STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175551	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Olathe	21250 West 151st Street Olathe, KS 66061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 59 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from neglect. On 01/15/25 between 08:00 PM and 09:00 PM, R1 propelled himself in his wheelchair to the bathroom. He reached for the grab bar beside the toilet and the momentum of that action caused him to slip from his wheelchair and fall to the right, into the walk-in shower. R1 laid on the floor, unable to move or reach the call light beside the toilet. R1 remained on the floor until Licensed Nurse (LN) G discovered him on 01/16/25 at approximately 05:10 AM when she entered his room to empty his catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) bag. R1 told LN G he hit his head and he complained of right rib pain. The facility sent R1 to the hospital for evaluation where the hospital found no acute injuries. Upon investigation, the facility discovered Certified Nurse Aide (CNA) M failed to complete two-hour rounding on her assigned residents. This deficient practice placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of contracture (abnormal permanent fixation of a joint or muscle) of the right and left hand, lack of coordination, repeated falls, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R1 required partial to moderate assistance with toileting, upper and lower body dressing, bed mobility, and chair transfers. R1 required substantial to maximal assistance with sit-to-standing, toilet transfers, and bathing transfers. R1 had an indwelling catheter and was occasionally incontinent of bowel movements. R1 had no falls since the last assessment. The Quarterly MDS dated [DATE], documented a BIMS score of 13. R1 required partial to moderate assistance with toileting hygiene, rolling left to right, toilet transfers, and bathing transfers. R1 required substantial to maximal assistance with upper body dressing, from sitting to standing, and chair/bed to chair transfers. R1 required staff dependence with lower body dressing. R1 had no falls since the last assessment. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 10/09/24, documented R1 needed assistance with activities of daily living (ADL). (continued on next page)

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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan dated 10/25/21, documented R1 had an ADL self-care performance deficit related to back pain and falls and R1 required assistance of one staff with toileting and transfers. R1's Care Plan documented R1 was at risk for falls related to required assistance with ADL, cognitive loss, medication side effects, and a history of falls. The Care Plan included R1 needed a safe environment including a working and reachable call light. The facility's 01/21/25 Investigation documented on 01/16/25 at approximately 05:10 AM LN G found R1 on his bathroom floor. R1's care plan included he needed one staff assistance for toilet transfers, however, R1 attempted to transfer himself without calling staff for help. R1 stated he fell on [DATE] at approximately 09:00 PM and could not reach the call light for help. During the post-fall assessment completed by LN G, R1 stated he hit his head. LN G notified Administrative Nurse E, the provider, and R1's family with a decision made at that time to send R1 to the hospital for further evaluation. The hospital found no major injuries. The investigation concluded CNA M did not complete her two-hour rounds on the residents in her care. LN G received a final written warning to ensure CNAs completed their two-hour rounding. R1's EMR revealed the following: A Nursing note on 01/16/25 at 06:52 AM documented LN G entered R1's room to empty his catheter bag at the end of the shift on 01/16/25 at approximately 05:05 AM. Upon entering R1's room, LN G found R1 lying on the bathroom floor on his back with the upper half of his body in the shower. R1 used his jacket as a pillow behind his head. LN G asked R1 what happened and R1 stated he tried to go to the bathroom last night before bed at approximately 09:30 PM and he slipped out of his wheelchair onto the floor. R1 stated he hit his head and had some pain in his right-sided ribs, and he complained of soreness from lying on the bathroom floor. R1 stated he was okay, and he just wanted to get off the floor. LN G took R1's vital signs before picking him up off the floor. LN G asked R1 if he tried to scream for help and R1 stated what was the point, you guys would not have heard me. LN G sent R1 to the hospital for evaluation and treatment and notified the provider and Administrative Nurse E. A Fall Committee Interdisciplinary Team (IDT) note on 01/16/25 at 03:10 PM documented the Fall Committee met to discuss R1's fall in his bathroom last night at approximately 09:00 PM. R1 was at the hospital in the emergency room (ER) after he voiced he laid on the floor after his fall, for an extended period of time. When LN G found R1, he voiced he fell and hit his head. R1 complained of head pain and LN G immediately sent him to the hospital. R1 was unable to pull his bathroom call light as it was wrapped around the bar, and he had hand contractures. A Computed Tomography (CT scan- a test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) scan on 01/16/25 at 07:36 AM documented no acute intracranial (within the skull) process and no acute fracture noted in the cervical (neck), thoracic (middle back), or lumbar (low back) spine. In a witness statement on 01/17/25, LN G stated she went to give R1 his medications at approximately 06:45 PM to 07:00 PM and he was in the bathroom. She stated she went back to give him his medications and he refused his eye drops and neck cream. LN G stated CNA M entered R1's room a couple of minutes later and emptied R1's trash. She stated she did not go back into R1's room and she did not know that he needed help to bed. She stated she saw R1 again a little before 05:00 AM on 01/16/25 when she went to empty his catheter bag and found him on the floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/23/25 at 01:21 PM, R1 sat in his wheelchair in his room. He had a pendant call light around his neck. On 01/23/25 at 01:53 PM, R1's bathroom had a call light cord beside the toilet. The shower had a small lip on the floor to separate from the bathroom floor. On 01/23/25 at 01:21 PM, R1 stated on 01/15/25 he tried to get on the toilet and made the mistake of sitting on the edge of the cushion and the momentum of going forward caused him to slide off and fall onto the floor in the shower. He stated he fell on to the shower floor with his head under the shower seat and only his feet were not in the shower. R1 stated his hands and feet were useless so he could not crawl out of the shower to reach the call light for help. He stated when he laid on the floor, he prayed a lot, sang songs to himself, thought over things, went stir-crazy, and was thirsty. R1 stated the doors were thick so he did not scream for help because staff would not have been able to hear him. He stated he thought he was dying while he laid on the floor, he was cold and did not have a pillow. R1 stated his family almost lost him due to negligence. On 01/23/25 at 02:14 PM, CNA N stated not checking on residents, leaving them soiled, not providing cares that needed done, and not doing rounds were neglect. She stated she completed two-hour checks and for fall risk residents, she checked on them every time she walked past their room. CNA N stated she made sure every resident was where they needed to be and hopefully not on the floor. On 01/23/25 at 02:39 PM, LN H stated not feeding a resident, not changing someone, not giving medications, and not doing rounds were neglect. She stated staff completed rounds every two hours and laid eyes on the residents. LN H stated agency staff read through the agency book policies with the facility staff. On 01/23/25 at 02:45 PM, Administrative Nurse D stated not answering call lights timely, not turning/repositioning, not following treatment orders, and not completing rounds appropriately and timely were neglect. She stated she expected staff to do rounds every two hours, even if the resident was sleeping to make sure their needs were met. She expected facility staff to go over the agency book with the agency staff and the CNA received report. Administrative Nurse D stated the report did state that R1 would pop his head out when he wanted to go to bed. On 01/23/25 at 02:56 PM, Administrative Staff A stated not answering call lights, not checking on residents, and not changing residents were neglect. She stated she expected staff to do two-hour rounds and put eyes on the residents. She stated before agency staff touched a resident, they reviewed the agency book with facility staff, signed it, and then received report. Administrative Staff A stated on 01/16/25, LN G found R1 on the floor and sent him to the hospital. She stated R1 reported he fell around 08:00 PM to 09:00 PM on 01/15/25. She stated she started the investigation, and they determined the root cause analysis was CNA M failed to complete two-hour rounding. On 01/29/25 at 09:00 AM, CNA M stated on 01/15/25 she last saw R1 when she emptied his trash and asked if he needed anything which he did not, but she was unable to recall the time. She stated she received report that R1 would call when he wanted to go to bed. CNA M stated she found it strange that he never called to go to bed, but she did her best to trust what was told in report. She stated she completed rounds every two hours but could not remember going into his room again. On 01/29/25 at 09:04 AM, LN G was unavailable for interview. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Abuse: Prevention and Prohibition Against policy, last revised December 2023, directed each resident had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. The policy defined neglect as the failure of the facility to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility failed to ensure R1 remained free from neglect. On 01/15/25 between 08:00 PM and 09:00 PM, R1 fell on to the bathroom floor and remained there until LN G found him on 01/16/25 at approximately 05:10 AM. The facility sent R1 to the hospital for evaluation where the hospital found no acute injuries. Upon investigation, the facility discovered CNA M failed to complete two-hour rounding on her assigned residents. This deficient practice placed R1 in immediate jeopardy. On 01/29/25 at 04:08 PM, Administrative Staff A was provided a copy of the IJ template and notified of the facility's failure to ensure R1 remained from neglect which placed him in immediate jeopardy. The facility identified and implemented the following corrective measures, completed by 01/20/25: The facility placed CNA M on the do not return list on 01/16/25. LN G received a final written warning for not completing rounding on 01/17/25. The facility started two-hour rounding check sheets at night on 01/16/25. The facility started two-hour rounding check sheets all day on 01/18/25 The facility updated R1's care plan to include a call-light pendant on 01/20/25. The facility completed staff education on rounding, agency education, and abuse/neglect/exploitation by 01/20/25. The surveyor verified the implemented corrective actions on 01/29/25 at 04:14 PM. Due to the facility's corrective actions completed prior to the surveyor's arrival onsite, the deficient practice was deemed past non-compliance at a J scope and severity.