct care staff D entered resident #14's room. She pushed the high-back wheelchair parallel to the bed and lowered the wheelchair back to almost flat. Direct care staff B	{S5205}		

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{S5205}	Continued From page 2 & C joined staff D at that time and using the fitted bed sheet they slid the resident over from the bed to the wheelchair. The elapsed time then was 3 minutes and 2 seconds. At 3 minutes 18 seconds all 3 staff remained in the room working with resident #14. Resident #13 called out from her room for help because she was stuck in the doorway. The 3 staff where working with getting resident #14's wheelchair to get the back into the upright position and securing the resident. At 3 minutes 30 seconds direct care staff B exited resident #14's room traveling towards the east hall, direct care staff C went to help resident #13 and direct care staff D began to maneuver resident #14 out of the room into the hallway. Direct care staff D struggled getting the high-back wheelchair lined up straight enough to get through the doorframe. The stopwatch had an elapsed time of 3 minutes and 40 seconds when resident #14 was propelled out of the room into the hallway and taken outside by staff D. Meanwhile, direct care staff C had freed resident #13 from her doorway and the resident propelled herself in the powerchair to the outside. Also, at the elapsed time of 3 minutes 40 seconds, the surveyor observed in the east hallway resident #15 in a wheelchair with her bottom barely on the seat and she was starting to slide. Direct care staff A and B adjusted her in the wheelchair. The elapsed time now was 4 minutes and 39 seconds. Meanwhile, no residents or staff were able to exit the front door because resident #13 was having difficulty getting her powerchair to fit through the door. Residents #15, #16, #17 and #18 were still in the house along with staff. At elapsed the time of 4 minutes and 52 seconds resident #13 was through the front door with staff's help. At the elapsed time of 5 minutes and 23 seconds	{S5205}		

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{S5205}	Continued From page 3	{S5205}		

the surveyor witnessed 6 residents had been evacuated (#11, #12, #13, #14, #15 and #16). Direct care staff A & D were getting residents #17 and #18 up and out. Resident #17 is independently ambulatory with a walker and cueing. Resident #18 is independently ambulatory without device but needed guidance due to dementia and wandering.

When staff reported all the residents were evacuated the surveyor stopped the stopwatch with an elapsed time of 6 minutes and 8 seconds total time for 4 staff to perform an evacuation of 8 dependent residents.

The state fire marshal life safety code included directions for a facility of 8 or less residents without a sprinkler fire suppression system must be evacuated in under 3 minutes.

On 04-29-21 at 5:33 AM administrative staff E acting on behalf of operator F received notification of the evacuation drill, the length of time being 6 minutes and 8 seconds which placed the 8 residents in immediate jeopardy for harm, injury or death.

In the facility's disaster/emergency preparedness book was a document titled, Emergency Preparedness: Fire Drill and Actual Fire. Fire drill: when to evacuate: The fire alarm goes off and there is a fire, the fire department enters the building and activated the alarm and a fire drill will be done 4 times a year. You are to evacuate the building completely and immediately. The time goal is 3 minutes.

The operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an

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{S5205}	Continued From page 4 emergency or disaster to a secure location. This deficient practice placed the 8 dependent residents in immediate jeopardy for harm, injury or death. On 04-29-21 at 9:21 AM the surveyor received the facility's written plan to address the immediate jeopardy of the residents in regard to evacuation in under 3 minutes. The plan included the following measures: 1. Resident #13 received notice of the need to transfer to another facility based on her care needs and time taken for the evacuation. 2. Operator F revised the evacuation plan/flow without resident #13 and this plan included detailed steps staff would take and the order in which to evacuate the 7 remaining residents. The plan included staffing with 3 staff (A, B & C) on each shift every day. The jeopardy was removed on 04-29-21 at 10:45 AM when the operator reported the discharge/transfer of resident #13 to another facility.	{S5205}		