

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 565 SS=E	The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 08/10/22. Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565			

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

TITLE

(X6) DATE

08/10/2022

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.

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 565	Continued From page 1 family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed ensure the resident council was able to meet regularly, which placed the residents at risk for unmet concerns related to life in the facility. Findings included: - Record review of the "Resident Council Meeting" revealed the facility had no minutes or meetings for the months of August 2021, September 2021, January 2022, and April 2022. On 08/01/22 at 01:03 PM Social Services X reported the meetings were scheduled monthly. Social Services X stated she could not remember why no meeting was conducted in August 2021. The September meeting had been canceled due to staffing issues. The January 2022 meeting was canceled due to a Covid (highly contagious, potentially life-threatening respiratory infection) outbreak in the assisted living building. The April 2022 meeting was canceled due to staffing issues. Social Services X verified she had not rescheduled the meeting during the previously noted months. On 08/02/22 at 11:53 AM, Administrative Staff A verified the resident council meetings should be allowed to meet at least monthly monthly and should have been rescheduled to facilitate the	F 565			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 565	Continued From page 2 meetings. The facility's undated "Resident and Family Group" policy documented the facility is committed to consideration of views of the resident group and will act promptly upon grievances and recommendation of the group concerns issues of resident care and life in the facility, and meeting will be included on the monthly activity calendar. The facility failed to ensure the resident council was able to meet at least monthly placing the residents at risk for unmet concerns.	F 565			
F 657 SS=E	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	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 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 had a census of 43 residents. The sample included 12 residents of which six were reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to update interventions on the care plans to prevent falls and hot beverage spill for Resident (R) 6, R34, R14, and 32. This deficient practice placed the residents at risk for injuries and accidents due to uncommunicated care needs. Findings included: - The "Medical Diagnosis" section within R6's Electronic Medical Record (EMR) included diagnoses of unspecified fall, hypertension (elevated blood pressure), traumatic subdural hemorrhage (collection of blood on the surface of the brain) without loss of consciousness, and dementia (progressive mental disorder characterized by failing memory, confusion). The "Quarterly Minimum Data Set" (MDS), dated 07/15/22, documented R6 had moderately impaired cognition, required supervision to limited assistance with activities of daily living, was not steady, but was able to stabilize without staff assistance with moving from a seated to standing position, moving on and off the toilet, and surface to surface transfers. R6 was not steady and only able to stabilize with staff assistance with turning	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 4 around and facing the opposite direction when walking. The MDS further documented R6 had no trial of a toileting program, was frequently incontinent of urine and bowel, and had two or more falls with no injury and one fall with injury since last assessment. The "Fall Care Area Assessment" (CAA), dated 01/18/22, documented R6 had been admitted following hospitalization after a fall in which had resulted in subdural hematoma. The "Fall Care Plan", revised on 02/07/22, documented R6 was at risk for falls related to impaired balance, gait, and poor safety awareness. The care plan directed staff to ensure R6 wore appropriate footwear when ambulating, transferring or mobilizing in her wheelchair. Staff were to anticipate R6's needs, check frequently, ensure touch call light pad within reach with encouragement and remind R6 to use it for assistance, and to respond for requested assistance. The care plan further directed staff to keep floor free from spills and clutter, use of glare free light, bed in low position at night, handrails on walls in the bathroom, and keep personal items within reach. The "Fall Care Plan," revised on 04/21/22, directed staff to toilet R6 between 02:00 AM to 03:00 AM and ensure a nightlight was kept on in the bathroom to reduce chance of early morning falls. The care plan lacked intervention related to falls on 02/02/22, 02/16/22, 02/27/22, 03/04/22, 03/25/22, 05/31/22, 06/08/22, 06/26/22, 06/30/22, 07/16/22, and 07/26/22. The "Physician Order", dated 01/10/22, documented the admission of R6 to the facility	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 5 due to a fall resulting in a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to back of head. The facility's "Fall Risk Assessment" dated 01/11/22, documented R6 was at moderate risk for falls. The facility's "Fall Risk Assessment", dated 04/14/22 and 07/14/22 documented R6 scored at high risk for falls. The "Progress Notes" recorded the following falls: 02/02/22 at 02:47 PM, fell in bathroom reaching for incontinent pad and received a skin tear to right hand. 02/16/22 at 05:10 AM, found on floor by her recliner, incontinent of urine, and had cut to right eyebrow, bruise to right cheek bone, and hematoma to back of right hand. 02/27/22 at 12:52 AM, resident on floor of room. R6 reported she fell in the bathroom changing her incontinent product. 03/04/22 at 03:00 AM, resident on floor of her bathroom, incontinent of urine; she reported she hit her head on the wall. 03/25/22 at 08:52 AM, found lying on her back next to her bed, holding transfer bar, had golf ball size hematoma to left side frontal lobe (forehead) with three skin tears to left hand. R6 reported she had backed up to the chair and fell to the side. 04/18/22 at 03:00 AM, found on floor of bathroom, incontinent of urine, reported reaching for incontinent product and slid to floor. Skin tear to right elbow. 05/31/22 at 10:57 AM, fell while making her way to the bathroom, holding lip stick in one hand and reaching for the doorknob with the other hand. 06/08/22 at 01:53 AM, found on floor of	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 6 bathroom, reported trying to sit on toilet and lost balance, hitting back of her head. 06/26/22 at 05:47 AM, found on floor, reported she tried to pick up her shoe and landed on her face. She had some signs of bruising and small skin tear. 06/30/22 at 01:15 PM, R6 pulled out a chair in the dining room and lost her balance. 07/16/22 at 01:00 PM, R6 returned from outing with a family member, her walker caught on carpet in the entry way. Family member tried to catch her, and the resident fell onto the family member. 07/26/22 at 02:45 AM, found sitting on bathroom floor, incontinent of urine. On 08/01/22 at 09:30 AM, observation revealed R6 sat in her room in her recliner with her eyes closed. She was dressed for the day and wore tennis shoes. R6 reported her call light was on her bed and she should use it when going to the bathroom. On 08/01/22 at 08:57 AM, Certified Medication Aide (CMA) R reported if a resident fell, staff were to immediately notify the charge nurse, to assess the resident. The staff were alerted the resident had fallen in the communication system of the electronic record. On 08/01/22 at 10:00 AM, Licensed Nurse (LN) H reported when a resident fell, the staff alert the charge nurse to assess the resident; a neurological exam and 15-minute checks were initiated. LN H stated a new intervention should be placed at the time of the fall, and the care plan should be updated with the intervention. On 08/02/22 at 08:41 AM, Administrative Nurse D	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 7 verified R6's care plan had not been updated with interventions to prevent falls. She stated it was her responsibility to investigate falls and update the care plans. The facility's undated "Care Plan Revision/Updates" policy documented each resident will have a care plan developed to meet their individual needs and cares. All resident care plans are reviewed quarterly, annually, and with any significant change in status. The facility failed to identify and implement interventions to the care plan to prevent falls for R6 who had multiple falls. This deficient practice placed R6 at increased risk for further falls and injury. - R34's "Medical Diagnosis" section within the Electronic Medical Record (EMR) included diagnosis of age-related physical debility, difficulty in walking, hypertension (elevated blood pressure), major depressive (major mood disorder) disorder recurrent, severe with psychotic (any major mental disorder characterized by a gross impairment in reality testing) symptoms, spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, right shoulder pain, anterograde amnesia (a type of memory loss that occurs when person cannot form new memories), and alcoholic cirrhosis (chronic degenerative disease of the liver) of liver with ascites (the accumulation of fluid in the abdominal cavity, causing swelling).	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 8 The "Quarterly Minimum Data Set" (MDS), date 07/01/22, documented R34 had intact cognition, required supervision to limited assistance of one staff for activities of daily living. R34 was not steady but able to stabilize without staff assistance with moving from a seated to standing position, moving on and off the toilet and surface to surface transfer, walking, and turning around and face the opposite direction while walking. The MDS further documented R34 had no trial of toileting program, was frequently incontinent of urine, always continent of bowel, and had pain. R34 had two or more falls with injury. The "Fall Care Plan", revised on 02/18/22, documented R34 at risk for falls related to impaired balance, strength, and safety awareness. The care plan further documented to encourage and remind R34 to use the call light, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility. The care plan directed staff to ensure R34's wheelchair was next to the bed and the brakes were locked, to wear appropriate footwear, keep safe environment free from spills and clutter, use glare free lights, reachable call light, bed in low position at night, handrails in bathroom and keep personal items within reach. The care plan further documented R34 attempted to get up unassisted and needed frequent checks to anticipate needs. The care plan lacked intervention for falls on 06/11/22 and 06/25/22. The "Progress Note", dated 06/11/22 at 06:30 PM, R34 was found sitting upright on the floor, incontinent of urine and reported she was looking for her TV remote.	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 9 The "Progress Note", dated 06/25/22, documented around 11:40 PM the resident was found on the floor by the wall. R34 stated she was going to the bathroom, lost her balance, and fell hitting her right shoulder against the wall. The "Physician Order" dated 06/26/22 directed staff to obtain two view x-ray of the right shoulder following a fall for swelling, bruising, and pain with movement. On 07/28/22 at 12:26 PM observation revealed R34 left the dining room independently with her walker. On 08/01/22 at 12:18 PM, Certified Medication Aide (CMA) R reported R34 was a standby for assistance with toileting as an intervention to prevent falls. On 08/01/22 at 10:00 AM, Licensed Nurse (LN) H reported when a resident fell, the staff alert the charge nurse to assess the resident, a neurological exam and 15-minute checks were initiated. LN H stated a new intervention should be placed at time of fall, and the care plan should be updated with intervention. On 08/02/22 at 08:41 AM, Administrative Nurse D verified R34's care plan had not been updated with interventions to prevent falls. She stated it was her responsibility to investigate falls and update the care plans. The facility's undated "Care Plan Revision/Updates" policy documented each resident will have a care plan developed to meet their individual needs and cares. All resident care plans are reviewed quarterly, annually, and with	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 10 any significant change in status. The facility failed to identify and update interventions on the care plan to prevent falls placing R34 at risk for further falls and injury. - The Electronic Medical Record (EMR) for R14 documented diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Quarterly Minimum Data Set" (MDS), dated 05/09/22, documented R14 had severely impaired cognition and had only transferred with one staff two or fewer times, did not ambulate, had unsteady balance, and had no functional impairment. The MDS further documented R14 had two or more non injury falls since prior assessment. The "Fall Risk Assessment," dated 05/03/22, documented the resident a high risk for falls. The "Care Plan," dated 05/09/22, initiated on 11/14/21, directed staff to use two staff to assist with transfers on and off of the shower chair, and provide and serve her diet as ordered. The care plan documented R14 was able to feed herself but occasionally required reminders and cuing during meals. The care plan lacked documentation R14 required lids on her hot and cold drinks. The "Nurse's Note," dated 04/13/22 at 09:04 AM, documented R14 spilled hot coffee down the left	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 11 side of her chest and abdomen, had slight redness, no blisters or burns present, and improved after five minutes. The "Nurse's Note," dated 06/26/22 at 03:45 PM, documented R14 spilled warm coffee on her left abdomen and upper thigh earlier that morning. The note documented R14 was sleepy upon rising from bed at 07:00 AM, had no redness or injury. The "Investigation Report," dated 07/09/22, documented R14 spilled her hot coffee onto her chest after a dietary aide had given it to her without a lid. The report further documented R14's had scattered redness to the front of her lower chest, lower abdomen and very slightly to the front of her thighs. The area of redness to the left chest measured 9 centimeters (cm) x 4 cm, redness to abdomen measured 5 cm x 1.7 cm x 0.7 cm in three different spots. The coffee had a temperature of 161.8 and directed dietary staff to ensure the temperature of hot beverages were within acceptable range when serving. The report documented R14 was on a list to have cooled coffee with a cup and lid and staff would receive further training regarding hot liquids. The "Physician's Order," dated 07/09/22, directed staff to apply silvadene cream 1% (an antibiotic cream used to treat burns) apply to left chest, abdomen, and thighs topically, twice a day for seven days. The "Nurse's Note," dated 07/10/22, documented no redness or blistering noted in relation to R14's coffee spill. The "Weekly Skin Assessment," dated 07/14/22,	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 12 documented R14 had faint red markings on the center of her abdomen. The "Investigation Report," dated 07/14/22, documented a Certified Nurse Aide (CNA) had to bear hug a resident to hold her up in the shower so another CNA could provide pericare after R14 had a bowel movement (bm). The report documented R14's feet slid due to the floor was wet and the CNA had to lower the resident onto the floor. The resident was assessed without injury and due to the resident unable to bear weight, staff used the hoist (mechanical lift) to assist the resident off of the floor and into her wheelchair. The report further documented R14 should have been properly positioned in the shower chair and should have been transferred with two staff. On 08/01/22 at 10:47 AM, observation revealed CNA M placed a gait belt around R14's waist, had her lean forward, count to three, and CNA M and Licensed Nurse (LN) I tried to stand the resident up straight. Further observation revealed R14 sat back down and CNA M counted to three again, and the resident was able to partially stand up and pivot to the wheelchair. R14 sat crooked in her wheelchair and CNA M took the back of her pants and pulled up to reposition the resident into the wheelchair. CNA M pushed R14 into the dining room, without foot pedals, into the dining room. On 07/28/22 at 08:47 AM, CNA M stated she did not know if R14 had any falls and would need to ask her nurse. CNA M further stated R14 required cups with lids so she did not spill on herself. On 08/02/22 at 10:05 AM, LN I stated R14 was a	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 13 two- person transfer and had a recent fall in the shower room. R14 stated staff should use foot pedals on the wheelchairs when transporting residents. On 08/02/22 at 08:30 AM, Administrative Nurse D stated R14 was on a list for resident's who required lids on their cups and that was not communicated to the dietary staff member. Administrative Nurse D stated the resident required two staff to transfers and should not have been transferred by one staff in the shower room. Administrative Nurse D stated she was responsible to update the care plan after a fall or incident and verified she had not done so. The facility's "Care Plan Revision/Updates" policy, undated, documented each resident would have a care plan developed to meet their individual needs and cares and would be reviewed and changed with each significant change of status. The facility failed to revise R14's care plan with interventions to prevent further falls and accident hazards, placing the resident at risk for further falls and injury. - The Electronic Medical Record (EMR), documented for R32 diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Quarterly Minimum Data Set" (MDS), dated	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 14 06/30/22, documented R32 had moderately impaired cognition and required extensive assistance of one staff for bed mobility and supervision and one staff for transfers. The MDS further documented R32 had unsteady balance, no functional impairment, and no falls. The "Fall Risk Assessments," dated 09/23/21 and 12/24/21 documented R32 a high risk for falls and 06/28/22 a moderate risk for falls. The "Care Plan," dated 07/07/22, initiated on 10/08/21, directed staff to ensure the call light was within reach and remind the resident to use it, ensure resident wore appropriate footwear when ambulating or transferring, and required one person assist for safe transfers. The care plan lacked interventions to prevent further falls. The "Fall Investigation," dated 12/07/21 at 02:29 PM, documented R32 fell while straightening the sheet on her bed, had soreness to bilateral knees, and denied hitting her head. The investigation further documented R32 reported she was messing with the edge of her sheet before getting into bed for a nap, slipped and fell to her knees. The clinical record lacked evidence a resident centered intervention was put into place to prevent further falls. The "Fall Investigation," dated 07/05/22 at 03:29 PM, documented at approximately 11:15 AM, R32 was observed on the floor in her room and the resident was seated in the upright position facing the hallway with her back against her nightstand. The resident stated she lost her balance while she tried to make her bed. R32 stated she did not hit her head and denied pain. The investigation documented R32 had poor safety awareness and	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 15 would continue to monitor the resident. The clinical record lacked evidence a resident centered intervention was put into place to prevent further falls. The "Fall Investigation," dated 07/07/22 at 09:45 PM, documented R32 was observed lying on her right side, on the floor, in her room with her legs stretched out in front of her. The investigation documented R32 had reached over her head to pick up colored pencils she had dropped on the floor and fell. The investigation further documented R32 did not sustain any injuries and was shown her call light and educated to push the red button for assistance. The clinical record lacked evidence a resident centered intervention was put into place to prevent further falls. On 08/01/22 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) M place a gait belt around R32's waist, had the resident reach with her right hand to the right armrest of her wheelchair, stand, and then sit down into her wheelchair. On 08/01/22 at 11:20 AM, CNA M stated R32 required reminders to use her call light because she was forgetful. CNA M was unsure of any recent falls for R32. On 08/02/22 at 09:56 AM, Licensed Nurse (LN) I stated R32 often tried to get up unassisted and they reeducate her to use her call light. LN I further stated staff keep R32's bed in the lowest position and make sure the resident used her wheelchair because she had poor balance. On 08/02/22 at 12:38 PM, Administrative Nurse D verified the care plan lacked interventions for the	F 657			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 16 falls and stated R32's cognition changed daily and staff should assist the resident to make her bed or let the resident assist the staff so she did not feel she needed to do it by herself. The facility's "Care Plan Revision/Updates" policy, undated, documented each resident would have a care plan developed to meet their individual needs and cares and would be reviewed and changed with each significant change of status. The facility failed to revise R32's care plan with meaningful, resident centered interventions for cognitively impaired R32, who had falls, placing the resident at risk for further falls.	F 657			
F 689 SS=E	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 Electronic Medical Record (EMR) for R14 documented diagnoses of hypertension (high blood pressure), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Quarterly Minimum Data Set" (MDS), dated	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 17 05/09/22, documented R14 had severely impaired cognition and had only transferred with one staff two or fewer times, did not ambulate, had unsteady balance, and had no functional impairment. The MDS further documented R14 had two or more non injury falls since prior assessment. The "Fall Risk Assessment," dated 05/03/22, documented the resident a high risk for falls. The "Care Plan," dated 05/09/22, initiated on 11/14/21, directed staff to use two staff to assist with transfers on and off of the shower chair, provide and serve her diet as ordered. The care plan documented R14 was able to feed herself but occasionally required reminders and cuing during meals. The care plan lacked documentation R14 required lids on her hot and cold drinks. The "Nurse's Note," dated 04/13/22 at 09:04 AM, documented R14 spilled hot coffee down the left side of her chest and abdomen, had slight redness, no blisters or burns present, and improved after five minutes. The "Nurse's Note," dated 06/26/22 at 03:45 PM, documented R14 spilled warm coffee on her left abdomen and upper thigh earlier that morning. The note documented R14 was sleepy upon rising from bed at 07:00 AM, had no redness or injury. The "Investigation Report," dated 07/09/22, documented R14 spilled her hot coffee onto her chest after a dietary aide had given it to her without a lid. The report further documented R14's had scattered redness to the front of her	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 18 lower chest, lower abdomen and very slightly to the front of her thighs. The area of redness to the left chest measured 9 centimeters (cm) x 4 cm, redness to abdomen measured 5 cm x 1.7 cm x 0.7 cm in three different spots. The coffee had a temperature of 161.8 and directed dietary staff to ensure the temperature of hot beverages were within acceptable range when serving. The report documented R14 was on a list to have cooled coffee with a cup and lid and staff would receive further training regarding hot liquids. The "Physician's Order," dated 07/09/22, directed staff to apply silvadene cream 1% (an antibiotic cream used to treat burns) apply to left chest, abdomen, and thighs topically, twice a day for seven days. The "Nurse's Note," dated 07/10/22, documented no redness or blistering noted in relation to R14's coffee spill. The "Weekly Skin Assessment," dated 07/14/22, documented R14 had faint red markings on the center of her abdomen. The "Investigation Report," dated 07/14/22, documented a Certified Nurse Aide (CNA) had to bear hug a resident to hold her up in the shower so another CNA could provide pericare after R14 had a bowel movement (bm). The report documented R14's feet slid due to the floor was wet and the CNA had to lower the resident onto the floor. The resident was assessed without injury and due to the resident unable to bear weight, staff used the hooyer (mechanical lift) to assist the resident off of the floor and into her wheelchair. The report further documented R14 should have been properly positioned in the	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 19 shower chair and should have been transferred with two staff. On 08/01/22 at 10:47 AM, observation revealed CNA M placed a gait belt around R14's waist, had her lean forward, count to three, and CNA M and Licensed Nurse (LN) I tried to stand the resident up straight. Further observation revealed R14 sat back down and CNA M counted to three again, and the resident was able to partially stand up and pivot to the wheelchair. R14 sat crooked in her wheelchair and CNA M took the back of her pants and pulled up to reposition the resident into the wheelchair. CNA M pushed R14 into the dining room, without foot pedals, into the dining room. On 07/28/22 at 08:47 AM, CNA M stated she did not know if R14 had any falls and would need to ask her nurse. CNA M further stated R14 required cups with lids so she did not spill on herself. On 08/02/22 at 10:05 AM, LN I stated R14 was a two- person transfer and had a recent fall in the shower room. R14 stated staff should use foot pedals on the wheelchairs when transporting residents. On 08/02/22 at 08:30 AM, Administrative Nurse D stated R14 was on a list for resident's who required lids on their cups and that was not communicated to the dietary staff member. Administrative Nurse D stated the resident required two staff to transfers and should not have been transferred by one staff in the shower room. Administrative Nurse D stated she was responsible to update the care plan after a fall and verified she had not done so.	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 20 The facility's "Fall Prevention Protocol," policy, undated, documented each senior who resided at the facility would be provided services and care that ensured an environment to prevent accidents. The policy documented all staff members would be educated on the fall reduction program annually through the mandated safety inservice and more often based on needed. The facility's "Accident Prevention/Hazards" policy, undated, documented all staff members of the facility would ensure that each senior's environment remained as free from accident hazards as possible. Each senior was assisted with activities of daily living, based on his/her needs including bathing, dressing, eating, oral hygiene, ambulation, and toileting activities. Clinical staff would ensure each senior was as safe from accidents as he/she received restorative services as possible. The facility failed to prevent coffee spills for cognitively impaired R14, which resulted in a mild burn, and failed to follow R14's care plan which resulted in a fall in the shower. These deficient practices placed the resident at increased risk for further injury. - The Electronic Medical Record (EMR), documented for R32 diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 21 The "Quarterly Minimum Data Set" (MDS), dated 06/30/22, documented R32 had moderately impaired cognition and required extensive assistance of one staff for bed mobility and supervision and one staff for transfers. The MDS further documented R32 had unsteady balance, no functional impairment, and no falls. The "Fall Risk Assessments," dated 09/23/21 and 12/24/21 documented R32 a high risk for falls and 06/28/22 a moderate risk for falls. The "Care Plan," dated 07/07/22, initiated on 10/08/21, directed staff to ensure the call light was within reach and remind the resident to use it, ensure resident wore appropriate footwear when ambulating or transferring, and required one person assist for safe transfers. The care plan lacked interventions to prevent further falls. The "Fall Investigation," dated 12/07/21 at 02:29 PM, documented R32 fell while straightening the sheet on her bed, had soreness to bilateral knees, and denied hitting her head. The investigation further documented R32 reported she was messing with the edge of her sheet before getting into bed for a nap, slipped and fell to her knees. The clinical record lacked evidence a resident centered intervention was put into place to prevent further falls. The "Fall Investigation," dated 07/05/22 at 03:29 PM, documented at approximately 11:15 AM, R32 was observed on the floor in her room and the resident was seated in the upright position facing the hallway with her back against her nightstand. The resident stated she lost her balance while she tried to make her bed. R32 stated she did not hit her head and denied pain. The investigation	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 22 documented R32 had poor safety awareness and would continue to monitor the resident. The clinical record lacked evidence f a resident centered intervention was put into place to prevent further falls. The "Fall Investigation," dated 07/07/22 at 09:45 PM, documented R14 was observed lying on her right side, on the floor, in her room with her legs stretched out in front of her. The investigation documented R32 had reached over her head to pick up colored pencils she had dropped on the floor and fell. The investigation further documented R32 did not sustain any injuries and was shown her call light and educated to push the red button for assistance. The clinical record lacked evidence a resident centered intervention was put into place to prevent further falls. On 08/01/22 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) M place a gait belt around R32's waist, had the resident reach with her right hand to the right armrest of her wheelchair, stand, and then sit down into her wheelchair. On 08/01/22 at 11:20 AM, CNA M stated R32 required reminders to use her call light because she was forgetful. CNA M said she was unsure of any recent falls R32. On 08/02/22 at 09:56 AM, Licensed Nurse (LN) I stated R32 often tried to get up unassisted and they reeducate her to use her call light. LN I further stated staff keep R32's bed in the lowest position and make sure the resident used her wheelchair because she had poor balance. On 08/02/22 at 12:38 PM, Administrative Nurse D	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 23 verified the care plan lacked interventions for the falls and stated R32's cognition changed daily and staff should assist the resident to make her bed or let the resident assist the staff so she did not feel she needed to do it by herself. The facility's "Fall Prevention Protocol," policy, undated, documented each senior who resided at the facility would be provided services and care that ensured an environment to prevent accidents. The policy documented all staff members would be educated on the fall reduction program annually through the mandated safety in-service and more often based on needed. The facility failed to implement meaningful, resident centered interventions for cognitively impaired R32, who had falls, placing the resident at risk for further falls. - The Electronic Medical Record (EMR) for R38 documented diagnoses of hypertension (high blood pressure), heart failure (a condition when the heart does not pump enough blood for the body's needs), and cerebrovascular accident (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 "Significant Change Minimum Data Set" (MDS), dated 07/03/22, documented R38 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, and did not ambulate. The MDS further documented R38 had unsteady balance, no functional impairment, and had a fall with injury. The "Fall Risk Assessment," dated 06/21/22 documented R38 was a high risk for falls.	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 24 The "Care Plan," dated 07/29/22, initiated on 08/27/21, directed staff to ensure R38 wore appropriate footwear when in wheelchair, ensure foot pedals were on the wheelchair when pushing him to and from his room; ensure his call light was within reach. The "Fall Investigation," dated 06/15/22 at 05:50 PM, documented R38 had a witnessed fall in the dining room. Staff pushed the resident in his wheelchair out of the dining room without feet pedals and the resident's feet went under the wheelchair which caused him to fall forward out of the wheelchair. The investigation documented R38 yelled out in pain and stated his back hurt. Staff contacted the physician and were directed to send the resident to the Emergency Room (ER) for treatment. The investigation documented the ambulance arrived and R38 denied back pain. The facility contacted R38's family and it was decided not to send the resident to the ER. On 08/01/22 at 11:45 AM, observation revealed Certified Nurse Aide (CNA) M and CNA N assisted R38 from his bed and into his Broda chair (repositioning chair) . With the sling for the lift (mechanical lift) already underneath the resident, CNA M attached the sling to the lift, raised R38 up and lowered him into the chair. On 08/01/22 at 11:45 AM, CNA N stated she did not think R38 had any recent falls and stated he used to be in a regular wheelchair but he was recently placed on hospice and the Broda chair was better for him. On 08/02/22 at 10:11 AM, Licensed Nurse I stated R38 fell in the dining room and should	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 25 have had the foot pedals on the wheelchair before he was pushed anywhere. On 08/02/22 at 12:54 PN, Administrative Nurse D stated R38 had been in a regular wheelchair and should have had wheelchair pedals on before he was ever pushed into the dining room. Administrative Nurse D verified the care plan was not followed. The facility's "Fall Prevention Protocol," policy, undated, documented each senior who resided at the facility would be provided services and care that ensured an environment to prevent accidents. The policy documented all staff members would be educated on the fall reduction program annually through the mandated safety in-service and more often based on needed. The facility failed to follow R38's care plan to make sure he had wheelchair pedals on his wheelchair before he was pushed to and from his room which resulted in a fall. The facility had a census of 43 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to identify and/or implement interventions to prevent falls for Resident (R)6, R34, R14, R32 and R38. which placed the residents at increased risk for ongoing falls and injuries. Findings included: -The "Medical Diagnosis" section within R6's Electronic Medical Record (EMR) included diagnoses of unspecified fall, hypertension	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 26 (elevated blood pressure), traumatic subdural hemorrhage (collection of blood on the surface of the brain) without loss of consciousness, and dementia (progressive mental disorder characterized by failing memory, confusion). The "Quarterly Minimum Data Set" (MDS), dated 07/15/22, documented R6 had moderately impaired cognition, required supervision to limited assistance with activities of daily living, was not steady, but was able to stabilize without staff assistance with moving from a seated to standing position, moving on and off the toilet, and surface to surface transfers. R6 was not steady and only able to stabilize with staff assistance with turning around and facing the opposite direction when walking. The MDS further documented R6 had no trial of a toileting program, was frequently incontinent of urine and bowel, and had two or more falls with no injury and one fall with injury since last assessment. The "Fall Care Area Assessment" (CAA), dated 01/18/22, documented R6 had been admitted following hospitalization after a fall in which had resulted in subdural hematoma. The "Fall Care Plan", revised on 02/07/22, documented R6 at risk for falls related to impaired balance, gait, and poor safety awareness. The care plan directed staff to ensure R6 wore appropriate footwear when ambulating, transferring or mobilizing in her wheelchair. Staff were to anticipate R6's needs, check frequently, ensure touch call light pad within reach with encouragement and remind R6 to use it for assistance, and to respond for requested assistance. The care plan further directed staff to keep floor free from spills and clutter, use of glare	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 27 free light, bed in low position at night, handrails on walls in the bathroom, and keep personal items within reach. The "Fall Care Plan", revised on 04/21/22, documented staff to toilet R6 between 02:00 AM to 03:00 AM and ensure a nightlight was kept on in the bathroom, to reduce chance of early morning falls. The "Physician Order", dated 01/10/22, documented the admission of R6 to the facility due to a fall resulting in a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to back of head. The facility's "Fall Risk Assessment" dated 01/11/22, documented R6 was at moderate risk for falls. The facility's "Fall Risk Assessment", dated 04/14/22 and 07/14/22 documented R6 scored at high risk for falls. The facility's "Bowel and Bladder Program Screener", dated 01/11/22, 04/14/22, and 07/14/22, scored R6 a good candidate for retraining. The "Progress Notes" recorded the following falls: 02/02/22 at 02:47 PM, fell in bathroom reaching for incontinent pad and received a skin tear to right hand. 02/16/22 at 05:10 AM, found on floor by her recliner, incontinent of urine, and had cut to right eyebrow, bruise to right cheek bone, and hematoma to back of right hand. 02/27/22 at 12:52 AM, resident on floor of room. R6 reported she fell in the bathroom changing her	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 28 incontinent product. 03/04/22 at 03:00 AM, resident on floor of her bathroom, incontinent of urine; she reported she hit her head on the wall. 03/25/22 at 08:52 AM, found lying on her back next to her bed, holding transfer bar, had golf ball size hematoma to left side frontal lobe (forehead) with three skin tears to left hand. R6 reported she had backed up to the chair and fell to the side. 04/18/22 at 03:00 AM, found on floor of bathroom, incontinent of urine, reported reaching for incontinent product and slid to floor. Skin tear to right elbow. 05/31/22 at 10:57 AM, fell while making her way to the bathroom, holding lip stick in one hand and reaching for the doorknob with the other hand. 06/08/22 at 01:53 AM, found on floor of bathroom, reported trying to sit on toilet and lost balance, hitting back of her head. 06/26/22 at 05:47 AM, found on floor, reported she tried to pick up her shoe and landed on her face. She had some signs of bruising and small skin tear. 06/30/22 at 01:15 PM, R6 pulled out a chair in the dining room and lost her balance. 07/16/22 at 01:00 PM, R6 returned from outing with a family member, her walker caught on carpet in the entry way. Family member tried to catch her, and the resident fell onto the family member. 07/26/22 at 02:45 AM, found sitting on bathroom floor, incontinent of urine. On 08/01/22 at 08:57 AM, Certified Medication Aide (CMA) R reported if a resident fell, staff were to immediately notify the charge nurse, to assess the resident. The staff was alerted that the resident had fallen in the communication system of the electronic record.	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 29 On 08/01/22 at 10:00 AM, Licensed Nurse (LN) H reported when a resident fell, the staff alert the charge nurse to assess the resident; a neurological exam and 15-minute checks were initiated. LN H stated a new intervention should be placed at the time of the fall, and the care plan should be updated with the intervention. On 08/02/22 at 08:41 AM, Administrative Nurse D verified no new interventions had been developed and implemented for R6 to prevent falls. She stated it was her responsibility to investigate falls and update the care plans. The facility's undated "Fall Prevention Protocol", documented the effectiveness of fall reduction activities, including assessment, causal factors, interventions, and education will be evaluated by the Interdisciplinary Care Plan team at time of each comprehensive assessment. The effectiveness of the facility fall reduction activities will be evaluated on a monthly basis by Quality Assurance Performance Improvement (QAPI) committee. Outcome indicators include the number of falls, and the severity of fall-related injuries, and effectiveness of implemented care plan interventions. The facility failed to identify and implement interventions to prevent falls for R6 who had multiple falls. This deficient practice placed R6 at increased risk for further falls and injury. - R34's "Medical Diagnosis" section within the Electronic Medical Record (EMR) included diagnosis of age-related physical debility, difficulty in walking, hypertension (elevated blood pressure), major depressive (major mood	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 30 disorder) disorder recurrent, severe with psychotic (any major mental disorder characterized by a gross impairment in reality testing)symptoms, spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), muscle weakness, right shoulder pain, anterograde amnesia (a type of memory loss that occurs when person cannot form new memories), and alcoholic cirrhosis (chronic degenerative disease of the liver) of liver with ascites (the accumulation of fluid in the abdominal cavity, causing swelling). The "Quarterly Minimum Data Set" (MDS), date 07/01/22, documented R34 had intact cognition, required supervision to limited assistance of one staff for activities of daily living. R34 was not steady but able to stabilize without staff assistance with moving from a seated to standing position, moving on and off the toilet and surface to surface transfer, walking, and turning around and face the opposite direction while walking. The MDS further documented R34 had no trial of toileting program, was frequently incontinent of urine and always continent of bowel, had pain. R34 had two or more falls with injury. The "Fall Care Plan", revised on 02/18/22, documented R34 at risk for falls related to impaired balance, strength, and safety awareness. The care plan further documented to encourage and remind R34 to use the call light, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility. The care plan directed staff to	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 31 ensure R34's wheelchair was next to the bed and the brakes were locked, to wear appropriate footwear, keep safe environment free from spills and clutter, use glare free lights, reachable call light, bed in low position at night, handrails in bathroom and keep personal items within reach. The care plan further documented R 34 attempted to get up unassisted and needed frequent checks to anticipate needs. The "Progress Note", dated 06/11/22 at 06:30 PM, R34 was found sitting upright on the floor, incontinent of urine and reported she was looking for her TV remote. The "Progress Note", dated 06/25/22, documented around 11:40 PM the resident was found on the floor by the wall. R34 stated she was going to the bathroom, lost her balance, and fell hitting her right shoulder against the wall. On 07/28/22 at 12:26 PM observation revealed R34 left the dining room independently with her walker. On 08/01/22 at 12:18 PM, Certified Medication Aide (CMA) R reported R34 was a standby for assistance with toileting as an intervention to prevent falls. On 08/01/22 at 10:00 AM, Licensed Nurse (LN) H reported when a resident fell, the staff alert the charge nurse to assess the resident, a neurological exam and 15-minute checks were initiated. LN H stated a new intervention should be placed at time of fall, and the care plan should be updated with intervention. On 08/02/22 at 08:41 AM, Administrative Nurse D	F 689			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 689	Continued From page 32 verified new interventions had not developed or implemented for R34 to prevent falls. She stated it was her responsibility to investigate falls and update the care plans. The facility's undated "Fall Prevention Protocol", documented the effectiveness of fall reduction activities, including assessment, causal factors, interventions, and education will be evaluated by the Interdisciplinary Care Plan team at time of each comprehensive assessment. The effectiveness of the facility fall reduction activities will be evaluated on a monthly basis by Quality Assurance Performance Improvement (QAPI) committee. Outcome indicators include the number of falls, and the severity of fall-related injuries, and effectiveness of implemented care plan interventions. The facility failed to identify and implement interventions to prevent falls placing R34 at risk for further falls and injury.	F 689			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 33 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility's Consultant Pharmacist (CP) failed to identify and report no blood sugar parameters for Resident (R) 25, who received insulin (hormone used to control blood sugar levels). The facility further failed to ensure the CP identified and reported the lack of a stop date for Resident (R) 28's as needed (PRN) Ativan (a sedative used to treat anxiety). This placed R25 at risk for hyperglycemic (high blood sugar) or	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 34 hypoglycemic (low blood sugar) episodes and R28 at risk for side effects from psychotropic (alters mood or thought) medication. Findings included: - The Electronic Medical Record (EMR) for R25 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory and confusion), hypotension (low blood pressure), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and chronic diastolic heart failure (when the left heart ventricle has decreased blood flow). The "Quarterly Minimum Data Set" (MDS), dated 07/15/22, documented R25 had intact cognition and required supervision and one staff assistance with bed mobility, transfers, toileting and personal hygiene. The MDS documented the resident received insulin (a hormone produced in the pancreas by the cells in the pancreas), an antidepressant (a class of medication that used to treat mood disorders and relieve symptoms of depression), and a diuretic (medication to help the body get rid of extra fluids) during the look back period. The "Diabetes Mellitus Care Plan," dated 03/18/22, documented staff obtain accu-checks (a system which measures blood glucose in the body) before meals, at bedtime, and at 03:00 AM. It directed staff to observe for signs and symptoms of hypoglycemia and hyperglycemia.	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 35 The "Physician's Order," dated 07/26/21, directed staff to obtain accu-checks before meals and at bedtime. The order lacked blood sugar parameters for the resident. The "Physician's Order," dated 12/31/21, directed staff to obtain accu-checks at 03:00AM. The order lacked blood sugar parameters for the resident. A "Physician's Order" dated 7/13/22 directed Toujeo (long acting insulin) solostar pen inject 28 units twice daily for type 2 DM. A "Physician's Order" dated 7/13/22 directed Novolog (fast acting insulin) flex pen inject 16 units three times daily for type 2 DM. The "Medication Regimen Review," dated 04/06/22, 05/05/22, 06/13/22, and 07/07/22 lacked documentation the CP identified and reported R25 lacked blood sugar parameters. On 08/01/22 at 12:20 PM, observation revealed R25, in her room, asleep in her chair. On 07/28/22 at 01:20 PM, Licensed Nurse (LN) G stated they did not have any blood sugar parameters from the physician. LN G stated she used her nursing judgement to determine when to call the physician. On 08/02/22 at 12:38 PM, Administrative Nurse D stated the resident should have blood sugar parameters and the pharmacist should have recognized this. On 08/03/22 at 10:38 AM, Consultant Pharmacist GG stated that although she looked at the	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 36 resident's blood sugars, she did not look to see if the resident had blood sugar parameters. The facility's "Consultant Pharmacist " policy, undated, documented the pharmacist consultant reviewed the drug regimen review of each resident in the health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards and documenting the review and findings in the resident's clinical record. The pharmacist would communicate potential or actual problems detected related medication therapy orders to the responsible physician and the Director of Nursing. The facility's Consultant Pharmacist failed to identify and report to the Director of Nursing, physician, and medical director R25 lacked blood sugar parameter's, placing the resident at risk for hyperglycemic or hypoglycemic episodes. -The "Medical Diagnosis" section withing R28's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), retention of urine, hypertension (elevated blood pressure), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear (disorder, heart failure and chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Quarterly Minimum Data Set" (MDS), dated	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 37 06/24/22, documented R28 had intact cognition, had verbal and other behavioral symptoms not directed toward other one to three days of the look back period, required extensive assistance of one staff for activities of daily living, and frequently incontinent of urine and bowel. The MDS further documented R28 received an antianxiety medication on a routine basis. The "Care Plan", dated 06/28/22, documented R28 was at risk for adverse side effects related to psychotropic medication. The care plan directed staff to give medications ordered by physician, document side effects and effectiveness, to provide education about risks and benefits and the side effect of lorazepam (Ativan). The care plan further documented a Registered Pharmacist to review drug regimen monthly. The "Physician Order", dated 10/28/19, directed staff to administer lorazepam 0.5 milligrams (mg) by mouth every 24 hours as needed for anxiety. The ordered did not have a stop date. Record review revealed R28 received PRN lorazepam on May 1, 5, 11, 12, 16, 24, and 30 2022. June 3, 6, 13, 26, and 28 2022, and July 1, 8, 26, 2022. On 08/02/22 at 09:03 AM, Administrative Nurse D verified the PRN lorazepam did not have a stop date and would have expected the pharmacist to have reviewed the order and brought it to the attention of the facility and physician. On 08/03/22 at 10:29 AM, Consultant GG stated during the pharmacy monthly review the as needed psychotropic medications are reviewed and would notify the facility and physician to	F 756			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 756	Continued From page 38 obtain a stop date. Consultant GG reported the resident had been hospitalized in January 2022 and had returned with the as needed lorazepam which she had not realized and had not sent a request to the facility and physician for a stop date. The facility's "Consultant Pharmacist Services Provider Requirements", dated 09/18/17, documented review the medication regimen(drug regimen review of each resident in health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards and documenting the review of findings in the resident's clinical record. Communicating to the responsible physician and the facility Director of Nursing potential or actual problems detected and other findings related to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. The facility failed to ensure the CP identified and reported the lack of a stop date on R28's as needed lorazepam. This placed the resident at risk for adverse side effects related to psychotropic medication.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 757	Continued From page 39 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to obtain, from the physician, blood sugar parameters for Resident (R) 25, who received insulin (hormone used to control blood sugar levels) and had her blood sugar taken five times per day. This placed the resident at risk for hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) episodes. Findings included: - The Electronic Medical Record (EMR) for R25 documented diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory and confusion), hypotension (low blood pressure), major depression (abnormal emotional state characterized by exaggerated feelings of	F 757			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 757	Continued From page 40 sadness, worthlessness and emptiness), and chronic diastolic heart failure (when the left heart ventricle has decreased blood flow). The "Quarterly Minimum Data Set" (MDS), dated 07/15/22, documented R25 had intact cognition and required supervision and one staff assistance with bed mobility, transfers, toileting and personal hygiene. The MDS documented the resident received insulin (a hormone produced in the pancreas by the cells in the pancreas), an antidepressant (a class of medication that used to treat mood disorders and relieve symptoms of depression), and a diuretic (medication to help the body get rid of extra fluids) during the look back period. The "Diabetes Mellitus Care Plan," dated 03/18/22, documented staff obtain accu-checks (a system which measures blood glucose in the body) before meals, at bedtime, and at 03:00 AM. It directed staff to observe for signs and symptoms of hypoglycemia and hyperglycemia. The "Physician's Order," dated 07/26/21, directed staff to obtain accu-checks (point of care test to measure blood sugar levels) before meals and at bedtime. The order lacked blood sugar parameters for the resident. The "Physician's Order," dated 12/31/21, directed staff to obtain accu-checks at 03:00AM. The order lacked blood sugar parameters for the resident. A "Physician's Order" dated 7/13/22 directed Toujeo (long acting insulin) solostar pen inject 28 units twice daily for type 2 DM.	F 757			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 757	Continued From page 41 A "Physician's Order" dated 7/13/22 directed Novolog (fast acting insulin) flex pen inject 16 units three times daily for type 2 DM. On 08/01/22 at 12:20 PM, observation revealed R25, in her room, asleep in her chair. On 07/28/22 at 01:20 PM, Licensed Nurse (LN) G stated they did not have any blood sugar parameters from the physician. LN G stated she used her nursing judgement to determine when to call the physician. On 08/02/22 at 12:38 PM, Administrative Nurse D stated the resident should have blood sugar parameters. The facility's "Blood Sugar Parameter" policy, undated, documented the facility had the responsibility to care for the resident who received accu-check test and medication either oral or insulin for hypoglycemia and hyperglycemia and unless specific parameters are ordered by the physician, the standing orders would be used. The facility failed to obtain, from the physician, blood sugar parameters for R25 who had accu-checks five times per day. This placed the resident at risk for hyperglycemic or hypoglycemic episodes.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 758	Continued From page 42 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 758	Continued From page 43 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure Resident (R) 28's as needed lorazepam (an antianxiety medication) had a stop date as required, placing the resident at risk for adverse side effects related to psychotropic (altering mood or mind) medication use. Findings included: -The "Medical Diagnosis" section withing R28's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), retention of urine, hypertension (elevated blood pressure), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear (disorder, heart failure and chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing)). The "Quarterly Minimum Data Set" (MDS), dated 06/24/22, documented R28 had intact cognition, had verbal and other behavioral symptoms not	F 758			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 758	Continued From page 44 directed toward other one to three days of the look back period, required extensive assistance of one staff for activities of daily living, and frequently incontinent of urine and bowel. The MDS further documented R28 received an antianxiety medication on a routine basis. The "Care Plan", dated 06/28/22, documented R28 was at risk for adverse side effects related to psychotropic medication. The care plan directed staff to give medications ordered by physician, document side effects and effectiveness, to provide education about risks and benefits and the side effect of lorazepam. The care plan further documented a Registered Pharmacist to review drug regimen monthly. The "Physician Order", dated 10/28/19, directed staff to administer lorazepam 0.5 milligrams (mg) by mouth every 24 hours as needed for anxiety. The ordered did not have a stop date. Record review revealed R28 received as needed lorazepam on May 1, 5, 11, 12, 16, 24, and 30 2022. June 3, 6, 13, 26, and 28 2022, and July 1, 8, 26, 2022. Observation on 08/01/22 at 09:16 AM R28 sat in the dining room with supplemental oxygen supplied by tank attached to her wheelchair. On 08/02/22 at 09:03 AM, Administrative Nurse D verified the as needed lorazepam did not have a stop date as required. The facility's "Consultant Pharmacist Services Provider Requirements", dated 09/18/17, documented review the medication regimen (drug regimen review of each resident in health center	F 758			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 758	Continued From page 45 at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards and documenting the review of findings in the resident's clinical record. Communicating to the responsible physician and the facility Director of Nursing potential or actual problems detected and other findings related to medication therapy orders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. The facility failed to ensure R28 as needed lorazepam had a stop date as required, placing the resident at risk for adverse side effects related to psychotropic medication.	F 758			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 812	Continued From page 46 by: The facility had a census of 43 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to store, prepare, and serve food in a sanitary condition for 43 residents who received meals from the kitchen, and ate in the dining room placing them at risk for food borne illness. Findings included: - On 08/01/22 at 11:23 AM during the kitchen inspection, observation revealed the testing sanitizing solution lacked documentation for the month of July 2022. The sanitizing test strips were found without an expiration date, and the ventilation vent cover above the cooking surface in the kitchenette attached to the dining room in the long-term care area, was covered with thick dust like debris. The dining room had numerous chairs found to have dried food particles on the seat, arms, and back of chairs. The chairs also had dark liquid spill stains on the seats. On 08/02/22 at 08:30 AM, Dietary Staff (DS) CC verified the testing strips did not have a expire date on them and no logs for sanitizing solution were found. DS CC verified the vent above the cook stove should be cleaned. On 08/02/22 at 11:25 AM, Administrative Staff A verified the dining room chairs had dried food debris and dark liquid type stains on the seats. He reported it was the responsibility of all staff to maintain a clean environment for the residents. The facility's undated "General Cleaning and Maintenance of Resident Environment" policy, documented Environmental Service and	F 812			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 812	Continued From page 47 Custodial staff will keep furnishings and equipment safe and in good repair and will maintain a safe and functional dining environment. The policy further documented the staff will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, functional and comfortable interior. The facility did not provide a policy for testing and maintaining record of sanitizing solution logs. The facility failed to store, prepare, and serve food in a sanitary condition for 43 resident who resided in the facility and received meals from the kitchen and dining room, placing them at risk for food borne illness.	F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 880	Continued From page 48 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 880	Continued From page 49 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents. The facility identified two staff members currently positive for COVID-19 (highly contagious, potentially life-threatening respiratory virus). Based on observation, record review, and interview, the facility failed to follow the core principles of infection control for resident surveillance of signs/symptoms of COVID-19 when they failed to complete a respiratory assessment and temperature at least daily for 12 sampled residents, Resident (R) 5, R6, R14, R16, R23, R25, R28, R31, R32, R34, R38, and R142. This deficient practice placed the residents at increased risk for transmission and/or development of COVID-19. Findings included: - The Electronic Medical Record (EMR) for R5 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R6 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature.	F 880			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 880	Continued From page 50 The Electronic Medical Record (EMR) for R14 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R16 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R23 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R25 from 03/02/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R28 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R31 from 06/12/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R32 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for	F 880			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 880	Continued From page 51 COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R34 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R38 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. The Electronic Medical Record (EMR) for R142 from 02/07/22 - 08/02/22 lacked documentation for monitoring and assessing the resident for COVID-19 symptoms including respiratory status and temperature. On 07/28/22 at 12:26 PM observation revealed R34 left the dining room independently with her walker. Observation on 08/01/22 at 09:16 AM R28 sat in the dining room with supplemental oxygen supplied by tank attached to her wheelchair. On 08/01/22 at 12:20 PM, observation revealed R25, in her room, asleep in her chair. On 07/27/22 at 11:19 AM, Administrative Nurse D stated they had not been screening the residents' respiratory status for a few months because she had talked to her local health department who stated the facility did not need to screen residents daily. Administrative Nurse D further stated her medical director also told them they did not need	F 880			

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

PRINTED: 08/10/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2022
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
(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 880	Continued From page 52 to. Administrative Nurse D stated they were told to assess the resident if they were exhibiting symptoms. The Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) guidance dated 04/02/20 recommended: Long-term care facilities should immediately implement symptom screening for all. In accordance with previous (CMS) guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked, Facilities should limit access points and ensure that all accessible entrances have a screening station. In accordance with previous CDC guidance, every resident should be assessed for symptoms and have their temperature checked every day. The facility failed to follow the guidelines set by the CDC and CMS for monitoring and assessing residents' respiratory status and temperatures at least daily, which placed the residents at risk for transmission and/or development of COVID-19.	F 880			