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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 complaint investigation #KS00174579, #KS00174968, KS#00175340, KS#00175817, and #KS00176619. On 01/05/23 at 01:43 PM Administrative Staff A was provided a copy of the IJ template and notified the facility failed to continue elopement risk interventions for R2 when assessed on 06/2/122 as at risk for elopement. R2 had cognitive impairment and was independently mobile with a history of elopement when the facility discontinued her elopement risk interventions. R2 who continued to have severe cognitive impairment, exited the facility without staff awareness or supervision on 09/23/22 and crossed a heavily traveled four lane street when staff, who were outside of the facility on break, observed her and assisted her back to the building. This placed R2 in immediate jeopardy. The facility provided an acceptable plan for removal of the immediate jeopardy on 01/25/23 at 02:35 PM. The survey team validated the immediate jeopardy was removed on 09/23/22 at 09:00 PM following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at an IJ scope and severity following the removal of the immediate jeopardy. This 2567 was electronically sent to the facility on 01/26/2023.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the	F 553		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/26/2023

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
	175218	A. BUILDING _____ B. WING _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 553	Continued From page 1	F 553		

development and implementation of his or her person-centered plan of care, including but not limited to:
(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
(iii) The right to be informed, in advance, of changes to the plan of care.
(iv) The right to receive the services and/or items included in the plan of care.
(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents with 11 selected for review including one reviewed for participation in the care planning process. Based on interview and record review, the facility failed to facilitate the inclusion of Resident (R)4's representative in care plan

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 553	Continued From page 2	F 553		

meetings.

Findings included:

- The "Admission Minimum Data Set" (MDS) dated 05/25/22 revealed R4 admitted to the facility on 02/25/22 and was assessed with a "Brief Interview of Mental Status Score" (BIMS) of three, indicating severe cognitive impairment. The facility did not assess how important it was to R9 to have family or a close friend involved in discussion about his care.

The "Care Plan" dated 12/03/22 for R4 revealed an intervention for "friends/family involvement in my care: my brother."

The "Profile" tab revealed R4's brother was his Durable Power of Attorney (DPOA) for healthcare and the resident's first emergency contact.

The "Progress Note" dated 06/08/22, for R4 revealed the care plan team met with him to review his care plan. The progress note lacked any family participation in the meeting.

The "Progress Note" dated 07/06/22 revealed a care plan meeting was held for R4 and the team called his brother who was also his DPOA.

The "Progress Note" dated 11/02/22 revealed the care plan team met with R4 to review his plan of care. The progress note lacked any family participation in the meeting.

The "Interdisciplinary Care Plan Conference Notes - V2" dated 11/02/22 revealed R4's brother notified on 10/12/22 per mail of the care plan meeting on 11/02/22. R4 attended the meeting

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 553	Continued From page 3 and the DPOA did not. The note lacked if the facility attempted to phone conference with R4's representative for the meeting. The facility lacked documentation in the progress notes, or the care plan conference notes, that the staff notified the DPOA of the meeting on 06/08/22. On 01/10/23 at 09:23 AM, an unidentified family member stated, "we have never been notified of a care plan meeting." On 01/11/23 at 12:22 PM, Administrative Nurse E stated the social worker sends out invitations for the care plan meetings, and if the family cannot attend the phone would be used to conference with them. The first care plan meeting with a resident would be held within 48 hours of admission. Administrative Nurse E stated she recalled having a meeting with R4's brother and his wife but could not recall when that was. On 01/13/23 at 02:33 PM, Administrative Staff A stated he expected the resident representative to be notified of a resident's care plan meeting. The facility lacked a policy for care plan meetings. The facility failed to facilitate inclusion of the representative of R4, who had cognitive impairment, to participate in two of three care plan meetings with the facility staff.	F 553		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 4	F 580		

consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 5	F 580		

that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents with eleven selected for review including three residents reviewed for notification of changes. Based on observation, record review, and interview, the facility failed to notify the resident representative after falls for Resident (R)4 and R3.

Findings included:

- The "Profile" tab revealed R4's brother was the Durable Power of Attorney (DPOA) and the first emergency contact.

The Electronic Medical Record, (EMR) revealed R4 fell five times between 04/23/22 through 06/02/22.

The "Progress Note" dated 04/23/22 revealed R4 was sitting on the floor in front of his wheelchair and the note lacked notification of the fall to the DPOA.

The "Fall" investigation for 04/23/22 lacked notification to the DPOA.

The "Progress Note" dated 05/05/22 revealed R4 was lying on his back on the floor next to his wheelchair and a skin tear that had a scab on his left forearm reopened. The note lacked

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 580	Continued From page 6	F 580		

notification of the fall to the DPOA.

The "Fall" investigation for 05/05/22 lacked notification of the DPOA.

The "Progress Note" dated 05/27/22 revealed the resident had a fall.

The facility "Risk Watch" report lacked notification of the DPOA of the fall and revealed notification was "self- 05/27/22".

The facility "Witness Statement" dated 06/02/22 revealed R4 was face down on the floor by his bed.

The "Progress Notes" lacked documentation of the fall. The facility was not able to provide any other documentation/investigation about the fall. The facility failed to notify the DPOA of the fall.

The facility failed to notify the DPOA for four of five fall occurrences from 04/23/22 through 06/02/22.

On 01/05/23 at 08:21 AM R4 stated he had not had any falls since he came to the facility.

On 01/10/23 at 09:23 AM an unidentified family member stated, "We are never notified of falls."

On 01/10/23 at 09:58 AM observed R4 resting in bed, which was in a low position, a mat on the floor next to his bed, and call light across his in reach on top of the covers.

On 01/11/23 at 02:12 PM, Licensed Nurse (LN) G stated families were to be communicated with after falls.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 580	Continued From page 7	F 580		

On 01/13/22 at 01:33 PM, Administrative Staff A stated he would expect the staff to notify the resident representative after each fall.

The facility "Fall Policy" dated 09/17/19 revealed as updates occur the resident representative will continue to be notified and encouraged to assist with new interventions.

The facility failed to provide notification to R4's representative for four of the five falls that occurred between 04/23/22 and 06/02/22.

- The "Quarterly Minimum Data Set" (MDS) dated 10/12/22 assessed R3 with a "Brief Interview of Mental Status" (BIMS) score of three, indicating severe cognitive impairment.

The "Profile" tab revealed R3 had a daughter who was the DPOA and the first emergency contact.

The Electronic Medical Record (EMR) revealed R3 fell three times between 08/17/22 through 09/07/22.

The "Progress Note" dated 08/17/22 revealed R3 was sitting on the floor in her room in front of the wheelchair. The note lacked notification to the DPOA.

The "Progress Note" dated 09/07/22 at 05:45 AM, revealed R3 was sitting on the floor in front of the TV stand.

The facility "Fall" report revealed the first shift would notify the family.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 580	Continued From page 8 The "Progress Notes" lacked family notification of the fall on 09/07/22. On 01/05/23 at 08:54 AM, observed R3 sitting in the wheelchair in her room, unattended, leaning forward with her hands together at her knees and a blanket on her lap. On 01/11/23 at 02:12 PM, Licensed Nurse (LN) G stated families were to be communicated with after falls. On 01/13/22 at 01:33 PM, Administrative Staff A stated he would expect the staff to notify the resident representative after each fall. The facility "Fall Policy" dated 09/17/19 revealed as updates occur the resident representative will continue to be notified and encouraged to assist with new interventions. The facility failed to provide notification to R3's representative for two of the three falls which occurred between 08/17/22 through 09/07/22.	F 580		
F 689 SS=J	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 reported a census of 55 residents	F 689	Past noncompliance: no plan of	

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 9	F 689		

with 11 selected for review including three reviewed for risk of elopement (an incident in which a cognitively impaired resident with poor or impaired decision-making ability/safety awareness leaves the facility without the knowledge of staff). Based on observation, record review, and interview, the facility failed to ensure a safe environment for cognitively impaired and independently mobile Resident (R)2, who was identified as at risk of elopement, had a history of elopement, and the facility discontinued her elopement risk interventions. On 09/23/22, R2 exited the facility without staff awareness or supervision and crossed a heavily traveled four lane street. The staff who were outside of the facility on break, observed her and assisted her back to the building. This deficient practice placed the resident in immediate jeopardy. Additionally, the facility identified R8 as an elopement risk and failed to complete 15 minute checks, and identified R9 as an elopement risk and failed to check the wander alarm bracelet (bracelet that sets off an alarm when resident wearing one nears or attempts to exit facility without an escort) for placement and function. Furthermore, upon review of three residents for accident hazards, the facility failed to implement appropriate interventions following falls and failed to investigate all falls for R4. The facility failed to implement new interventions following falls for R3 and failed to investigate all falls, failed to implement fall interventions, and failed to transfer R3 in a safe manner.

Findings included:

- The "Medical Diagnosis" tab for R2 included diagnoses of dementia (progressive mental disorder characterized by failing memory,

correction required.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 10	F 689		

confusion), muscle weakness, anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), restlessness, and agitation.

The "Quarterly Minimum Data Set " (MDS) dated 09/26/22, assessed R2 with a "Brief Interview of Mental Status Score" (BIMS) of two, indicating severe cognitive impairment, and noted R2 did not wander. R2 required supervision and setup help for walking and used a wander/elopement alarm daily.

The "Annual MDS" dated 12/23/22, assessed R2 with a BIMS score of six, indicating severe cognitive impairment. The MDS noted R2 continued not to wander, was independent with walking, and used a wander/elopement alarm daily.

The "Activities of Daily Living [ADL] Care Area Assessment" (CAA) dated 12/31/22 revealed R2 ambulated throughout the facility independently.

The "Elopement Assessment -V3" dated 06/21/22 revealed R2 was cognitively impaired and independently mobile and had a history of elopement. Since those items were answered on the assessment, the assessment indicated the resident was at risk for elopement and to proceed with interventions and elopement risk care plan. The assessment revealed "discontinued off elopement risk because she acclimated to facility and is no longer exit seeking."

The "Care Plan" dated 12/03/22 revealed R2 ambulated through the facility with no assistive

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 689	Continued From page 11	F 689		

device, was a risk for elopement or to wander, a wander alert device was added on 09/23/22, and the staff added her picture to the elopement book due to her elopement/wandering risk. The care plan history revealed the facility discontinued her elopement risk problem on 08/10/22.

The "Progress Note" dated 09/23/22 at 11:29 AM revealed the staff informed R2's DPOA (Durable Power of Attorney) she left the building this morning after following a visitor out. The staff observed R2 walking down the sidewalk. The staff placed a wander alarm bracelet on her for her safety.

The facility "Incident Information" dated 09/26/22 revealed on 09/23/22 at approximately 09:45 AM the housekeeping staff who were outside on break, discovered R2 walking across the street from the facility, headed towards a park (located across the heavily traveled four lane street). When the staff approached her, R2 stated she was "going for a walk" and when asked how she got out, R2 stated "the lady let me out." The staff brought her back to the facility at 09:50 AM. R2 had been last seen at 09:30 AM holding some clothes and hangers sitting in the common area, which were later discovered on her bed. The facility concluded R2 was let out by a visitor while she was sitting close to the main entrance.

The "Witness Statement" dated 09/23/22 by Administrative Nurse F revealed staff saw R2 walking about in the dining room and the common area about 09:30 AM with clothes hanging over her arm, with the hangers still attached, and R2 spoke to other residents and staff.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 12	F 689		

The "Witness Statement" dated 09/23/22 by Housekeeping/Maintenance Staff U revealed while outside on break in the back parking lot talking to two other housekeepers, one of the housekeepers asked if that was R2. When the staff looked up, Housekeeping/Maintenance Staff U saw R2 stumble and they ran to R2, who was on the other side of street, south of the facility. R2 told Housekeeping/Maintenance Staff U she was going on a walk and a lady let her out. When brought back inside, the staff applied a wander alarm bracelet to R2.

On 01/04/23 at 03:02 PM, observed R2 sitting in the dining room for a facility activity, a she wore a wander alarm bracelet on her left ankle.

On 01/04/23 at 03:47 PM observed, with Administrative Staff A, the area the facility staff saw R2 on 09/23/22, when she exited. The street was a four-lane road with a speed limit of 30 miles per hour and heavily traveled. The location R2 crossed lacked a stop sign or traffic light for the four-lane traffic traveling alongside the north of the facility grounds. The park was located across the busy street.

On 01/04/23 at 03:50 PM, Administrative Staff A stated a visitor let R2 out but the facility did not know who it was and the facility has a sign posted about not letting anyone out without checking with the staff.

On 01/04/23 at 05:03 PM, Administrative Nurse D stated when the staff completed the elopement risk assessment in June 2022, R2 was at risk and to discontinue the elopement interventions was "probably not the correct intervention."

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 13	F 689		

On 01/05/23 at 09:44 AM, Administrative Staff A stated R2 sat by the front doors before the morning meeting and R2 said she followed a visitor out, so that was how the facility knew R2 went out one the front doors (on 09/23/22).

On 01/05/23 at 09:58 AM Housekeeping/Maintenance Staff U stated she was outside on break when she noticed R2 walking across the street, so she ran to get R2. R2 was walking on one street then crossed to the other street and was stumbling trying to step up on the curb. R2 was on the sidewalk when Housekeeping/Maintenance Staff U got to her. R2 went back to the facility with Housekeeping/Maintenance Staff U. R2 had said a lady let her out however, she could not describe her and did not know who she was. Housekeeping/Maintenance Staff U stated as R2 crossed the street there was not any traffic traveling on one road, but there was on their way back to the facility and she had to stop the traffic for her and R2 to cross the street.

The facility "Elopement Policy" undated, revealed using the MDS assessment schedule, all residents are reviewed for safety concerns and precautions. Any residents that are at risk for elopement should be identified and interventions placed in their individual plan of care. Residents at risk for elopement shall be placed in an elopement book located at the reception desk and nurse's stations. This will be updated whenever new resident safety issues are identified.

The facility failed to continue with elopement risk interventions for R2, who had severe cognitive impairment and was independently ambulatory,

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 14	F 689		

when assessed at risk on the elopement assessment on 06/21/22 and eloped on 09/23/22. This placed R2 at risk for immediate jeopardy.

On 01/05/23 at 01:43 PM, Administrative Staff A was informed that they were in immediate jeopardy status and provided the "Immediate Jeopardy Template" for failure to continue with elopement risk interventions when R2 was at risk per the elopement assessment completed on 06/21/22. R2 eloped from the facility on 09/23/22.

The facility completed implementation of the following corrective measures on 09/23/22 at 09:00 PM:
1. Wander alarm initiated to her left ankle.
2. Picture and resident information added to the elopement book.
3. Staff re-educated on elopement policy immediately following the resident's return back to the building, further education provided to staff before the beginning of their shifts. The majority, of staff, received education on 09/23/22.
4. All resident elopement assessments reviewed and updated.
5. R2's care plan reviewed and updated.
6. Maintenance director conducted wander alarm door inspection to all exit doors.

The deficient practice with elopement was deemed past non-compliance due to the implemented corrective actions and existed at a "J" scope and severity.

- The "Medical Diagnosis" tab for R9 included diagnoses of anxiety (feelings of worry, anxiety, or fear that are strong enough to interfere with

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 15	F 689		

one's daily activities), encephalopathy (the functioning of the brain is affected by some agent or condition such as a viral infection or toxins in the blood), muscle weakness, and abnormalities of gait and mobility.

The "Admission Minimum Data Set " (MDS) dated 10/12/22 assessed R9 with a "Brief Interview of Mental Status" (BIMS) score of eight, indicating moderate cognitive impairment, rejected care one to three days, and wandered one to three days. R9 walked in/out of room with supervision and did not require setup assistance from staff, used a walker for mobility and she required a wander/elopement alarm to be used daily.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 10/18/22 revealed R9 ambulated with a walker and the staff supervised as needed.

The "Care Plan" dated 12/03/22 revealed R9 had been seen several times within the area lost and not knowing where she lived or where she was going and had come to the facility for long term care and was finding adjusting difficult. R9 was at risk for elopement and lacked a wander alarm was in place. Staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and a book.

The "Elopement Assessment V-3" dated 09/29/22 revealed R9 was cognitively impaired and independently mobile, had a desire to leave the facility, was exit seeking with a purpose, and had wandering activity. This indicated R9 was at risk

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 16	F 689		

for elopement.

The "Orders" tab for R9 lacked instructions for the staff to check for placement and functioning of a wander/alarm bracelet.

The "Task" tab lacked instructions for the Certified Nurse Aides (CNA's) to check for wander alarm placement and functioning.

On 01/04/23 at 03:15 PM observed R9 in her room with a wander alarm bracelet in place to her right ankle.

On 01/05/23 at 08:46 AM observed R9 ambulating down the hallway on her own using a walker, wander alarm bracelet was in place to her right ankle.

On 01/10/23 at 01:57 PM CNA N stated R9 was at risk for elopement and that she had a wander alarm bracelet in place, she has helped put her hose on so knows she has one. CNA N stated the CNA's do not document anything about wander alarms and believed "management checks them." CNA N stated R9 wanted to get out of the facility when she first came I but had not witnessed her exit seeking or talking about leaving.

On 01/11/23 at 08:53 AM Administrative Nurse D stated each nurse's cart had a device to check the wander alarm bracelet each 12-hour shift and would document the check on the "Treatment Administration Record" (TAR). Administrative Nurse D stated if a resident had a wander alarm in place it would be on the TAR to check for placement and function, and the wander alarm would be on the care plan.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 17	F 689		

On 01/11/23 at 09:15 AM, Administrative Nurse D stated R9 did not have the wander alarm in place on the TAR to instruct the staff to check for placement and functioning.

On 01/11/23 at 09:35 AM, CNA P stated R9 was at risk for elopement and had a wander alarm bracelet in place to her ankle.

On 01/11/23 at 02:12 PM, Licensed Nurse (LN) G stated if a resident was an elopement risk, she would let Administrative Nurse A know, get an order from the doctor for a wander alarm bracelet, and would do checks to see if wander alarm was in place and working. When the order comes from the doctor it would be placed on the TAR for the nurses to check every shift or placement and if it is working with the device the facility has to check the wander alarm with.

The facility "Elopement Policy" undated, lacked instructions for checking for placement and function of the wander alarm bracelet.

The facility failed to perform checks of the wander alarm bracelet for placement and functioning, which increased the risk of R9, who had moderate cognitive impairment, to exit the facility without staff awareness.

- The "Medical Diagnosis" tab for R8 included a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbance (serious illness affecting how one thinks and perceives reality).

The "Annual Minimum Data Set" (MDS) dated

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 18	F 689		

09/15/22 for R8 assessed him with a "Brief Interview of Mental Status" (BIMS) score of six, indicating moderate cognitive impairment and did not exhibit wandering. R8 required supervision and setup for walking in/out of the room and used a wheelchair and walker for mobility. R8 did not require a wander/elopement alarm.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/26/22 revealed R8 had cognitive loss due to head trauma.

The "Activities of Daily Living [ADL] CAA" dated 09/26/22 revealed R8 was independent with most ADL's but may need assistance of one person with "some."

The "Quarterly MDS" dated 12/16/22, assessed R8 with a BIMS score of seven, indicating severe cognitive impairment, rejected care one to three days, and did not require a wander/elopement alarm.

The "Care Plan" dated 12/03/22 revealed the facility identified R8 as a risk for elopement on 08/31/22. He attempted elopement on 10/27/22 when upset that the staff had not taken him to Walmart. R8 observed the staff leave the facility and thought they were not going to take him, so he decided to go himself. The care plan revealed the staff were to communicate the time they would take him and talk to him if the time needed to be changed. The staff placed R8's picture and resident information in the elopement book. The care plan included on 11/08/22 R8 removed two wander alarm bracelets and would not keep them on and would not allow a third to be placed on his person. The staff were to monitor and document his location in the facility, the nurses every two

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 19	F 689		

hours and the aides were to document hourly. The care plan revealed R8 ambulated independently, with or without a device, and would use a wheelchair for mobility or he would walk.

The "Elopement Assessment V-3" dated 09/23/22 revealed R8 was cognitively impaired and independently mobile and had a desire to leave the facility. This placed the resident at risk for elopement and the staff were to proceed with interventions and an elopement risk care plan.

The "Task" tab instructed staff to "Monitor - every one-hour check" and revealed from 12/27/22 through 01/16/23 the staff failed to perform hourly checks on 01/04/23, 01/08/23, 01/10/23, and 01/15/23. Each day from 12/27/22 through 01/16/23 revealed hours of the day the staff failed to complete the instructed hourly checks.

The "Progress Note" dated 10/31/22 at 06:36 PM, revealed R8 refused a wander alarm and stated, "I decided to stay." Another staff attempted to place a wander alarm and he refused and became agitated.

The "Progress Note" dated 11/08/22 at 04:35 AM, revealed the staff placed a wander alarm on R8 and he removed it stating he would stay there and not try to leave again.

On 01/04/23 at 01:50 PM, observed R8 without a wander alarm in place. R8 was in his room resting on his bed.

On 01/04/23 at 05:08 PM, Administrative Nurse A stated R8 is not supposed to have a wander alarm bracelet on, he had removed two and

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 20	F 689		

refused the third to be placed. The nursing staff was to check him every two hours and instructed them to do so on the Treatment Administration Record. Administrative Nurse A stated R8 walked independently, however, he stayed in his room or close to the nurse's station.

On 01/05/23 at 08:20 AM, observed R8 sitting in a wheelchair in the dining room eating breakfast.

On 01/10/23 at 01:00 PM, Certified Nurse Aide (CNA) M stated R8 usually eats breakfast in the dining room and has lunch and supper in his room. He will come out of his room if he wants to use the phone and will use the wheelchair to come out of his room but walk on his own in the room. CNA M stated R8 was an elopement risk, and they were to do hourly checks on him and document. CNA M stated she was "pretty sure" he had a wander alarm bracelet on his ankle.

On 01/11/23 at 08:30 AM, observed R8 move himself away from the table in the dining room, move the foot pedals on his wheelchair down, place his feet on the pedals, and propel himself to his room.

On 01/11/23 at 08:53 AM, Administrative Nurse A stated she expected the CNA's to complete hourly checks.

The facility policy "Elopement Policy" undated, revealed any residents that are at risk for elopement should be identified and interventions placed in their individual plan of care.

The facility failed to follow the care plan by lack of completion of hourly checks for R8, with severe cognitive impairment and assessed at risk for

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 21	F 689		

elopement, placing him at increased risk to exit the facility without staff awareness.

- The "Medical Diagnosis" tab for R4 included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebrovascular disease (reduction of blood flow to your brain or bleeding in part of the brain) affecting right dominant side, tremor, muscle weakness, and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 03/10/22 for R4 assessed him with a "Brief Interview of Mental Status" (BIMS) score of 10, indicating moderate cognitive impairment. He required limited assist of one for transfers and walking in/out of the room. R4's balance was not steady and required staff assistance to stabilize and he had limitations to one side of his upper and lower extremities. He used a walker and a wheelchair for mobility. R4 was always continent of bladder and occasionally incontinent of bowel. R4 had falls in the last six months prior to entry and had no falls since admission, on 02/25/22.

The "Admission MDS" dated 05/25/22 for R4 assessed him with a BIMS score of three indicating severe cognitive impairment and required extensive assist of one staff for transfers. R4 did not ambulate and continued to require staff to stabilize his balance. There were not changes to his upper and lower extremity range of motion and continued to use a walker and wheelchair for mobility. R4 was frequently incontinent of urine and always incontinent of bowel. He had falls in the last month and last two to six months prior to reentry, and no falls since

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 22	F 689		

reentry on 05/12/22.

The "Falls Care Area Assessment" dated 05/26/22 revealed R4 had right sided weakness and was a fall risk. He walked with a walker and had unsteady gait. The staff were to observe him with ambulation and provide one person assist as needed.

The "Quarterly MDS" dated 11/23/22 assessed R4 with a BIMS score of three, indicating severe cognitive impairment and was totally dependent of two or more staff for transfers. He did not ambulate. His balance during transitions and walking did not occur and there were no changes to his range of motion. R4 used a wheelchair for mobility and was always incontinent of bowel and bladder. Resident had no falls since the prior assessment on 08/26/22.

The "Care Plan" dated 12/03/22 revealed R4 was a high risk for falls, and included these fall interventions:
1. On 02/25/22, the staff were to make sure his call light was within reach and to encourage him to use it for assistance as needed.
2. On 03/18/22, the staff educated R4 to ask for assistance when ready to stand up in the shower.
3. On 03/20/22, the staff placed a "Call don't fall" sign.
4. On 04/02/22, the Certified Nurse Aides (CNA's) were to offer him to be one of the first residents assisted to meals.
5. On 04/14/22, R4's room changed to one with a more open floor plan to better enable him to get in and out of the bathroom.
6. On 04/23/22, the staff were to assist R4 to the bathroom after meals as needed.
7. On 05/03/22, the staff were to place R4's bed

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 23	F 689		

in a low position.
8. On 05/05/22, the staff were to place a floor mat on the floor beside the bed when R4 was in bed.
9. On 06/11/22, the staff were to offer to assist R4 to the recliner or bed after meals.
10. On 06/13/22, the staff were to encourage him to watch something other than ghost/haunted shows at bedtime.
11. On 06/25/22, the staff were to offer reposition, fluids, snack, and/or bathroom during rounds.
12. On 07/17/22, the staff were educated/reminded that R4's bed was to be in the low position and the floor mat next to his bed when napping.
13. On 08/20/22, the staff educated R4 to use the call light and to use safety when trying to reach items.

The "Fall Risk Data Collection 1019 - V 2" dated 02/25/22 for R4 revealed a score of 29, indicating high risk for falls. intervention was for call light within reach and encourage him to use it for assistance as needed.

The Electronic Medical Record (EMR) and facility documentation revealed R4 had 14 falls between 03/18/22 through 08/20/22.

The "Progress Note" dated 03/18/22 at 07:30 PM revealed R4 was lying on the floor on his back in the shower room. He did not respond at first then was slow responding and a small "lump" was on the back of his head. R4 could not recall falling. The intervention for the fall was education to ask for assistance when ready to stand up in the shower. The facility failed to implement an appropriate intervention as his BIMS score was 10, indicating moderate cognitive impairment.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 24	F 689		

The "Progress Note" dated 05/03/22 at 06:03 PM revealed R4 was found on his knees in front of the bed, the wheelchair brakes were not locked, had regular socks on his feet, the room was dark, and he was incontinent at the time of the fall. R4 had a scabbed over skin tear to his left forearm from a previous fall that re-opened. R4 stated he was trying to walk to his closet to get pants to change into and lost his balance and fell in front of the closet then "scooted" on his knees back to his bed. The intervention was to place the bed in the low position. The facility failed to implement an appropriate intervention relating to the cause of the fall.

The "Progress Note" dated 05/05/22 at 06:30 AM revealed R4 was found in his room lying on his back on the floor next to the wheelchair and recliner. The facility lacked a post fall investigation to determine the root cause analysis of the fall. The facility implemented an intervention to place a floor mat on the floor beside the bed when he was in bed.

The "Progress Note" dated 05/27/22 at 10:30 AM revealed R4 had a fall this shift.

The facility "Risk Watch" report dated 05/27/22 revealed R4 was self-transferring from bed to wheelchair and could not find the call light in the bedding. The facility failed to implement a new intervention to prevent further falls.

The facility "Witness Statement" dated 06/02/22 revealed at 10:30 AM while delivering clean linen, R4 was found faced down on the floor by his bed. The facility has no documentation of this event, unknown if it was a new fall or regarding the fall on 05/27/22. The care plan lacked a fall

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 25	F 689		

intervention for 05/27/22 and 06/02/22.

The "Progress Notes" dated 07/18/22 at 03:48 AM revealed R4 was on the floor of his room sitting facing his bed with legs folded under him, his left arm was across the bed and right arm hanging at side, and the wheelchair was directly behind him. R4 stated he was leaning across the bed and slipped out of bed landing on knees. The intervention was the staff educated R4 to use the call light and use safety when trying to reach items. The intervention was not appropriate, as R4's BIMS score was three, indicating severe cognitive impairment.

On 01/10/23 at 09:58 AM, observed R4 resting in bed in a semi-private room, bed in low position, mat on floor next to bed, and call light across the blanket covering him.

On 01/11/23 at 09:19 AM, observed R4 sitting up in his wheelchair in his room, next to and facing the bed, lights off in the room, and the call light activated.

On 01/11/23 at 09:24 AM, CNA NN and CNA P responded to the call light and R4 told them he was ready to lay down. CNA NN and CNA P transferred R4 using the lift from his wheelchair to his bed, bed placed in low position, mat placed on floor beside him on the left side of the bed. CNA NN asked if he was dry and R4 responded "yes." The CNAs did not offer toileting to R4 at the time.

On 01/11/23 at 09:35 AM, CNA P stated she was made aware of falls and the new interventions by a "teachable moment board" in the nurses' station, which is on a clipboard which informs the staff if there was a care plan change, and the

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 26	F 689		

board is looked at before shift starts. CNA P stated R4 was a fall risk, he was to have a fall mat beside the bed and his bed was to be lowered to the floor, make sure his call light was in reach, and explained that he was not on a toileting program.

On 01/11/23 at 02:12 PM, Licensed Nurse (LN) G stated when a resident has a fall, she does an assessment, asks questions, has the CNA's write statements, completes the facility fall packet, and can add an intervention to the care plan from the electronic assessment. The family, medical provider and Administrative Staff D would be notified of the fall and documented in the progress note or the "Risk Watch" report. New interventions would be documented on the fall assessment and the floor staff educated.

On 01/24/23 at 01:16 PM, Administrative Staff A stated each fall should have a new intervention implemented, each fall should be investigated to determine the root cause of the fall, the staff should follow the care plan, and education to a resident when their BIMS score was below 13 was not an appropriate intervention.

The facility "Fall Policy" dated 09/17/19 revealed following any falls, the facility staff completes an "Occurrence Report." Details of the fall would be recorded, and potential causative factors identified and investigated. Interventions would be implemented, and the care plan updated. The "Occurrence Reports" would be reviewed at clinical meetings to ensure completeness.

The facility failed to implement new and appropriate interventions for the above falls and failed to investigate falls to determine the root

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 27	F 689		

cause, placing him at risk for further falls and injury.

- The "Medical Diagnosis" tab for R3 included diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), muscle weakness, and abnormalities of gait and mobility.

The "Annual Minimum Data Set" (MDS) dated 04/11/22 assessed R3 with a "Brief Interview of Mental Status" (BIMS) score of three indicating severe cognitive impairment and required two assist or more for transfers and walking in/out of her room. Her balance during transitions and walking was not steady and required staff assistance to stabilize. R3 had no impairments to her range of motion and used a walker and a wheelchair for mobility. She had two or more non-injury falls since the prior assessment on 03/31/22.

The "Falls Care Area Assessment" dated 04/28/22 revealed R3 was a fall risk, had vascular dementia, and impaired standing and walking balance. The resident required assistance with activities of daily living (ADL's). She was incontinent of bowel and bladder and had fall interventions in place.

The "Quarterly MDS" dated 07/12/22 assessed R3 with the same BIMS score and transfer status. She required extensive assist of one person for walking in the room and two or more when walking in the corridor. There were no changes in her balance or range of motion, and she used a wheelchair only for mobility. R3 had one

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 28	F 689		

non-injury fall since the last assessment on 04/11/22.

The "Quarterly MDS" dated 10/12/22 assessed R3 with the same BIMS score as the prior assessment. She required extensive assistance of two or more staff for transfers and did not ambulate in or out of her room. Her walking balance assessment did not occur, and she continued to need staff to stabilize her when moving from seated to standing. There were no changes to her range of motion and continued to use the wheelchair for mobility. R3 had two or more non-injury falls since the prior assessment.

The "Care Plan" dated 12/03/22 for R3 revealed she was at risk for falls related to her dementia, impaired mobility, and decreased safety awareness and included these interventions:
1. On 04/02/21, the staff were to make sure her call light was in reach and encourage her to use if for assistance as needed, revised on 06/02/21.
2. On 04/07/21, R3 will get down and crawl on the floor when she sees something she wants to get. The staff were to ensure her personal items were within reach.
3. On 04/07/21, R3's bed was to be in the low position when she was in bed, revised on 12/27/22.
4. On 04/08/21 R3 was to have gripper socks. Intervention revised 08/26/22.
5. On 04/09/21, mat on floor beside bed when resident is in bed.
6. On 04/20/21, Dycem (non-slip material) to be under the wheelchair cushion and on top of the cushion.
7. On 04/21/21, grip strips in font of recliner.
8. On 05/05/21, anti-roll back brakes on wheelchair, revised on 08/26/22.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 29	F 689		

9. On 05/07/21, Dycem to the armchair seat, revised on 08/26/22.
10. On 06/01/21, the staff were to make sure the recliner was in the right position before the grip strips.
11. On 06/23/21, Dycem to be on top of pad in recliner (replaced 02/01/22 related to a non-injury fall).
12. On 03/07/22, the staff replaced the sign family had placed on the door to say R3 was a fall risk and "please peek in on me I may be on the floor thank you" and the family wants the sign left up.
13. On 08/09/22, R3 was found on the floor, and she has a history of putting herself on the floor, suspected she did this on this day however not witnessed, monitor her as able when in the wheelchair.
14. On 08/17/22 and 08/20/22 R3 slid out from wheelchair when trying to transfer herself, anti-roll brakes were not put on this new chair and maintenance had applied them now.
15. On 09/02/22, the staff were to offer her snacks, toileting, nap, or activity to discourage behavior of sitting herself on the floor to get attention.
16. On 09/07/22, R3 found on floor, continue all previous interventions. R3 crawls to the floor when she has incontinence and wants changed, this was "a behavior with her and cannot be stopped."

The "Fall Risk Data Collection 1019 - V2" assessed her for high risk for falls on 02/14/22, 08/20/22, 09/07/22, and 10/09/22.

The "Progress Notes" revealed R3 fell five times between 08/09/22 and 12/26/22, not including times the staff believed she placed herself on the floor.

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 30	F 689		

The "Progress Note" dated 08/09/22 at 04:49 PM, revealed R3 was sitting on the floor of her room in the doorway and the wheelchair was behind her, R3 unable to state how she fell and stated she sat on the floor. The facility failed to implement a new intervention to prevent further falls, the facility suspected she put herself on the floor.

The "Progress Note" dated 08/17/22 at 05:10 PM, revealed R3 was sitting on the floor in front of her wheelchair and stated she had slid out of the wheelchair. The facility failed to implement an intervention until 08/20/22 when she had a subsequent fall. The anti-roll brakes were not in place on her wheelchair for either fall. The facility failed to follow the care plan.

The "Progress Note" dated 08/20/22 at 02:26 PM, revealed R3 was sitting on the floor in her room and wheelchair behind her and stated she was attempting to transfer to the bed and the wheelchair slid out from behind her. The facility then applied anti-roll brakes to her wheelchair as they were not in place to her new wheelchair.

The "Progress Note" dated 09/07/22 at 05:45 AM, revealed while doing rounds R3 was found sitting on the floor in front of the TV stand with no "bottoms on" and with her legs out in front of her.

The facility "CNA Fall Scene Investigation Questionnaire" dated 09/07/22 revealed R3 was sitting on the floor in front of her TV stand, her brief was in the trash can, her bed was unmade and there was feces on the floor from her scooting across the floor.

The facility failed to implement a new intervention

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 31	F 689		

to prevent further falls, the care plan indicated it was a behavior and to continue previous interventions.

The "Progress Note" dated 12/27/22 at 12:00 AM, revealed R3 was sitting on the floor at bedside, another resident had heard her crying and alerted the staff. R3 stated she rolled out of bed and her head hurt. R3 had a "large bump" with bruising above her right eye, centered on her forehead, and an abrasion to the left side of her nose with a small amount of bleeding. The facility contacted the provide and ordered to send her to the emergency room for evaluation and treatment. R3 left the facility at 11:15 PM on 12/26/22.

The "Progress Note" dated 12/27/22 at 05:46 AM, revealed R3 returned to the facility at 05:15 AM by emergency medical services and continued to complain of a mild headache. The staff assisted R3 to bed, lowered the bed to the floor, and put the fall mat in place. The emergency room nurse reported no fracture or other injury found on the CT (computerized tomography- a series of x-ray images taken from different angles around your body) of the head and spine.

The facility "Witness Statement" dated 12/26/22 by CNA OO revealed R3's bed was on the floor when she entered the room to respond to activated call light. R3 was sitting on the floor crying and said she hit her head on the bed and fell to the floor.

The facility "Witness Statement" dated 12/26/22 by CNA PP revealed she followed a coworker and the nurse down the hall after finding out R3 fell. R3 was sitting on the floor and there was water on the floor. R3 could not communicate how she

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 32	F 689		

fell and had a "bump" in the middle of her forehead and a cut on her nose.

The facility failed to determine if interventions were in place at the time of the fall and failed to implement a new intervention to prevent further falls.

On 01/04/23 at 11:08 AM, observed R3 sitting in her reclining chair in her room with feet elevated and house shoes in place, touch pad call light within reach on the overbed table beside her, yellow and purple bruising present to her forehead, around her eyes and her nose. Anti-roll brakes observed on her wheelchair which was parked out of reach by the sink in her room and a walker was against the wall by the TV stand folded up. A mattress observed leaning up against the wall and the bed on the right side.

On 01/04/23 at 11:10 AM, R3 stated she fell out of bed about a week ago and did not go the emergency room following the fall.

On 01/04/23 at 02:00 PM an unidentified family member stated the fall R3 just had could have easily been prevented. The family member stated the staff lower her bed to the floor when she sleeps in it and places the mattress on the right side, the side her first fall was from, but with this fall she fell from the left side of the bed. The family member stated R3 went to the emergency room due to the "goose egg" and the abrasion on her head, her face was pretty swollen, and the fall happened a week ago. The family member stated she had concerns about the extended time R3 was left in the wheelchair and many times she slides herself to the floor because she wants to be changed and the staff were supposed to

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 33	F 689		

check on her and take her to the bathroom every couple of hours. The family member stated they had addressed with the facility to not leave her in the wheelchair in the room unattended because she thinks she can transfer herself and does not know to lock the wheelchair. The family member stated she was unsure if the bed had been lowered to the floor when she fell because when she came in the next day the cord was wrapped around the bar below the mattress at the foot of the bed three times.

On 01/05/23 at 08:54 AM, observed R3 sitting unattended in her wheelchair in her room, leaning forward with her hands at her knees and a blanket on her lap. CNA N walked by the room, looked in as walking by, and kept walking down the hall.

On 01/05/23 at 08:58 AM, CNA N entered R3's room and spoke R3's name. R3 sat up straight and was ready to get in the recliner when CNA N asked her. Observed anti-roll bars on the wheelchair. CNA N placed R3's walker in front of her and R3 placed her hands on the walker and CNA N assisted R3 to stand by lifting under R3's right arm. The wheelchair lacked Dycem on top of the cushion, and the there was a washable incontinence pad on the recliner seat, Dycem not observed on the recliner seat. A gait belt was on the floor behind the recliner, and the floor lacked grip strips in front of the recliner. The staff failed to transfer R3 in a safe manner and failed to ensure care plan interventions were in place to prevent falls.

On 01/10/23 at 09:17 AM, observed R3 in her room sitting in her wheelchair and her head resting on the bed, then sat up in the chair but

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 34	F 689		

now with her back up against the back of the wheelchair. The call light clipped to the back of the recliner behind her.

On 01/10/23 at 11:00 AM, an unidentified family member stated when R3 gets tired of sitting in the wheelchair she will try to get out of it and fall and had told the facility not to leave her in her room in it by herself.

On 01/10/23 at 01:00 PM, CNA M stated R3 was a fall risk and had a fall mat to the side of her bathroom (right side) the staff were to use and she was to be taken to the bathroom and keep her bed in the low position. R3 was to be taken to the bathroom every two hours to be changed and either uses the wheelchair to get there or walks with the walker with the staff. CNA M stated R3 does refuse at times to be changed. CNA M stated two staff were to transfer R3 using a gait belt and the walker, and she requires the staff to assist her to stand up. CNA M was not sure if R3 was to have Dycem on the recliner seat and above and below wheelchair cushion. CNA M stated new fall interventions were communicated at rounds with the prior shift and by the nurse, or a teachable moment was done.

On 01/10/23 at 01:13 PM, observed CNA M and CNA LL use a gait belt and the walker and assist R3 to the bathroom. The wheelchair cushion had Dycem below it but not above and the recliner did not have Dycem above or below the washable incontinence pad. A sign on the wall above her recliner read "please use a gait belt when you transfer me."

On 01/10/23 at 01:57 PM, CNA N stated R3 was to have two people to assist her and the gait belt

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 35	F 689		

for "anything we do with her." CNA N stated R3 had a recent fall out of bed, she was to have a fall mat to the right side of her bed, but she fell out of the left side and the bed was kept really low when she lays down. CNA M stated thought the new intervention after her fall from bed was to make sure the mat was down, and the bed was all the way down. CNA M stated they take R3 to the bathroom and she does resist at times.

On 01/11/23 at 08:28 AM, CNA N assisted R3 out of the dining room per her wheelchair and propelled R3 to her room, left her in the wheelchair, and the call light was behind her out of her reach.

On 01/11/23 at 08:38 AM, R3 continues sitting in her wheelchair in her room and has moved the wheelchair to the left towards the recliner and placed the lap blanket in the seat of the recliner. R3 leaned forward slightly in the wheelchair and held her head in the down position.

On 01/11/23 at 08:40 AM, R3 continues sitting in wheelchair in her room and has her left hand placed on the right arm of the recliner and with her right hand moving the position of the blanket in the seat then moved her hands back to her and leaned forward in the wheelchair again.

On 01/11/23 at 08:43 AM, CNA N and CNA MM enter room and R3 shook her head no when CNA N questioned her if she needed to go to the bathroom. A gait belt was hanging on the wall behind her recliner. CNA N and CNA MM lift R3 under the arms, one on each side of her to stand her up at the walker placed in front of her. The staff assisted her to sit in the recliner which lacked Dycem to the seat. The wheelchair lacked

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 36	F 689		

Dycem on top of the cushion.

On 01/11/23 at 09:35 AM, CNA P stated R3 was a fall risk and the staff were to have her bed lowered to the floor and thought the fall mat was taken out. CNA P stated R3 fell recently, and she does not use the call light and she had witnessed R3 before try to crawl out of her wheelchair but not the bed. CNA P stated when transferring R3 she believed they were to use the gait belt and the walker and assist of two staff, and if weak could use the sit to stand mechanical lift.

On 01/11/23 at 11:45 AM, Administrative Nurse D stated she could not locate a fall investigation for R3's fall on 12/26/22 or a "CNA Fall Questionnaire." Administrative Nurse D stated the re was a fall packet the staff were to complete after a fall and she created a binder with that information so the agency staff would have access to it. Administrative Nurse D did not know what side of the bed R3 fell from, if the bed was in the low position, if the fall mat was by the bed, or what the new intervention was to prevent further falls. Administrative D stated she would expect the staff to follow the care plan.

On 01/11/23 at 12:41 PM, Administrative Nurse D stated she believed R3's fall mat was to be on both sides of the bed and was not saying the fall mattress was not in place but going by the injury to her injury, her face hit the floor, but not by knowledge. Observed R3's room with Administrative D and there was one available mattress to place on the floor by the bed.

On 01/11/23 at 12:58 PM, CNA QQ, on duty at the time of R3's fall on 12/26/22 stated she was late for work that shift and R3 had already fell

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	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 689	Continued From page 37	F 689		

when she arrived for duty.

On 01/11/23 at 02:12 PM, Licensed Nurse (LN) G stated when a resident has a fall, she does an assessment, asks questions, has the CNA's write statements, completes the facility fall packet, and can add an intervention to the care plan from the electronic assessment. The family, medical provider and Administrative Staff D would be notified of the fall and documented in the progress note or the "Risk Watch" report. New interventions would be documented on the fall assessment and the floor staff educated.

On 01/24/23 at 01:16 PM, Administrative Staff A stated each fall should have a new intervention implemented, each fall should be investigated to determine the root cause of the fall, and the staff should follow the care plan. It was facility protocol for use of gait belts and should be used to assist a resident and the staff should not lift a resident under the arms.

The facility "Fall Policy" dated 09/17/19 revealed following any falls, the facility staff completes an "Occurrence Report." Details of the fall would be recorded, and potential causative factors identified and investigated. Interventions would be implemented, and the care plan updated. The "Occurrence Reports" would be reviewed at clinical meetings to ensure completeness.

The facility failed to follow the care plan to prevent further falls, failed to investigate falls, and failed to implement new interventions following falls. Additionally, the facility failed to ensure transfers of the resident in a safe manner. These practices increased the risk of R3, who had severe cognitive impairment, to have further falls

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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	**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 689	Continued From page 38 with injury.	F 689		