STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 The following citations represent the findings of complaint investigation #KS00172593. The 2567 was sent electronically on 07.05.22	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 106. The sample included three residents with three residents reviewed for accidents. Based on observations, record review, and interviews, the facility failed to ensure that Resident (R) 1 remained free from accidents when facility staff failed to utilize two staff assistance for Hoyer lift (total body mechanical lift used to transfer residents) transfer as directed in R1's plan of care. This deficient practice resulted in R1 falling during a transfer and sustaining skin tears, bruises, and abrasions. Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and encounter for	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/05/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 1	F 689		

palliative care.

The "Significant Minimum Data Set (MDS)" dated 03/01/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. R1 required extensive physical assistance with one staff for bed mobility, transfers, toileting, dressing, and personal hygiene. R1 had two non-injury falls and one injury fall since last assessment.

The "Quarterly MDS" dated 05/31/22, documented R1 had a BIMS score of four, which indicated severe cognitive impairment. R1 required extensive physical assistance with two staff for bed mobility, dressing, and personal hygiene; total physical dependence with two staff for transfers and toileting. R1 had two noninjury falls since last assessment.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 03/03/22, documented R1 had impaired cognition.

The "Falls CAA" dated 03/03/22, documented R1 had impaired balance and had a history of falling with injuries, poor recall ability, poor safety awareness, poor strength/endurance, muscle weakness, impaired balance, and impaired mobility. R1 received staff support for transfers and safety needs.

The "Care Plan" dated 07/07/21, documented R1 had an impaired ability to take care of himself and needed help with performing activities of daily living (ADLs). An intervention, dated 03/08/22, documented R1 needed assistance with two staff and a Hoyer lift for transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 2	F 689		

The facility's "Investigation" dated 06/22/22, documented on 06/17/22 at approximately 06:45 AM, Certified Nurse Aide (CNA) M transferred R1 via Hoyer lift and reported to Licensed Nurse (G) that R1 was slipping out of the sling so she lowered him to the floor. When LN G entered the room to assess, she observed R1 lying across the Hoyer lift supports. R1 had a bump to his head that was bleeding and his left elbow was bleeding. R1 was care planned to have two assist with transfers via Hoyer lift. R1 was alert to self at time of incident, but was unable to describe what occurred. R1 was sent to the Emergency Department (ER) for evaluation and treatment then returned a couple hours later with no new orders. Upon return from the hospital, LN G conducted a skin assessment, she noted bruising and two abrasions across his upper back.

In a "Witness Statement" on 06/17/22, LN G stated at approximately 06:40 AM to 06:45 AM, she had exited another resident's room and was in the hall getting ready to do a task when CNA M called for her to go to R1's room. LN G entered R1's room and observed him lying on the floor by his bed with some of his body over the Hoyer lift leg. She stated she was assessed for injuries and observed bleeding with a bump on the back of his head. A towel was applied and bleeding slowed down promptly, but was still bleeding. LN G had CNA M stayed with R1 while she got LN H to assist with the head wound while LN G called R1's family member to send R1 to the ER. LN I called emergency transportation. R1 left the facility with Emergency Medical Services (EMS) to hospital.

In a "Witness Statement" on 06/17/22, CNA M stated she got R1 dressed and put him on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 3	F 689		

Hoyer lift. She went to put R1 in his chair and he was sliding out of the Hoyer lift. CNA M lowered R1 to the floor, removed him from the lift, then called for the nurse.

The "Emergency Room Record" dated 06/17/22, documented R1 had a one by three centimeter (cm) skin tear noted to posterior head and a one by one cm skin tear noted to right posterior scalp.

R1's EMR revealed the following:

A "Fall or Follow on Fall Note" on 06/17/22 at 12:27 PM documented at approximately 06:40 AM and 06:45 AM, LN G was in the hall and CNA M asked her to go see R1. Upon entering the room, it was observed that R1 was on the floor and some of his body was on the Hoyer lift leg. After further assessment, R1 had some blood coming from the back of his head and his left elbow. LN G called R1's family member and informed him R1 needed to be sent out. R1 left for the hospital between 07:00 AM and 07:15 AM with EMS.

A "Fall or Follow on Fall Note" on 06/17/22 at 02:31 PM documented R1 returned from the hospital and a skin assessment was completed. R1 had purple bruises across his shoulder blades and two abrasions on his back in the same area.

On 06/27/22 at 02:32 PM, R1 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the day room with eyes closed. He appeared to be resting comfortably and without signs of distress or discomfort. One dressing noted to posterior head and one dressing noted to posterior right side of head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 4	F 689		

On 06/27/22 at 01:48 PM, CNA N stated typically Hoyer lifts required two staff to use for transfers because so much could go wrong. She stated the Kardex (CNA plan of care) documented what type of assistance each resident needed for transfers and staff always carried a Kardex on them.

On 06/27/22 at 01:52 PM, LN G stated on 06/17/22 she was doing her morning tasks when CNA M needed help in R1's room. Upon entering room, LN G observed R1 lying on the floor on one of the Hoyer legs. She stated Hoyer lifts did not always require two staff assistance, the Kardex/care plan documented what level of assistance each resident required.

On 06/27/22 at 02:10 PM, Administrative Nurse D stated on 06/17/22, LN G told her R1 had been in the Hoyer lift and had slipped from the sling. She said R1 was sent out to ER for evaluation and when he returned, a full skin assessment was completed which revealed abrasions and bruising on his back.

On 06/27/22 at 02:13 PM, Administrative Staff A stated the facility's policy directed Hoyer lifts could be used with one staff assistance unless the Kardex said otherwise. He stated R1 was care planned for two staff assistance with transfers.

On 06/27/22 at 02:54 PM, CNA M stated on 06/17/22 she hooked R1 up to the Hoyer lift while he was in bed. She pulled the Hoyer lift out from the bed to place R1 in his Broda chair and noticed he was sliding out of the sling. CNA M stated she pressed the emergency button and held him up from behind all the way down to the floor. She stated she did not have a Kardex on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. BUILDING _____ B. WING _____	C 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW VILLAGE	13840 W 91ST TERRACE LENEXA, KS 66215

(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 5	F 689		

her at that time and after the incident, she reviewed the Kardex, which documented he required two staff assistance with transfers.

The facility's "Use of the Total Mechanical Lift for Transfers" policy, dated June 2015, directed the type of lift and type of sling was listed on the resident's Kardex/CNA plan of care for the staff to follow.

The facility's "Resident Directed Care Plans" policy, last revised 01/09/17, directed the plan of care was communicated to the neighborhood team by use of the Kardex. The Kardex is the most current plan of care at all times and was updated as changes happened with the resident on a daily basis.

The facility failed to ensure R1 remained free of accidents when staff failed to utilize two staff assistance for Hoyer lift transfer as directed in R1's plan of care. This deficient practice resulted in R1 falling during a transfer and sustaining skin tears, bruises, and abrasions,