

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

PRINTED: 12/10/2020
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 12/01/2020	
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 A COVID-19 Focused Infection Control Survey was conducted by Kansas Department on Aging and disability services (KDADS) on behalf of the Centers for Medicare & Medicaid Services (CMS) on December 1, 2020. The facility was found to not be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. On 12/01/20 at 03:00 PM, the Nursing Home Administrator was provided a copy of the Immediate Jeopardy (IJ) Template and notified that the facility was in Immediate Jeopardy for failing to follow the Centers for Medicare and Medicaid (CMS) and Center for Disease Control and Prevention (CDC) guidelines for the mitigation of the transmission of COVID-19 when the facility failed to establish cohorting which removed COVID negative residents from continued exposure to COVID positives residents. On 11/11/20 Resident (R) 5 developed signs and symptoms of COVID-19. The facility did not separate the symptomatic R5 from her roommate, R6. R5 and R6 both tested positive on 11/16/20. On 11/16/20, R7 tested positive for COVID-19 but remained in the same room with her COVID-19 negative room mate R8, who then tested positive three days later. R8 died in the facility on 11/25/20. On 11/23/20 R1 developed signs and symptoms of COVID-19. On 11/28/20 R1 tested positive for COVID-19. R2, who was negative for COVID-19 remained in the same shared room with R1. On 11/23/20 R3 tested positive for COVID-19. R3's room mate, whose COVID status was unknown remain in the room			F 000			

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

TITLE

(X6) DATE

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: 12/10/2020
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 12/01/2020
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	Continued From page 1 with her COVID-19 positive room mate for four days after the room mate tested positive. The deficient practice placed the residents in the semi-private rooms in immediate jeopardy due to increased risk for transmission of COVID-19. The facility submitted a plan of correction on 12/01/20 and the IJ was verified removed at 5:00 PM on 12/01/20.	F 000			
F 880 SS=K	The 2567 was sent electronically on 12/10/20. 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 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	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 2 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 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 3 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 22 residents, with 17 residents and 16 employees diagnosed with Covid-19 (an infectious disease caused by a severe acute respiratory syndrome which caused an ongoing world-wide pandemic). The sample included nine residents. The facility failed to protect residents from further exposure to the Covid-19 virus when they did not separate residents in semi-private rooms when one became positive for Covid-19. The facility's failure to move or segregate Covid-19 positive residents and/or Covid-19 symptomatic residents from Covid-19 negative residents in the same room placed those residents into "Immediate Jeopardy." Findings included: - Review of the "Census" tab in the electronic medical record (EMR) and of the facility provided list of admissions and discharges revealed the following admissions from outside the long term care facility: The facility admitted a male resident on 11/6/20, a female on 11/6/20, a female resident on 11/12/20, and another female resident on 11/14/20. The "Census" revealed an empty semi-private bed on 11/16 and two empty private rooms on 11/23/20. R1's electronic medical record (EMR), under the "Census Tab," indicated R1 resided in a semiprivate room since 4/7/18. A nurse's "Progress Note," in the EMR, dated 11/23/20 revealed R1 had a stomachache and had not eaten much. She had congestion in the	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 4 morning. She denied shortness of breath and her respirations were not labored. The facility obtained a "Polymerase Chain Reaction" (PCR) test (a test used to detect Covid-19 via a nasal swab to collect mucus sample) that afternoon with results expected within 48 hours. R1's laboratory reports revealed a PCR test collection date of 11/23/20, received by the laboratory on 11/24/20, and a result of negative on 11/25/20. A "Point OF Care" (POC- a rapid test used to detect Covid-19 via a nasal swab to collect a mucus sample in which results were obtained in about 15 minutes) test obtained on 11/28/20 was positive. A nurse's "Progress Note" in R2's EMR under the "Census Tab" indicated R2 resided with R1 in a semi-private room. R2's EMR revealed a nurse's progress note, dated 11/22/20, which documented the facility informed her family on 11/21/20 that R2 tested for Covid-19 on 11/19/20 and she was negative. Record review revealed the facility did not separate Covid-19 symptomatic R1 from the Covid-19 asymptomatic and negative R2 upon identifying R1 had symptoms of Covid-19. R3's EMR, under the "Census Tab," indicated R3 resided in a semi-private room since 05/03/15. The facility's PCR "Testing Logs" indicated R3 was negative for Covid-19 on 11/16/20, 11/19/20 and positive on 11/23/20. She remained in the semi-private room until discharged to the hospital on 11/27/20. R4's EMR, under the "Census Tab" indicated R4 resided in room a semi-private room since	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 5 06/05/18. The facility's PCR "Testing Logs" indicated R4 had negative Covid-19 tests on 11/16/20 and 11/19/20. The 11/23/20 sample was rejected due to an insufficient sample. A nurse's "Progress Note" dated 11/26/20 for R4 revealed a rapid Covid-19 test performed on 11/26/20 at 12:36 PM was negative. Despite the Covid-19 positive test for R4's roommate (R3), R4 remained in the same room with R3 for four days after R3 tested positive for Covid-19. R5's EMR, under the "Census Tab" indicated R5 resided in a semi-private room since 06/29/19. A nurse's "Progress Note" dated 11/11/20 documented R5 was seen by the nurse practitioner, due to complaints of cough, sore throat, shortness of air, and a runny nose. A rapid Covid-19 test was performed, and the results were negative at 12:58 PM. A PCR test was done on 11/16/20 with negative results. R5's 11/19/20 PCR test had positive results. She remained in the semi-private room. R6's EMR, under the "Census Tab" indicated R6 resided in a semi-private room since 07/31/18. Per the facility's PCR "Testing Logs" R6 had a positive PCR test on 11/16/20. She remained in the room. Despite R5 becoming symptomatic of Covid-19, she remained in the room with R6 who became Covid-19 positive five days later.	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 6 R7's EMR under the "Census Tab" indicated R7 resided in a semi-private room. The facility's PCR "Testing Logs" indicated R7 was positive for Covid-19 on 11/16/20. A nurse's "Progress Note" dated 11/20/20 indicated R7 tested positive for Covid-19 and staff isolated the resident to her room. She continued to reside in the same room as R8. R8's EMR under the "Census Tab" indicated R8 resided in a semi-private room since 05/28/20. Per the facility's PCR "Testing Logs" R8 had a negative test on 11/16/20 and was positive for Covid-19 on 11/19/20. She remained in the same room until her death on 11/25/20. R8, who was Covid-19 negative at the time, remained in the same room with Covid-19 positive R7 for three days. R8 subsequently tested positive for Covid-19 and died in the facility. On 12/1/20 at 12:40 PM R4 sat in a recliner in her room. She was alert, cheerful, and showed no signs of respiratory distress. R4 stated she worried about her roommate, since she was in the hospital and she was not able to see R3. R4 stated she was not afraid of getting sick. On 12/1/20 at 11:27 AM Administrative Staff A stated the facility interpreted the Centers for Medicare and Medicaid Services (CMS) guidelines as when a resident tested positive, there was the potential for the roommate to be positive and the resident which tested negative	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 7 did not necessarily have to be moved to another room. The facility started a plan for a Covid-19 isolation hall, but due to limited room availability and the fast spread of the disease they were unable to dedicate a hall for isolation. On 12/1/20 at 01:10 PM R4's responsible party stated the facility updated the family on positive Covid-19 cases and knew R4's roommate had Covid-19. The facility kept the family updated on R4's condition and so far, she did not have Covid-19. The facility had not offered to move the resident after her roommate had tested positive. On 12/1/20 at 01:31 PM R2's responsible party stated their family had been apprised of the Covid-19 cases in the facility. The facility updated the family on R2's condition regularly. He could not confirm the exact date they were informed of R2's roommate was positive for Covid-19 and since there were multiple children involved, was not certain if a new room had been offered to R2. The facility's "Coronavirus Disease (Covid-19) -Identification and Management of Ill Residents" policy dated April 2020 documented with signs and/or symptoms of Covid-19 were identified and isolated to help control the spread of infection to other residents, staff, and visitors. The Centers for Medicare and Medicaid (CMS) document "COVID-19 Long-Term Care Facility Guidance" dated April 2, 2020 recorded "Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status... long-term care facilities should work with State and local community leaders to identify and designate facilities dedicated to	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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 880	Continued From page 8 patients and residents with known COVID-19-positive and those with suspected COVID-19, ensuring they are separate from patients and residents who are COVID-19-negative." The facility failed to protect residents from further exposure to the Covid-19 virus when they did not separate resident's positive for Covid-19 and/or had symptoms consistent with Covid-19 from roommates with negative Covid-19 test results. This deficient practice placed all facility residents residing in semi-private rooms in immediate jeopardy. The facility removed the immediacy by completing the following: The remaining negative resident that was in a shared room with a presumptive positive resident (tested positive on a rapid test, not PCR confirmed) was moved to a private room. All residents on the health care unit are in private rooms. The facility will be creating a separate area where negative residents can be cohorted away from positive residents. This area is separated from the rest of the unit by fire doors. These doors will remain closed. Once this outbreak is cleared, that area will remain unoccupied and will only be used to house any future residents who test positive for COVID-19. Staff will be educated on this COVID-19 Cohorting policy and infection control guidelines The deficient practice remained at scope and severity of an E	F 880			

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

PRINTED: 12/10/2020
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 12/01/2020
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	