STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	12/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY	445 N WESTVIEW DR DERBY, KS 67037

(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 Investigations #147828 and #147060.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/05/2019

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 676	Continued From page 1 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 12 residents with four reviewed for Activities of Daily Living (ADLs). Based on observation, record review, and interview, the facility failed to provide the necessary care and services for eating for one of four sampled residents, Resident (R) 7. Finding included: - R7's "Physician Order Sheet," dated 11/04/19, documented diagnoses of dementia without behavioral disturbance (a condition in which a person loses the ability to think, remember, learn, and make decisions, and solve problems), severe osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of the bones wears down), dorsalgia (back pain), depression (a persistent feeling of sadness and loss of interest), and macular degeneration (a degenerative condition affecting the central part of the retina (a layer at the back of the eyeball containing cells that are sensitive to light and that trigger nerve impulses that pass via the optic nerve to the brain, where a visual image is formed) and resulting in distortion or loss of central vision). The "Quarterly Minimum Data Set" (MDS), dated 11/15/19, documented the resident had severely impaired cognition and independent with set up assistance for eating.	F 676		

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F 676	Continued From page 2	F 676		

The "ADL Care Area Assessment" (CAA) did not trigger.

The "ADL Care Plan," dated 11/21/19, documented the resident was able to eat foods independently on a divided plate, considered legally blind, and occasionally required staff assistance to complete her meal.

The "Oral/Nutritional Nursing Assessment," dated 11/15/19, documented the resident had no chewing or swallowing difficulty and was on a mechanically altered diet

On 11/26/19 at 12:02 PM, observation revealed the resident occasionally had difficulty finding food on her plate, placed the fork to her mouth with nothing on it, and no staff assisted. Observation revealed the resident independently ate her potatoes and green beans but had difficulty eating her meatloaf as her lower dentures slid forward out of her mouth.

On 11/27/19 at 07:45 AM, observation revealed the resident sat at the dining table with her eyes closed and lower dentures protruding out of her mouth. Further observation at 08:25 AM revealed staff served the resident an omelet and ground sausage with gravy. Continued observation revealed the resident independently ate her meal, but as the plate became empty the resident had difficulty finding food with her fork, and staff did not assist the resident. Observation at 09:15 AM revealed the resident continued to try to eat, got mostly gravy on her fork, and staff did not stop and assist her. Observation at 10:00 AM revealed the resident ate 100% of her meal. (two hours and 15 minutes after being placed in the dining room and one hour and 35 minutes after she

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received her breakfast meal)

On 12/02/19 at 08:09 AM, observation revealed the resident in the dining room table with a coffee cup waiting for breakfast. Further observation at 08:19 AM revealed staff served the resident an omelet and ground sausage with gravy on a divided plate. Observation revealed the resident ate independently, occasionally her lower dentures slipped forward in her mouth making it difficult to eat, and staff did not assist the resident. Continued observation at 10:07 AM revealed the resident finished her breakfast and staff removed the resident from of the dining room. (one hour and 58 minutes after being placed in the dining room and one hour and 48 minutes after she received her breakfast meal)

On 12/03/19 at 07:54 AM, observation revealed the resident in the dining room waiting for her breakfast. Further observation revealed staff served the resident pancakes and hot cereal in her divided plate and as the resident attempted to eat her breakfast food would fall off her fork. Continued observation at 08:45 AM revealed the resident held up her hand attempting to get staff's attention, after a few minutes and no one seeing her, she placed her hand on her face and became tearful. Observation revealed the resident held up her hand again, staff came over, and removed the resident from the table.

On 12/03/19 at 10:54 AM, Licensed Nurse (LN) G stated the resident ate very slow and when she saw the resident required assistance she encouraged and cued her.

On 12/3/19 at 11:00 AM, Certified Nurse Aide (CNA) M stated the resident would not allow

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anyone to feed her, staff could sit with her while she ate, and the resident took a long time to eat.

On 12/3/19 at 03:43 PM, Administrative Nurse D stated staff should check on the resident and offer assistance. Administrative Nurse D stated even though the resident does not want assistance with feeding, staff could sit with her and ensure the resident was able to get the food to her mouth.

The facility's "Assistance with Meals" policy, dated February 2014, documented the residents received assistance with meals in a manner that meets the individual needs of each resident. The facility staff would serve resident trays and help residents who require assistance with eating and to minimize foodborne illness.

The facility failed to provide R7 the necessary care and services for eating, placing the resident at risk for weight loss and an undignified eating experience.