

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

PRINTED: 01/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/30/2021
NAME OF PROVIDER OR SUPPLIER WESTCHESTER VILLAGE OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 8505 PFLUMM ROAD 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 a Health Resurvey and Complaint #KS00151768.	F 000			
F 550 SS=D	The 2567 was sent electronically on 01/06/22. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550			

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

TITLE

(X6) DATE

01/06/2022

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.

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents. Based on observation, record review, and interviews the facility failed to promote care in a manner to maintain and enhance dignity and respect, when staff obtained Resident (R) 23's blood pressure and R7's oxygen saturation at the dining room table, and administered a topical cream to R7's neck at the dining room table, with multiple residents in full view. This created the risk for impaired dignity and psychosocial wellbeing for R23 and R7. Findings included: - On 12/27/21 at 11:27 AM, observation revealed Licensed Nurse (LN) G obtained R23's blood pressure at the dining room table, while eating her meal, with five residents at the same table. On 12/29/21 at 11:38 AM, observation revealed Certified Medication Aide (CMA) R obtained R23's blood pressure at the dining room table, with five residents at the same table. On 12/30/21 at 08:48 AM, observation revealed LN H obtained R7's oxygen saturation and administered a topical cream to R7's neck, with	F 550			

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F 550	Continued From page 2 four residents at the same table. On 12/30/21 at 08:20 AM, Administrative Nurse D stated vitals and treatments were not to be done in the dining room because "it was a dignity issue." The facility's undated "Resident Rights," policy documented the resident had a right to a dignified existence and be treated with respect, dignity, and care for each resident in manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The facility failed to promote care for R23 and R7 in a manner to maintain and enhance dignity and respect.	F 550			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 661			

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F 661	Continued From page 3 (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents with one resident reviewed for discharge. Based on interview and record review, the facility failed to complete a discharge summary for Resident (R)32 that included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) summary of the resident's stay in the facility. This placed R32 at risk for miscommunication or interruptions in the continuum of care after. Findings included: - R32's medical record revealed the resident admitted to facility on 08/20/21. The "Admission Minimum Data Set", (MDS), dated 08/25/21, documented R32 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, transfers, toileting, personal hygiene, and extensive assistance of one staff for locomotion on and off the unit and dressing. The MDS documented ambulation did not occur during the look back period and R32 expected to be discharged to independent living.	F 661			

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F 661	Continued From page 4 The "Discharge Care Plan, " dated 09/16/21, documented R32 had impaired cognition and directed staff to evaluate, discuss with R32 and her family the prognosis for independent or assisted living, identify limitations, risks and benefits needed for maximum independence. The "Care Plan" directed staff to establish a pre-discharge plan with R32 and her family, evaluate progress and revise the plan of care if needed. The "Care Plan" further directed staff to make arrangements with required community resources to support independence post-discharge or outpatient therapy. The "Admission Nurse's Note," dated 08/19/21 at 09:06 AM, documented R32 was admitted due to a hip fracture (broken hip), had skilled therapy orders, and was alert with some forgetfulness. The "Nurse's Note," dated 10/02/21 at 07:05 PM, documented R32 was discharged from the facility. The "Recap Discharge Summary," dated 10/04/21, lacked a summary of R32's overall wellness, to include significant changes identified throughout the assessment process, and current condition at time of discharge. On 12/29/21 at 10:07 AM, Social Service X verified the "Recap Discharge Summary" lacked the recapitulation of the resident's stay in the facility. The facility's "Discharge Summary Checklist," dated 05/19/17, documented the checklist to be completed with course of illness, treatment, therapy during nursing stay , reconciliation of all	F 661			

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F 661	Continued From page 5 pre-discharge medications and post discharged medications, post discharge medical and non-medical services, radiology or other tests and results most recent, consultations along with findings and recommendations. The facility failed to develop a discharge summary that included a recapitulation summary of the resident's stay in the facility for R32.	F 661			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 12 residents with one reviewed for positioning and mobility. Based on observation, record review, and interview the facility failed to recognize and provide the necessary cares and services to ensure appropriate wheelchair and bed positioning for Resident (R) 10 which placed R10 at increased risk for increased pain and decreased function. Findings included: - R10's Electronic Medical Record (EMR) listed diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness	F 684			

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F 684	Continued From page 6 of one half of the body) following cerebral infarction (a brain lesion in which a cluster of brain cells die when they don't get enough blood) affecting left non dominant side, and muscle weakness. The "Quarterly Minimum Data Set" (MDS), dated 10/19/21, documented R10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R10 required total staff assistance with toileting, extensive staff assistance with bed mobility, transfer, dressing, personal hygiene, limited staff assistance with locomotion on and off the unit, and supervision with eating. The MDS documented R10 had upper and lower extremity impairment on one side, was on a turning/repositioning program, and used a wheelchair for mobility. The "Activity of Daily Living (ADL) Care Plan," revised on 10/22/2, documented R10 had limited range of motion (ROM) of left upper and lower extremities, muscle weakness, and poor balance. The "Care Plan" instructed staff to reposition the resident in bed or wheelchair frequently. The "Care Plan" instructed staff to position R10 with proper body alignment. On 12/28/21 at 12:40 PM, observation revealed R10 rested in bed with her eyes closed, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R repositioned the resident by using a bed pad to lift her up in bed. R10's head was positioned to the right with her neck stretched to the right and her torso was straight . On 12/28/21 at 03:11 PM, observation revealed R10 rested in bed on her back, with her head	F 684			

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F 684	Continued From page 7 positioned to the right, neck stretched to the right, and her torso straight. On 12/28/21 at 03:58 PM, observation revealed staff entered R10's room, provided incontinent cares, placed a pillow behind each side of the resident's upper torso. R10's legs were straight, and her head bent to the right, with her neck stretched to the right. On 12/29/21 at 08:11 AM, observation revealed R10 rested in bed with her eyes closed. She was positioned on her back. Her head leaned to the right, and her neck stretched to the right. On 12/29/21 at 09:32 AM, observation revealed Licensed Nurse (LN) J and CNA N entered R10's room, provided a dressing change and incontinent cares, and repositioned R10 onto her back with her head bent to the right, stretching her neck. R10's torso was straight and her legs were positioned to the right. CNA N started to cover the resident up. When R10 was asked by the surveyor if she was comfortable, R10 stated "No." CNA N and LN J then repositioned the R10's torso, but left her head bent to the right with neck stretched to the right. On 12/29/21 at 01:46 PM, observation revealed R10 sat in a wheelchair in her room with her head leaning to the right, stretching her neck. On 12/30/21 at 08:15 AM, observation revealed R10 sat in a wheelchair with a neck pillow supporting her head. On 12/29/21 at 01:43 PM, CNA O stated R10 required extensive staff assistance with most ADLs. CNA O stated she did not know how long	F 684			

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F 684	Continued From page 8 the resident had a neck pillow. On 12/30/21 at 03:04 PM, Administrative Nurse D stated she observed R10 in R10's room on 12/29/21 at noon, and R10 appeared uncomfortable. Administrative Nurse D offered R10 a neck pillow, and the resident accepted it. Administrative Nurse D stated R10 had a neck pillow since she was first admitted to the facility on 07/17/21. Upon request the facility did not provide a policy regarding positioning. The facility failed to provide the necessary cares and services to ensure appropriate wheelchair and bed posture and positioning for R10, placing the resident at risk for pain and decreased function.	F 684			
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 had a census of 28 residents. The sample included 12 residents, with four reviewed for accidents. Based on observation, record review, and interview, the facility failed to follow Resident (R)7's toileting and fall interventions as directed in the plan of care. This placed R7 at	F 689			

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F 689	Continued From page 9 increased risk for injuries related to accidents and/or hazards. Findings included: - The Electronic Medical Record (EMR) for R7 recorded diagnoses of overactive bladder (sudden need to urinate), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R7's "Admission Minimum Data Set"(MDS) dated 01/07/21, documented R7 had moderately impaired cognition and required extensive assistance of one staff for bed mobility, transfers, and toileting. R7 had unsteady balance, no functional impairment, frequently incontinent of bladder, and had one non injury fall. The "Quarterly MDS," dated 10/02/21, documented the resident had intact cognition and required extensive assistance of one staff for bed mobility, transfers, and toileting. R7 had unsteady balance, had no functional impairment, frequently incontinent of bladder, and had no falls. The "Fall Risk Assessments," dated 01/10/21, 04/11/21, 07/07/21, 08/05/21, 10/11/21, and 10/22/2, documented R7 was at high risk for falls. The revised "Fall Care Plan." dated 12/07/21, originally dated 01/08/21, directed staff to assist R7 with toileting, and make sure there was an unobstructed pathway to the bathroom. The update, dated 02/10/21, directed staff to check and offer toileting to R7 before and after meals. The update, dated 07/23/21, directed staff to ensure the bed was at wheelchair height. The update, dated 11/30/21, directed staff to offer to	F 689			

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F 689	Continued From page 10 assist R7 to the restroom at or around 06:30 AM. The "Fall Investigation," dated 07/23/21, at 10:45 PM, documented R7 fell trying to go to the bathroom. R7 told staff she was trying to get to her wheelchair to go to the bathroom, got weak, and lowered herself to the floor. The "Fall Investigation," dated 10/22/21 at 02:15 PM, documented the resident fell in the bathroom. R7 stated she took herself to the bathroom and forgot to lock her brakes during her transfer. The investigation documented the resident had a skin tear (a traumatic wound caused by mechanical forces) to her right elbow 1 centimeter (cm) long. The October "Toileting Log" documented R7 was last toileted at 11:05 AM. The "Fall Investigation," dated 10/28/21 at 10:48 AM, documented R7 was seated on the floor towards the end of the bed. R7 told staff she was trying to go to the bathroom and slid off the bed. The October "Toileting Log" documented R7 was last toileted at 05:59 AM. The "Fall Investigation," dated 11/20/21 at 07:30 AM, documented the resident was on the floor in her room. R7 told staff she was trying to go to the bathroom and slid off the bed. The investigation documented R7 was reminded to call for assistance and directed staff to offer to take her to the bathroom near or around 07:30 AM. The November "Toileting Log" documented the resident was last toileted at 03:16 AM. The "Fall Investigation," dated 11/30/21 at 07:25 AM, documented the resident was on the floor in her room and had last been toileted at 04:00 AM. R7's pajamas and socks were soaking wet, and	F 689			

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F 689	Continued From page 11 R7 stated she was trying to go the bathroom. The staff were directed to take the resident to the bathroom around 06:30 AM. On 12/29/21 at 01:12 PM, observation revealed Certified Nurse Aide (CNA) P pushed R7 into her room after lunch and placed her beside the bed. CNA M placed a gait belt around her waist and transferred the resident into bed, put a pillow under her feet, and gave the resident her call light. CNA P took the control to the bed and laid it by the resident. CNA M put R7's wheelchair beside the bed and told her not to go to the bathroom by herself. Observation revealed R7 was not offered toileting before she was transferred into bed. On 12/30/21 at 09:50 AM, R7 told Certified Medication Aide (CMA) S that she was finished with her lunch. CMA S stated "ok," and left the resident at the dining room table. Further observation revealed R7 propelled herself down the hall, nearly running into the walls several times, and into her room. Continued observation revealed Activity Aide Z came into R7's room and took her to an activity. R7 was not offered toileting after the breakfast meal or before going to the activity. On 12/28/21 at 08:14 AM CNA M stated R7 was at risk for falls and staff toileted the resident during the night and between 05:00 and 06:00 AM.. On 12/29/21 at 11:45 AM Licensed Nurse (LN) I stated R7 had a camera in her room so staff can visualize her when she was in her room. LN I further stated the night shift toileted the resident between 05:30 AM and 06:00 AM because of her			F 689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/30/2021
NAME OF PROVIDER OR SUPPLIER WESTCHESTER VILLAGE OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 8505 PFLUMM ROAD 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 12 history of falls. On 12/29/21 at 01:24 PM, CNA P verified R7 was not offered toileting after lunch. On 12/30/21 at 08:25 AM, Administrative Nurse D stated staff should follow R7's care plan and the toileting plan to prevent further falls. On 12/30/21 at 09:54 AM, R7 stated she often forgo to call for assistance and has had falls from her bed trying to go to the bathroom. R7 stated she was unsure when staff were supposed to take her to the bathroom. The facility's "Accidents and Occurrences" undated policy, documented each resident received adequate supervision and assistive devices to prevent occurrences. All occurrences on the facility premises must be investigated and reported to the Director of Nursing (DON) or designee. Immediate interventions are communicated, and the care plan was updated to prevent further falls. The DON or designee would review documentation to ensure relevant individualized interventions had been added to the care plan. The resident is reviewed at a weekly risk meeting to evaluate effectiveness of the interventions and to revise interventions if needed. The staff are notified via the 24-hour report of any new interventions. The facility failed to follow R7's toileting schedule as directed by her plan of care to prevent falls placing the resident at increased risk for injuries related to accidents and/or hazards.	F 689			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756			

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F 756	Continued From page 13 §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 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.			F 756			

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F 756	Continued From page 14 This REQUIREMENT is not met as evidenced by: The facility had a census of 28 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 multiple episodes of blood pressures outside of physician ordered parameter for Resident (R)8. This placed R8 at risk for physical decline and complications related to low blood pressure. Findings included: - R8's "Physician Order Sheet" (POS), dated 11/22/21, documented diagnoses of chronic diastolic heart failure (occurs when your left ventricle can no longer relax between heartbeats because the tissues have become still and won't fill up with blood before the next heart beat), coronary artery disease (damage or disease in the hearts major blood vessels), pulmonary hypertension (high blood pressure), and atrial fibrillation (rapid, irregular heart beat). The "Admission Minimum Data Set" (MDS), dated 10/07/21, documented R8 had intact cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, dressing and personal hygiene. The assessment further documented R8 received three days of a diuretic (medication to promote the formation and excretion of urine) during the lookback period. The "Coronary Artery Disease Care Plan," dated 10/13/21, directed staff to monitor blood pressure and notify physician of any abnormal readings.			F 756			

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F 756	Continued From page 15 The "Physicians Order," dated 10/01/21, directed staff to notify the physician if weekly vital signs were outside of the following parameters : systolic blood pressure (SBP-the maximum pressure the heart exerts while beating) greater than 200 or less than 90 beats per minute (bpm), diastolic blood pressure (DBP-the amount of pressure in the arteries between beats) greater than 115 bpm or less than 50 bpm. The "Vital Sign Record," dated 12/02/21, documented R8's blood pressure was 85/50. The medical record lacked documentation the physician was notified of the out of parameter blood pressure. The "Vital Sign Record," dated 12/08/21, documented R8's blood pressure was 89/42. The medical record lacked documentation the physician was notified of the out of parameter blood pressure. The "Vital Sign Record," dated 12/12/21, documented R8's blood pressure was 83/51. The medical record lacked documentation the physician was notified of the out of parameter blood pressure. The "Medication Regimen Review," dated 12/21/21, lacked evidence the CP identified and reported R8's blood pressures outside of physician ordered parameters. On 12/29/21 at 12:00 PM, observation revealed R8 in the hallway talking with staff. On 12/29/21 at 11:45 AM, Licensed Nurse (LN) I verified the blood pressures were out of the			F 756			

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F 756	Continued From page 16 physician ordered parameters and verified the physician had not been notified. On 12/30/21 at 08:30 AM, Administrative Nurse D stated staff were to follow the orders set by the physician and should notify the physician when the residents' vital signs were outside of ordered parameters and was unaware the pharmacist did not address the concern On 01/03/22 at 10:22 AM, Consultant Pharmacist GG stated she was aware of the low blood pressures and verified she had not notified the facility. The facility's "Medication Regimen Review Monthly Report" policy, dated January 2021, documented the facility assured that the consultant pharmacist had access to resident's medical record, and the providers medication profiles. The Medication Regimen Review of each resident would occur at least monthly; however a more frequent review may be deemed necessary and the consultant would identify irregularities through a variety of sources including, prescribes orders, progress notes, care plan, lab, diagnostic test results, behavior monitoring, interviews, assessing, and observations. The facility's CP failed to identify and report to the director of nursing, physician, and/or medical director R8's blood pressures outside of the physician ordered parameters, placing the resident at risk for physical decline.	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.	F 757			

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F 757	Continued From page 17 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 §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 28 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician of out of parameter blood pressures for Resident (R)8. This placed R8 at risk for physical decline and complications related to low blood pressure. Findings included: - R8's "Physician Order Sheet" (POS), dated 11/22/21, documented diagnoses of chronic diastolic heart failure (occurs when your left ventricle can no longer relax between heartbeats because the tissues have become still and won't	F 757			

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F 757	Continued From page 18 fill up with blood before the next heart beat), coronary artery disease (damage or disease in the hearts major blood vessels), pulmonary hypertension (high blood pressure), and atrial fibrillation (rapid, irregular heart beat). The "Admission Minimum Data Set" (MDS), dated 10/07/21, documented R8 had intact cognition and required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for transfers, dressing and personal hygiene. The assessment further documented R8 received three days of a diuretic (medication to promote the formation and excretion of urine) during the lookback period. The "Coronary Artery Disease Care Plan," dated 10/13/21, directed staff to monitor blood pressure and notify physician of any abnormal readings. The "Physicians Order," dated 10/01/21, directed staff to notify the physician if weekly vital signs were outside of the following parameters : systolic blood pressure (SBP-the maximum pressure the heart exerts while beating) greater than 200 or less than 90 beats per minute (bpm), diastolic blood pressure (DBP-the amount of pressure in the arteries between beats) greater than 115 bpm or less than 50 bpm. The "Vital Sign Record," dated 12/02/21, documented R8's blood pressure was 85/50. The medical record lacked documentation the physician was notified of the out of parameter blood pressure. The "Vital Sign Record," dated 12/08/21, documented R8's blood pressure was 89/42. The medical record lacked documentation the			F 757			

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F 757	Continued From page 19 physician was notified of the out of parameter blood pressure. The "Vital Sign Record," dated 12/12/21, documented R8's blood pressure was 83/51. The medical record lacked documentation the physician was notified of the out of parameter blood pressure. On 12/29/21 at 12:00 PM, observation revealed R8 in the hallway talking with staff. On 12/29/21 at 11:45 AM, Licensed Nurse (LN) I verified the blood pressures were out of the physician ordered parameters and verified the physician had not been notified. On 12/30/21 at 08:30 AM, Administrative Nurse D stated staff were to follow the orders set by the physician and should notify the physician when the residents' vital signs were outside of ordered parameters. The facility's "Vital Sign Monitoring" undated policy, documented each resident's vital signs are to be monitored at least monthly. If the physician has ordered more frequent vital sign monitoring, they are to be obtained and documented on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). The staff obtaining the vital signs would compare the resident's vital signs to the ordered parameters, if the obtained vital signs are outside of the ordered parameters for the resident, the nurse would evaluate, and the physician would be notified. The facility failed to report blood pressures which were outside of the physician ordered parameters for R8, placing him at risk for physical decline and			F 757			

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F 757	Continued From page 20	F 757			
F 880	Infection Prevention & Control	F 880			
SS=D	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 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				

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F 880	Continued From page 21 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 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 28 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure staff performed appropriate hand hygiene and/or glove usage during perineal care (involves washing the genital and rectal areas of the body or perineal area) for Resident (R) 10. This deficient practice placed	F 880			

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F 880	Continued From page 22 R10 at risk for cross-contamination and increased risk for infection. Findings included: - On 12/29/21 at 09:32 AM, observation revealed Licensed Nurse (LN) J and Certified nurse Aid (CNA) N entered R10's room and explained to the resident they were going to provide incontinent cares. Both staff applied gloves. LN J removed R10's wet incontinent brief, removed and discarded gloves, and applied new gloves. Observation revealed CNA N provided perineal care to R 10's front perineal area, then with the same soiled gloves, assisted LN J in applying a new incontinent brief. CNA N then touched R10's bed remote, shirt back, bed pad, and rolled up wash cloth in the resident's left hand contracture (abnormal permanent fixation of a joint) , with the same soiled gloves. On 12/29/21 at 09:55 AM CNA N stated she should have done a better job washing the resident's front perineal area. CNA N verified she had not changed gloves after providing perineal cares and before touching clean items. CNA N verified she should have changed her gloves. On 12/30/21 at 11:00 AM, Administrative Nurse D stated she would expect staff to change gloves between dirty and clean when providing incontinent cares. Upon request the facility did not provide a hand hygiene policy. The facility staff failed to change gloves between dirty and clean when providing R10 incontinent cares, placing the resident at risk for			F 880			

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F 880	Continued From page 23 development of a communicable disease and infection.	F 880			