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 12/05/2023

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 complaint survey and partial extended survey was conducted regarding the allegations in KS00184237, KS00182777 The investigation revealed noncompliance was found related to the allegations and the following deficiencies were cited. On 12/04/23 at 04:59 PM, Administrative Staff A, Administrative Nursing Staff D, and Administrative Nursing Staff E were provided a copy of the F689 immediate jeopardy (IJ) template and informed of the IJ for the failure to ensure the safety of Resident (R)1 when the facility failed to provide adequate supervision and ensure a safe environment on 11/20/23, when the facility sent cognitively impaired dependent R1 to R2's medical appointment. The facility mixed up R2 and R1's identity and dropped off R1 at the front doors of a medical clinic, alone, for R2's appointment. R1 did not have any identification on him and did not know why he was at the appointment. The facility did not know R1 was out of the facility until the medical clinic staff called the facility to point out the facility dropped off the incorrect resident. This failure placed the resident in Immediate Jeopardy. The facility provided an acceptable plan for removal of the immediate jeopardy on 12/05/23 at 11:00 AM. The surveyor verified the facility implemented the corrective actions while onsite on 12/05/23 at 11:30 AM. The deficient practice remained at a scope and severity of "D", after removal of the immediate jeopardy.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/11/2023

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 000	Continued From page 1 This 2567 was electronically sent to the facility on 12/11/23. Due to the results of an IDR on this deficiency, the scope and severity is being lowered to a D. A revision of this 2567 with the revised s/s will be sent to the facility on 1/25/24.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 67 residents, with three residents included in the sample. Based on observation, interview, and record review, the facility failed to provide adequate supervision and ensure a safe environment on 11/20/23, when the facility sent cognitively impaired dependent Resident (R)1 to R2's medical appointment. The facility mixed up R2 and R1's identity and dropped off R1 at the front doors of a medical clinic, alone, for R2's appointment. R1 did not have any identification on him and did not know why he was at the appointment. The facility did not know R1 was out of the facility until the medical clinic staff called the facility to point out the facility dropped off the incorrect resident. This failure placed the resident in Immediate Jeopardy.	F 689		

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F 689	Continued From page 2 Finding included: - The "Physician Orders" for R1, dated 10/18/23, revealed a diagnosis of cognitive communication deficit (difficult recalling short-term or long-term information). The "Significant Change of Status Minimum Data Set" (MDS), dated 01/12/23, revealed a "Brief Interview Mental Status" score of three, indicating severe cognitive impairment. R1 required extensive assistance of two staff with most Activities of Daily Living (ADL), used a mechanical lift for transfers, and a wheelchair for mobility. The "Quarterly MDS" dated 10/13/23, indicated a BIMS score of four, indicating severe cognitive impairment. R1 was dependent for ADLs, used a mechanical lift for transfers, and a wheelchair for mobility. The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 10/18/23, revealed the resident had cognitive loss, change in mental status, and short-term memory loss. The "Care Plan" revised 10/25/23, revealed R1 had impaired cognitive function or impaired decision making, and short-term memory loss. R1 required extensive assistance with ADLs. The "Nurses Notes" dated 11/20/23 at 11:34 AM, revealed a contracted transport company transported R1 to a hospital (mistakenly, for a R2's medical appointment) due to (mistaken identity due to R1 and R2 had) identical (first)	F 689		

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F 689	Continued From page 3 names. The staff notified R1's responsible party. The Electronic Medical Record for R1 lacked further documentation when facility staff sent a cognitively impaired R1 to R2's clinical medical appointment. The facility lacked an investigation following the return of R1 to the facility on 11/20/23 confirmed through interview with Administrative Nurse D. Observation on 12/04/23 at 09:35 AM revealed R1 sat in a high back wheelchair. R1 observed with a lift sling (sling usually of cloth material, placed under the resident for a transfer with a full body mechanical lift) underneath him. R1 had difficulty keeping his eyes open and could not hold a conversation. During an interview with the Medical Clinical Nursing Staff (MCN) Z on 12/04/23 at 09:45 AM, revealed the facility staff did not know R1 was not in the facility until the medical clinic called the facility. MCN Z stated R1 had paperwork for an appointment, and when the clinic nursing staff questioned R1, he could not tell the clinic staff member why he was there for an appointment. R1 was in a personal wheelchair with a mechanical lift sling underneath him. R1 did not have any identification, wallet, or cell phone on him, and when the clinic nursing staff asked his name during check-in, he replied with a different name than who was scheduled for the appointment, or his correct name. MCN Z reported the resident was very confused, and several clinic staff attempted to get information from him. There was no family or facility staff with him, so a clinic nursing staff took the appointment	F 689		

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F 689	Continued From page 4	F 689		

paperwork (R2's paperwork) and called the contact on the paperwork. MCN Z reported R2 answered the phone and informed clinic nursing staff that he was still at the facility, in his bedroom. Clinic nursing staff then notified the facility receptionist that R1 was at the medical clinic and was the wrong resident. After being placed on hold on the phone, the facility informed MCN Z there was a "mix up" on what resident should have been at the medical appointment. MCN Z reported the facility management they spoke with, "just did a little laugh and said they were super busy with some residents that were dying" and the facility had a new Certified Nurse Aide (CNA). MCN Z reported she told the facility management they needed to pick up the resident from their exam room. MCN Z said the facility should not have left a confused resident alone at the medical clinic with no one to help or no identification.

On 12/04/23 at 11:35 AM, Administrative Nurse D reported there was concern when staff transported the wrong resident to the appointment. There was a mix up of the residents. She reported she did not do an investigation and did not make a report to the State of Kansas Reporting hotline.

On 12/06/23 at 10:40 AM, Administrative Nurse D verified R1 left the facility on 11/20/23 at 09:30 AM and did not return to the facility until 11:30 AM (a total of two hours).

Interview with Licensed Nurse (LN) G on 12/04/23 at 03:30 PM, revealed the facility was short staffed when the resident mix-up occurred. The wrong confused dependent resident (R1)

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F 689	Continued From page 5 went to the appointment. When the (facility) receptionist called the nurses station and asked for the resident (by his first name only), staff took the wrong resident to the front desk for the transport. The facility failed to provide a policy regarding "Resident Identification System" as requested on 12/04/23. The facility failed to provide adequate supervision and ensure a safe environment on 11/20/23 when the facility sent cognitively impaired dependent R1 to R2's medical appointment. The facility mixed up R2 and R1's identity and the transportation company dropped off R1 at the front doors of a medical clinic, alone, for at least 2 hours. On 12/04/23 at 04:59 PM, Administrative Staff A, Administrative Nursing Staff D, and the Administrative Nursing Staff E were provided with the Immediate Jeopardy template and notified that the deficient practice placed R1 in immediate jeopardy. The facility provided an acceptable plan of removal on 12/05/23 at 11:00 AM which included the following: 1. On 12/05/23 at 09:40 AM, staff received re-education regarding resident identification, prior to any medical appointments, Staff would verify the picture of the resident on the face sheet. The staff would ensure all residents with appointments had appropriate paperwork and be transported to the front of the building after the verification of resident identification by photo and	F 689		

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F 689	Continued From page 6 name on the face sheet. Completion date of 12/06/23 at 07:00 PM. 2. On 12/05/23 at 09:30 AM, Administrator and or designee would complete 10 random quizzes weekly regarding transportation process for three months with results taken to the facility Quality Assurance and Performance Improvement (QAPI). 3. On 12/05/23 at 09:30 AM, Administrator and/designee would complete audits of the transportation process five times a week for four weeks, then weekly for four weeks, then monthly for one month. 4. A facility policy dated 12/04/23 "Resident Identification System" revealed a resident identification system is used to help the facility personnel provide complete coordination of medical and nursing care. The facility adopted a photo identification record which is confidential and used by nursing service and other applicable personnel when administering medication, treatments and preparing residents for community appointments. The surveyor verified the facility implemented the corrective actions while onsite on 12/05/23 at 11:30 AM. The deficient practice remained at a scope and severity of "D", after removal of the immediate jeopardy.	F 689		