

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 657 SS=D	The following citations represent the findings of complaint investigation #KS00185343. The 2567 was sent electronically on 02/19/24. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents.	F 657			

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

TITLE

(X6) DATE

02/19/2024

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.

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 657	Continued From page 1 The sample included three residents reviewed for care medications used. Based on record review, observation, and interview, the facility failed to revise the comprehensive care plan for resident R1's use of an injectable medication for a diagnosed skin condition. This placed R1 at risk for impaired care related to uncommunicated care needs. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic kidney disease, chronic lymphedema (swelling of the leg or arm) diabetes mellitus (DM-a condition characterized by high blood sugar levels and the body's inability to metabolize sugar), and psoriasis (a chronic, sometimes painful skin disease that causes a rash with itchy, scaly patches, on the knees, elbows, trunk, and scalp). The "Annual Minimum Data Set (MDS)," dated 12/26/23, documented R1 had a Brief Interview for Mental Status score of 15 which indicated R1's cognition was intact. The MDS documented R1 had no mobility problems and used a wheelchair for ambulation. R1 had occasional incontinence and had no pressure sores. The MDS documented R1 received insulin (hormone used in the treatment of DM) injections, antidepressant (medication used to treat mood disorders), hypnotic (medication which alters mood or thought and has sedative qualities), diuretic (used to promote the formation and excretion of urine), anti-platelet (medication used to thin the blood), and opioid (narcotic medication used to treat pain) medications. R1's EMR documented a "Physician's Order"	F 657			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 657	Continued From page 2 dated 01/13/23 for Skyrizi (prescription medication used to treat psoriasis) subcutaneous (under the skin) solution prefilled syringe 150 milligrams/milliliter (mg/ml); inject 150 mg (1 ml) subcutaneously one time a day every 84 day(s) for plaque psoriasis. R1's "Care Plan" revised on 01/04/24 and 02/06/24 lacked documentation to address the resident's use of, as well as directions and/or precautions, the quarterly Skyrizi injections. R1's "Care Plan" further lacked any measures of monitoring for effectiveness and/or unwanted side effects of the medication. A review of R1's "Medication Administration Record" (MAR) for September 2023 documented R1 last received the Skyrizi injection on 09/22/23. The "Medication Administration Record" (MAR) for December 2023 lacked documentation R1 received the medication on 12/15/23 per the physician's order. On 02/06/24 at 10:43 A.M. R1 sat in a wheelchair in her room dressed nicely and wearing protective soft boots (for prevention/treatment of heel sores). Interviewed on 02/06/24 at 10:43 A.M. R1 acknowledged that she receives an injectable medication every couple of months for psoriasis, R1 stated the facility missed a dose in December (2023) but stated she received the shot recently. R1 denied any itching and/or flare up of psoriasis at this time, Interviewed on 02/06/24 at 02:56 PM, Administrative Nurse D acknowledged R1's "Care Plan" lacked reference to the Skyrizi medication.	F 657			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 657	Continued From page 3 Administrative licensed nurse D noted because the order was for every 84 days and was supplied by a different pharmacy it was inadvertently missed on the order sheet and R1's "Care Plan." The facility's "Care Planning" policy revised 11/2023, documented a comprehensive care plan was developed within seven days of completion of the Comprehensive Minimum Data Set (MDS); and the residents plan of care was reviewed and revised on an ongoing basis quarterly, at a minimum and/or as needed with changes in condition. The facility failed to review and revise R1's comprehensive care plan to reflect the residents use of an injectable medication to treat a chronic skin condition. This placed R1 at risk for impaired care related to uncommunicated care needs. (Refer to F760)	F 657			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included three residents reviewed for medications. Based on record review, observation, and interviews, the facility failed to prevent a significant medication error when Resident (R)1 did not receive a scheduled injectable medication for the treatment of psoriasis (a chronic, sometimes painful skin disease that causes a rash with itchy, scaly patches, on the knees, elbows, trunk, and scalp).	F 760			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 760	Continued From page 4 On 01/21/24, after an inquiry from R1's representative, it was identified R1's quarterly injection was overdue by 40 days. This placed R1 at risk for decreased therapeutic effect of the medication and complications related to R1's skin disease. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic kidney disease, chronic lymphedema (swelling of the leg or arm) diabetes mellitus (DM-a condition characterized by high blood sugar levels and the body's inability to metabolize sugar), and psoriasis. The "Annual Minimum Data Set (MDS)," dated 12/26/23, documented R1 had a Brief Interview for Mental Status score of 15 which indicated R1's cognition was intact. The MDS documented R1 had no mobility problems and used a wheelchair for ambulation. R1 had occasional incontinence and had no pressure sores. The MDS documented R1 received insulin (hormone used in the treatment of DM) injections, antidepressant (medication used to treat mood disorders), hypnotic (medication which alters mood or thought and has sedative qualities), diuretic (used to promote the formation and excretion of urine), anti-platelet (medication used to thin the blood), and opioid (narcotic medication used to treat pain) medications. R1's EMR documented a "Physician's Order" dated 01/13/23 for Skyrizi (prescription medication used to treat psoriasis) subcutaneous (under the skin) solution prefilled syringe 150 milligrams/milliliter (mg/ml); inject 150 mg (1 ml)	F 760			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 760	Continued From page 5 subcutaneously one time a day every 84 day(s) for plaque psoriasis. R1's "Care Plan" revised on 01/04/24 and 02/06/24 lacked documentation to address the resident's use of, as well as directions and/or precautions, the quarterly Skyrizi injections. R1's "Care Plan" further lacked any measures of monitoring for effectiveness and/or unwanted side effects of the medication. A review of R1's "Medication Administration Record" (MAR) for September 2023 documented R1 last received the Skyrizi injection on 09/22/23. The "Medication Administration Record" (MAR) for December 2023 lacked documentation R1 received the medication on 12/15/23 per the physician's order. A "Nurses Progress Note" by the Consultant Nurse Practitioner GG dated 01/21/23 at 11:25 AM documented R1's representative brought it to Consultant GG's attention that R1 did not get her anti-psoriatic shot (Skyrizi) that she gets every 84 days and R1's representative felt frustrated that he had to follow up all the time. The note recorded a nurse on duty informed R1's representative the medication did not populate for administration that day. R1's representative was worried, so Consultant GG requested an administration history be printed out so Consultant GG and R1's representative could trace when R1 received the last dose. Consultant GG documented they identified that R1 had a missed dose due to hospitalization, therefore the schedule was reset in R1's EMR but not with the pharmacy that delivered the medication routinely. The note documented Consultant GG also verified the history of administration to ensure R1	F 760			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 760	Continued From page 6 was within a safe window to receive the next dose and authorized R1 to receive the injection that day and continue the next 84 days as ordered by dermatology (skin specialists). The nurse supervisor also set a monitoring protocol and delegated the task to herself for further management. Consultant GG directed to continue the Skyrizi subcutaneous solution 150 mg/ml one time a day every 84 days for psoriasis and supervise to ensure treatment compliance. Subsequent review of R1's "Nurses progress notes" and MAR lacked documentation the medication was administered on 01/21/24 however, it was confirmed as given by R1's representative. On 02/06/24 at 10:43 A.M. R1 sat in a wheelchair in her room dressed nicely and wearing protective soft boots (for prevention/treatment of heel sores). Interviewed on 02/06/24 at 10:43 A.M. R1 stated she was supposed to receive an injectable medication every couple of months for psoriasis, R1 stated the facility missed a dose in December (2023) but verified she received the shot recently. R1 denied any itching and/or flare-up of psoriasis at that time. Interviewed on 02/06/24 at 02:56 PM, Administrative Nurse D acknowledged the lack of a medication error report and/or documentation in the EMR regarding R1's missed dose of medication. Administrative Nurse D stated that because the order was for every 84 days, when R1 readmitted the order did not get placed on the order sheet and scheduled for administration. Administrative Nurse D said the medication was	F 760			

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

PRINTED: 02/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 760	Continued From page 7 supplied by a different pharmacy and sometimes was brought to the facility by R1's representative. Administrative Nurse D stated the facility confirmed by telephone that the nursing supervisor did give R1 the medication on 01/21/24. Administrative Nurse D stated the facility was working with the resident's physician, the facility pharmacist to address a method of tracking the medication. The facility's "Medication Administration" policy revised 01/2023, documented: It is the policy of this facility to retain, store, administer, and document medications in compliance with Federal and State regulations and accordance with current standards of practice and guidelines, The facility's "Medication Errors and Adverse Reactions" policy revised 05/2023, documented that a significant medication error causes the resident discomfort or jeopardizes his or her health and safety. A detailed account of the incident must be recorded on an incident report. Clinically relevant information about the follow-up of the resident should be recorded in the chart, including the date and time of the incident, the kind of medication error or adverse reaction, the name of the physician the date and time the physician was contacted, the physicians order, resident condition, and other information as necessary or appropriate. This same policy documented documentation of the resident's condition and response to treatment must be recorded during the monitoring period, and the medical director of nursing services and consulting pharmacist must be informed of all medication errors and adverse reactions. The facility failed to prevent a significant	F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2024
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 21250 WEST 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 760	Continued From page 8 medication error when R1's scheduled dose of psoriasis medication was not administered per the physician's order. This placed R1 at risk for decreased therapeutic effect of the medication and complications related to R1's skin disease.	F 760			