STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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 A partial extended complaint investigation for KS00168075 and KS00168221 was concluded by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 01/04/22. On 01/04/22 at 05:01 PM the Administrative Staff A, Administrative Staff B, and Administrative Nurse B were provided with the IJ template and notified that the facility failed to ensure an environment free from neglect when facilty staff completed multiple unsafe stand pivot transfers of dependent Resident (R)1, who had right sided paralysis, constituted immediate jeopardy at F600. The immediate jeopardy at F600 also constituted Substandard Quality of Care at 42 CFR 483.12. The immediate jeopardy was determined to first exist on 12/09/21 when R1 fell twice during stand pivot transfers. The facility presented an acceptable plan for removal of the immediate jeopardy on 01/04/22 at 06:47 PM. The survey team validated that the immediate jeopardy was removed on 01/04/22 onsite following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a "G" (isolated with actual harm) scope and severity following the removal of the immediate jeopardy.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/20/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

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AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

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F 600	Continued From page 1	F 600		

neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
The facility census totaled 42 residents. Based on observation, interview, and record review the facility failed to ensure an environment free from neglect when facilty staff completed multiple unsafe stand pivot transfers of dependent Resident (R)1, who had right sided paralysis. On 12/10/21 at 08:49 PM Hospitality Aide D, attempted to stand pivot transfer R1 alone, with no training, and without use of a gait belt. Hospitality Aide D lowered R1 to the floor after missing the seat of the wheelchair. Licensed Nurse (LN) C arrived to the room had multiple unsuccessful attempts to get R1 from the floor to the bed, without use of a gait belt, and R1 cried out in pain each time. After getting R1 to the bed, LN C then used R1's right mid upper arm only to transfer R1 from the bed to the wheelchair and caused R1 to cry out in pain. These failures placed the residents at risk for psychosocial, mental, and physical harm and increased pain, which constituted immediate jeopardy.

Findings included:

- Resident (R)1's pertinent diagnoses from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

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F 600	Continued From page 2	F 600		

"Physician's Orders" in the "Electronic Medical Record (EMR)" dated 12/08/21 revealed pain, muscle weakness, and hemiplegia (a muscular weakness of one half of the body)/hemiparesis (a paralysis of one side of the body) following cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The 11/22/21 "Significant Change Minimum Data Set" (MDS) revealed a staff assessment for mental status indicating R1 had long and short-term memory problems and moderately impaired decision-making skills. R1 required extensive assistance of one staff for transfers and had impairment to one side of her body, both upper/lower extremities (limbs). R1 experienced two or more non-injury falls and one fall with minor injury during the review period.

The 11/22/21 "Activities of Daily Living (ADL) Care Area Assessment (CAA)" revealed R1 required up to extensive assistance of two staff to meet daily her ADL needs.

The 11/22/21 "Falls CAA" revealed a recent history of falls, one with minor injury.

The 12/04/21 "Fall Risk Assessment" revealed R1 was at risk for falls.

The 09/24/21 "Comprehensive Care Plan" revealed R1 required extensive assistance of one staff for transfers and indicated R1 was at risk for falls due to her gait (manner or style of walking).

The facility provided information electronically on 01/05/22 which revealed R1 experienced a fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE WICHITA, KS 67205

(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 600	Continued From page 3	F 600		

12/04/21 at 07:15 AM. The investigation concluded it was "patient-behavior related" noting R1 grabbed the footboard of the bed when the CNA tried to tun the corner around the bed, to get R1 ready for bed.

The facility submitted information electronically on 01/05/21 which identified a date of service of 12/09/21 "Summary of Daily Skilled Services" which noted, "Consulted with nursing staff present for earlier incident, competency checked and passed for brake management during transfers." The note identified R1 required moderate assistance with verbal cues for lower extremity placement with weight shifting, required moderate assistance to complete weight shifting. R1 had a controlled fall earlier in the day, examined brakes and locked appropriately. This note was electronically signed by Occupational Therapy Assistant (OTA) on 12/15/21 at 09:04:28 AM.

An additional "Summary of Daily Skilled Services" with a date of service as 12/10/21 noted R1 required moderate assistance and 35% verbal cues for weight shifting and clothing management seated to edge of bed. R1 required minimal assistance with right lower extremity blocking for sit to stand from edge of bed. R1 required stand pivot transfer with verbal cues for body position, weight shifting and premature descent to wheelchair. The note was signed by the OTA on 12/15/21 at 09:04:28 AM.

The 12/09/21 at 09:48 AM "Fall Investigation" revealed R1 experienced a fall during a stand/pivot transfer by CNA I from her wheelchair to the bed and was lowered to the floor. The fall investigation noted this as a "staff related fall" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

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F 600	Continued From page 4	F 600		

the facility would follow-up for additional staff training to "ensure safe transfers."

The facility provided information electronically on 01/05/22 titled "Fall Investigations" which revealed R1 experienced a fall on 12/09/21 at 07:30 PM. The investigation noted the fall was "very similar to the 2nd fall that happened 10 hours earlier and I was able to re-educate staff on making certain they are aware of how to transfer a patient safely and how to get the information." The information also noted administrative staff "huddled with staff and re-educated the on safe transfers that included locking the brakes of a wheelchair every time. I also coached them on frequent re-education with impulsive patients ....PT Director involved as well to coach and re-educate staff on the specifics of safe weight-bearing transfers."

The 12/09/21 at 07:30 PM "Fall Investigation" revealed R1 experienced a fall during a stand pivot transfer by CNA F from her bed to the wheelchair and was lowered to floor. The fall was noted as "very similar to fall earlier in the day, re-educated staff on safe transfers."

The 12/09/21 "Grievance Log" with "Resident Grievance/Complaint Form" revealed a complaint of "inappropriate transfers" regarding CNA transfers on 12/09/21 at 09:48 AM and at 07:30 PM.

The facility did not have a "Fall Investigation" regarding falls for R1 from 12/10/21.

The electronic audio/video footage provided by the resident representative revealed the following, each 30 seconds long:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

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F 600	Continued From page 5	F 600		

On 12/01/21 at 10:30:21 PM an unidentified staff member assisted R1 to transfer from her bed to her wheelchair. The unidentified staff member pulled R1 to a seated position by R1's left hand. The staff member bent forward, placed her arms under the arms and around the back of R1 and completed a stand pivot transfer of R1, without use of a gait belt.

On 12/02/21 at 02:39:29 AM revealed two unidentified staff members in R1s room. One of the unidentified staff members assisted R1 from her bed to her wheelchair without use of a gait belt. The staff member put her right arm around R1's left side and her left hand under R1's bent right elbow. During the transfer, the staff member and R1 stumbled, and the other staff member in the room reached out with her right arm and quickly looped it through R1's bent right arm and helped situate R1 into the wheelchair. At this time (about 11 seconds into the video) the staff member told the other staff member "she is definitely a two person" and then says to the resident "Are you okay? Sorry about that." You could then hear the resident say "ohh ohh" in the video clip during the transfer. When the staff member walked behind the wheelchair to propel R1 away, the staff member made the gesture of falling backwards toward the other staff member out of sight of the resident (as if recounting the balance issue). R1 made a comment of "What?" and "you're talking about me" to which the two staff members chuckled and said something unintelligible.

On 12/02/21 at 07:05:56 PM an unidentified staff member assisted R1 from her bed to her wheelchair, without use of a gait belt, and held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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 600	Continued From page 6	F 600		

the resident under her arms. During the transfer the staff member stumbled back, with R1's body falling forward into the staff member and R1's right side of her lower body struck the inside of the right armrest of the wheelchair before the staff member recovered and lowered R1 in the wheelchair. Both the staff member and R1 made audible noises. The staff member loudly states "Foot! Foot! Ow! Oh! Oh!" while the resident said "Ow." After the staff member situated the resident into the wheelchair she told the resident "Sorry, I was slipping'" and the resident replied, "I know you were" and "Where did that get you?" The staff member inquired of R1, "Are you okay?" and R1 replied "I think so." The staff member then said, "I'm more worried about you right now" and R1 said "I think I'm alright." The staff member then walked behind the wheelchair and used her arms under R1's armpits to pull R1 back into the wheelchair fully, asking "Here, can you scoot back for me?'

On 12/10/21 at 08:49:40 PM Hospitality Aide D helped R1 up to the side of the bed into a seated position with R1's legs off the side of the bed and said to R1, "I believe in you. It's okay. We got this." R1 made a painful moan. Hospitality Aide D then positioned the resident's wheelchair to the right side of the resident (facing toward the resident at an angle) and applied the brakes. R1 then asked the staff member, "Is it just you?" and Hospitality Aide D told the resident, "Yes. You can hang onto me. I promise I got you, okay" as she bended forward to position her right arm around R1's left side and back, with no gait belt applied or seen in the video. Hospitality Aide D asked R1 "Can you put this arm around me?" as Hospitality Aide D used her left hand to cue/prompt R1 to lift R1's right hand away from her person (though the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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 600	Continued From page 7	F 600		

resident has paralysis on the right side of her body).

On 12/10/21 at 08:50:36 PM revealed Hospitality Aide D stood embraced with R1, holding R1 through a hug-type position with Hospitality Aide D's arms wrapped under the arms and around the upper back of R1, with no gait belt used. R1's right arm hung to her right side as Hospitality Aide D pivoted the resident counterclockwise over 90 degrees toward the seat of the wheelchair. Hospitality Aide D states, "step back again ....as best as you can" and you can see the unsteady movement as Hospitality Aide D backed R1 up toward the wheelchair, in a rocking side to side slow step. As Hospitality Aide D began lowering R1 toward the wheelchair seat, she asked R1 "Are you in the chair at all?" and R1 responded "No, no, no." You could see Hospitality Aide D looking over R1's right shoulder toward the wheelchair and stated, "It's Okay." R1 then reached with her left arm/hand toward the bed as Hospitality Aide D says "Get on the chair" in an urgent/alarmed tone of voice (louder and in an elevated pitch). Hospitality Aide D then lowered R1 more and appeared to miss the edge of the wheelchair, as R1 shifted downward suddenly. Hospitality Aide D said, "Oh my gosh" and lowered R1 to the floor in front of the wheelchair. Hospitality Aide D then helped the resident to a sitting up position on the floor asking R1 "Here. You sitting up okay?" R1 sounded breathless/winded in her responses as Hospitality Aide D asked if she were okay and she said "yeah" and Hospitality Aide D is seen reaching toward R1's back and said "The chair really got you okay."

On 12/10/21 at 08:52:11 PM R1 is on the flood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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 600	Continued From page 8	F 600		

seated in front of the wheelchair with her back to camera and is heard stating "my legs hurt so bad" as LN C and Hospitality Aide D arrive to her room. LN C walks over and says something unintelligible to the resident as he positions himself in front of R1 and he put R1's left arm onto the bed and then tried to push away the wheelchair from behind R1, so Hospitality Aide D backed the wheelchair up a little and the bent forward from the left side of the wheelchair (between the bed and wheelchair) and attempted to help lift R1 with LN C lifting her from her mid-upper arms, three times, without use of a gait belt. R1 yelled out in a painful manner and then began to sob loudly and say, "Oh my god, that hurts." LN C bent forward and said something to Hospitality Aide D about something was "caught on [unintelligible]" and you see Hospitality Aide D reaching toward the backside of R1.

On 12/10/21 at 08:52:51 PM, LN C continued to readjust his grip on R1's mid-upper arms in an attempt to pick R1 up from the floor, bringing R1's right elbow over R1's head as he lifted unsuccessfully. R1 remained seated on the floor in front of the wheelchair and bed, crying loudly. LN C attempted to lift R1 again and made a few grunting sounds from his efforts to lift R1 unsuccessfully. He then stepped around behind the resident (appears to trip over R1's extended legs as R1 sits on the floor parallel to the bed with her feet toward the head of the bed) and he positioned himself behind R1's back, bent forward and lifted her up from behind under her armpits to the edge of the bed while she screamed out in pain and sobbed saying "oh my god it hurts, oh my god, oh my god". Hospitality Aide D attempted to help reposition R1 onto the bed with LN C lifting R1 deeper into a seated position at the side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	**7057 WEST VILLAGE CIRCLE WICHITA, KS 67205**

(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 600	Continued From page 9	F 600		

of the bed as the video showed her right arm being lifted above her head, and R1 screamed out very loudly in pain and sobbed, rubbing her right arm saying, "this one hurts." LN C states to Hospitality Aide D to get another person next time before (to help transfer R1) then he asked, "she wanted to use the bathroom?" and R1 loudly said "Yes" as she cried.

On 12/20/21 at 08:53:31 PM, LN C pulled the wheelchair next to R1's bed and R1 was seated on the edge of the bed not crying, but guarding her right arm, with a grimacing facial expression, and R1 began to cry and rub her right upper arm as LN C positioned himself in front of her. Hospitality Aide D said "I'm so sorry honey" as she stood behind the wheelchair watching LN C and R1 in front of her. R1 said "oh my god, oh my god" and LN C said to R1, "You're okay." R1 began to cry and stated "I don't know if I want you to try it again." LN C grabbed her arms and put R1's left arm across her chest to her right elbow and said "put your hand like this" and R1 said "I'm trying" and as LN C readjusted his grip, R1's left arm moved back and LN C quickly moved her left arm back across her chest and said firmly "you have to put your hands like this." R1 sobbed "I am, I am" and then cried out as LN C lifted her up by only using her right mid-upper arm, without use of a gait belt, to transfer her from the bed to the wheelchair.

Observation of the resident on 01/04/22 at 08:53 AM revealed CNA L assisted the resident from her bed to her wheelchair with a gait belt.

Observation on 01/04/21 at 12:10 PM revealed R1 with healing, yellow bruising to both arms, and multiple circular areas of discoloration noted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE WICHITA, KS 67205

(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 600	Continued From page 10	F 600		

both upper and lower arms.

A confidential interview on 01/03/22 at 09:13 AM revealed R1 had falls because staff did not use the gait belt for transfers and had dropped the resident and the person did not know if staff knew how to take care of a stroke patient.

Interview with R1 on 01/04/22 at 12:10 PM revealed she could not remember staff names, but stated the staff grabbed under her arms to transfer her to the wheelchair or bed. R1 said, "it hurts when they do that" and said she could "do a stand/pivot transfer with the gait belt with one staff if they were strong enough. I have pain in my shoulders, arms, and in my right leg since the falls; four falls in one-week last month. It scares me so much that I am going to fall, it scares me so much."

Interview with Hospitality Aide D on 01/04/22 at 10:07 AM revealed she was a hospitality aide and could not provide assistance with resident transfers. When asked if she had ever transferred any residents in the facility, she stated "well, on 12/10/21 at approximately 08:00 PM or 09:00 PM, I assisted [R1] one time with a transfer but no gait belt and I set the resident on the floor." Hospitality Aide D stated CNA E told her to assist R1 because R1 was screaming in her room for assistance. Hospitality Aide D said she got LN C to help and he came in, but it was "brutal, uncaring." She stated the staff could have got the lift, but he did not. Hospitality Aide D said the resident cried out in pain, and LN C just kept pulling up roughly under R1's arms and her pants. Hospitality Aide D said the incident really hurt her and it was mortifying, as she felt so much guilt and fear from it. She said she was never trained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE WICHITA, KS 67205

(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 600	Continued From page 11	F 600		

to transfer or to use a gait belt, and no one had told her about the rules. She said she had an orientation but was not told what she could do as a hospitality aide. Hospitality Aide D stated she started CNA classes the next month, and now she knew she could not assist with resident transfers or cares. She said the resident told her it was one of many times facility staff tried to stand pivot transfer her without the use of a gait belt.

Interview with CNA E on 01/04/21 at 11:31 AM revealed it was possible she asked Hospitality Aide D to help R1 get whatever she needed, but stated R1 required a gait belt for her stand pivot transfers, and she did not think hospitality aides could transfer.

Interview with CNA H on 01/04/22 at 08:24 AM revealed R1 required assistance for transfers with a gait belt. CNA H said the resident had paralysis on her right side, upper body mostly. CNA H said she had transferred residents without a gait belt, but only if she were confident in the transfer.

Interview with CNA I on 01/05/22 at 08:31 AM revealed R1 required assistance with transfers with a gait belt. CNA I said one time she did not use a gait belt for transfer with R1.

Interview with CNA J on 01/05/22 at 08:47 AM revealed he saw Hospitality Aide D transfer residents. CNA J said she has not used a gait belt before and he told her she was a hospitality aide and could "not do any of this." CNA J said he talked to LN K about it, but he had not told Administrative Staff A or Administrative Nurse B.

Interview with LN K on 01/04/22 at 10:50 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

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(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 600	Continued From page 12	F 600		

revealed in the last few weeks R1 was tearful about transfers. LN K said she had not seen or heard of any resident transfers without the gait belt, and if she did, she would address and report it.

Interview with LN C on 01/04/21 at 03:19 PM revealed Hospitality Aide D came to him stating she lowered R1 to the floor during a transfer. He stated "then after that, I helped her to get [R1] back to bed. It was not normal to pick [R1] up under her arms without a gait belt, but I was so upset, and [R1] wants things fast, so I did it fast. We could have called someone else to help, because [Hospitality Aide D] was not a CNA" and said R1 then wanted to use the bathroom. LN C thought he called Administrative Nurse B because that was the procedure.

Interview with Administrative Nurse B on 01/04/22 at 09:34 AM revealed "it is not appropriate to lift a resident under their arms ... staff should be using the gait belts for every stand pivot transfer." Administrative Nurse B said the staff should be educated on the resident transfer status and resident capabilities. LN C was the nurse responsible for R1 the night of 12/10/21 and he usually called her for everything, but he did not call me that night. She continued "hospitality aides should not transfer residents, as they have no transfer training ... Neither staff followed policy for transfers or falls in this situation."

Interview with Administrative Staff G on 01/04/21 at 11:59 AM revealed Hospitality Aide D was hired on 12/08/21 and signed the "Hospitality Job Description with posttest" and completed general orientation.

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	175563	A. BUILDING _____ B. WING _____	C 01/04/2022

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F 600	Continued From page 13	F 600		

Interview with Administrative Staff A on 01/04/22 at 02:17 PM revealed "the licensed and certified staff would provide transfers. The hospitality aide could not provide transfers. Staff did not follow the facilities policies and [Hospitality Aide D] did not stay within her scope of practice .... Administration should have been notified at the time of the incident and a report could have been made."

The "Hospitality Aide Job Description" signed on 12/08/21 by Hospitality Aide D revealed the hospitality aide safeguards the health, safety and welfare of all residents under their care by following applicable laws, regulations, and established nursing policies and procedures. This position is not allowed to provide resident care.

The 12/2021 "Transfers" policy revealed use of a transfer belt during pivot transfer and/or transferring resident from the bed to the chair for the following reasons: to provide a firm grasping surface for the staff person, to protect the resident from accidental trauma to skin, to give the resident a sense of security and to allow the team member to lower the resident gradually (to the floor if necessary) without injury to either party.

The facility failed to ensure an environment free from neglect when facilty staff completed multiple unsafe stand pivot transfers of dependent Resident (R)1, who had right sided paralysis. On 12/10/21 at 08:49 PM Hospitality Aide D, attempted to stand pivot transfer R1 alone, with no training, and without use of a gait belt. Hospitality Aide D lowered R1 to the floor after missing the seat of the wheelchair. Licensed Nurse (LN) C arrived to the room had multiple

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F 600	Continued From page 14	F 600		

unsuccessful attempts to get R1 from the floor to the bed, without use of a gait belt, and R1 cried out in pain each time LN C pulled on her upper arms. After getting R1 to the bed, LN C then used R1's right mid upper arm only to transfer R1 from the bed to the wheelchair and caused R1 to cry out in pain. These failures placed the residents at risk for psychosocial, mental, and physical harm and increased pain, which constituted immediate jeopardy.

On 01/04/22 at 06:27 PM the facility provided an acceptable plan for removal of the immediate jeopardy, which included the following:

1. The facility evaluated R1 for injury with no injury noted.
2. The facility started an investigation and completed employee interviews/statements and suspension of Hospitality Aide and Licensed Nurse. The facility staff interviewed the alert and oriented residents on 01/04/22.
3. The facility completed a self-report to KDADS.
4. DON/designee reviewed documentation for past 14 days to ensure fall documentation and follow-up actions were completed/documented on 01/04/22.
5. The facility reviewed the current employee roster to identify any other hospitality aides on 01/04/22, and none employed at this time.
6. DON/designee reviewed current resident transfer status to ensure care plan/Kardex were current.
7. Immediate re-education-initiated with current nursing staff regarding safe transfers, fall prevention/post fall actions including documentation required.
8. Immediate education initiated for non-direct care staff on role in fall management.

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F 600	Continued From page 15 9. Transfer competency completed with licensed/certified nursing staff starting 01/04/22. 10. Immediate re-education to current licensed/certified staff regarding where to find fall interventions/transfer status for residents and re-education regarding ANE initiated 01/04/22. 11. DON or designee would complete observational audits of transfers three times a week for four weeks with results of the audits taken to Quality Assurance and Performance Improvement (QAPI, programs critical to improving the quality of life, care and services for residents in Long-Term Care Facilities). She would also audit fall documentation to ensure timely documentation occurred three times a week for four weeks with results taken to QAPI. The surveyor verified the implementation of the removal of the immediacy plan onsite on 01/04/22. The deficient practice remained at a "G" (isolated, with actual harm) scope and severity following removal of the immediate jeopardy.	F 600		