STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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. The 2567 was sent electronically on 04/11/23.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/11/2023

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
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 1	F 609		

The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to report to the state agency an unwitnessed fall which resulted in a fracture for Resident (R) 3, and an injury of unknown origin for R5, who had a laceration over her left eye. This placed the residents at risk for further injury and unidentified abuse or mistreatment.

Findings included:

- R3's Electronic Medical Record (EMR) recorded diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), transient ischemic attack (TIA-a temporary disruption in the blood supply to part of the brain), and incontinence (lack of voluntary control over urination).

R3's "Quarterly Minimum Data Set" (MDS), dated 07/29/22, documented moderately impaired cognition and indicated R3 required supervision and set up assistance with toileting, dressing, personal hygiene, and independent with ambulation in her room, bed mobility, and transfers. The MDS further documented R3 had unsteady balance, no functional impairment, and had no falls.

R3's "Annual MDS," dated 02/02/23, documented R3 had moderately impaired cognition and required extensive assistance of one staff for transfers, toileting, ambulation in her room, and limited assistance of one staff for ambulation in corridors, personal hygiene, and dressing. The MDS further documented R3 had unsteady balance, occasional incontinence, no functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 2	F 609		

impairment, and had one non-injury fall.

The "Fall Care Area Assessment [CAA]," dated 02/02/23, documented R3 had moderately impaired cognition, and ambulated with a walker. R3, at times, would not accept assistance from staff for toileting and dressing. The CAA further documented R3 was alert and oriented, and her mood changed frequently. R3 had episodes of refusing to allow evaluations or assistance and participated in activities of her choice.

The "Fall Assessments," dated 04/18/22, 07/27/22, and 02/02/23, all documented R3 was a high risk for falls.

The "Fall Investigation," dated 02/21/22, documented at 08:00 AM, R3 stated she tried to get out of bed to go to the bathroom, was unable to stand, and slid to the floor. The investigation further documented R3 did not have on any socks at the time of the fall, and nonskid socks were applied. The investigation noted R3 did not receive any injury.

The "Nurse's Note," dated 02/21/23 at 04:29 PM, documented R3 reported right breast pain and stated that earlier in the day she heard a "pop" and started to have severe pain. The note further documented R3 stated she often had acid reflux and refused to go to the emergency room for evaluation. The note documented the nurse administered antacid medication (used to treat heartburn) and pain medication.

The "Nurse's Note," dated 02/22/23 at 09:17 AM, documented R3 complained of pain under her right breast and continued to refuse to go to the emergency room for an x-ray (a photograph or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 3	F 609		

digital image of the internal composition of part of the body) or to have the physician evaluate her. The note further documented R3 requested medication for her heart burn and requested to stay in her bed because she was sore.

The "Nurse's Note," dated 02/22/23 at 12:39 PM, documented the nurse contacted the physician due to R3 had extreme discomfort under her right breast. The note further documented R3 did not have any swelling or redness in the area, continued to decline transfer to the emergency room, and did not want the physician notified. The noted documented R3 continued to have heart burn and the physician ordered a scheduled antacid.

The "Nurse's Note," dated 02/25/23 at 08:40 AM, documented R3 complained of severe pain under her right breast that was rated as a 10 out of 10 (a 0 to 10 pain scale with zero as no pain and 10 representing the worst pain imaginable). The nurse assessed the area under the resident's right breast and did not see any swelling, redness, or bruising. The area was symmetrical (made up of exactly similar parts facing each other) upon palpation on each side of her chest. The note documented R3 winced in pain with each movement. The nurse contacted the emergency room, who suggested R3 be sent to the walk-in clinic. The note documented R3 agreed to go to the clinic for evaluation.

The "Physician Orders," dated 02/25/23, directed staff to administer Aleve (over the counter pain medication), 220 milligrams (mg), by mouth, every eight hours for pain; and Tylenol (medication for minor aches and pains), 650 mg, by mouth, every four hours for five days, for pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 4	F 609		

The order further directed staff to apply a heat pack every two hours alternating with an ice pack every two hours as needed. The order directed staff to encourage R3 to deep breath and use an incentive spirometer (a handheld device used to help improve the functioning of lungs) every two hours while awake. The order directed staff to have R3 hold a pillow to her chest when coughing due to R3 had fracture of ribs 3, 4, and 5.

The "Nurse's Note," dated 02/27/23 at 02:38 PM, documented R3 had increased pain and agitation and the current pain medication was not effective for reducing pain.

The "Physician Order's," dated 02/27/23, directed staff to hold the resident's Tylenol and administer Norco (narcotic medication for moderate to severe pain), 5/325 mg, by mouth every four hours as needed for pain, and a Salanpas (pain patch), to the right chest, every 12 hours, as needed for pain.

On 03/28/23 at 09:08 AM, observation revealed R3 had gripper socks on while in bed but Certified Nurse Aide (CNA) R had to adjust them and put one of them back onto her foot. Further observation revealed CNA R assisted R3 to sit on the side of her bed, placed a gait belt around the resident's waist, and CNA R and CNA S had the resident stand up. R3 required extra assistance to stand, she slowly grabbed her walker and slowly walked with staff down the hall to the shower room with just the gripper socks on her feet.

On 03/27/23 at 11:20 AM, CNA R stated R3 had fallen many times due to not calling for assistance. CNA R further stated R3 used to walk without assistance. CNA R stated even though

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 5	F 609		

staff remind R3, R3 gets up before staff get to her to assist her.

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R3 refused assistance and would get up on her own because she felt she could still take care of herself. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated R3 was alert and orient and did not feel R3 had cognitive impairment, just behaviors. LN G stated R3 does not like to call for assistance even though they remind her often because she still thinks she can get up on her own.

On 03/28/23 at 01:35 PM, Administrative Staff A stated she did not call in the fall because she did not think she had to if the resident's care had not changed.

The facility's "Abuse, Neglect, Exploitation Prevention" policy, undated, documented The Director of Nursing, Administrator or other designated investigating individual would begin their own internal investigation and notify the State of Kansas agency within twenty-four (24) hours of identifying the concern of possible abuse, neglect, or exportation and will fully cooperate with the investigating agency. The risk management committee and Quality Assurance Performance Improvement Committee will analyze occurrences to determine changes to policies and procedures to prevent further occurrences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 6	F 609		

The facility failed to report R3's unwitnessed event which resulted in a significant injury to the State Agency. This placed the resident at risk for further injury and unidentified abuse or mistreatment.

- The Electronic Medical Record (EMR) documented R5 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), epilepsy (brain disorder characterized by repeated seizures), and dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion).

The "Significant Change Minimum Data Set" (MDS), dated 07/22/22, documented R5 had severely impaired cognition and required limited assistance of two staff for bed mobility, transfers, toileting and locomotion. The MDS further documented R5 had unsteady balance, occasional bladder incontinence, no functional impairment, and had two or more non-injury falls.

R5's "Quarterly MDS," dated 01/23/23, documented R5 had severely impaired cognition and required extensive assistance with bed mobility, transfers, locomotion, toileting, and personal hygiene. The MDS further documented R5 had unsteady balance, frequent bowel and bladder incontinence, no functional impairment, and had two or more falls.

The "Fall Care Area Assessment [CAA]," dated 07/22/22, documented R5 required a wheelchair for mobility due to increased weakness, increased confusion and instability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 7	F 609		

The "Fall Risk Assessments, " dated 0/23/22, 10/18/22, 11/05/22, 01/16/23, documented the resident was a high risk for falls.

The "Fall Care Plan," dated 11/03/20, documented R5 would have on appropriate footwear and/or nonskid socks during transfers. The update, dated 06/03/22, documented new shoes were ordered for the resident. The update, dated 07/30/22, documented a motion sensor was placed in her room. The update, dated 08/19/22, documented R5 had a high/low bed to be kept in the lowest position. The update, dated, 08/21/22, directed staff to utilize as needed medication when the resident had increased anxiety. The update, dated 12/29/22, directed staff to place a second motion sensor in her room. The update, dated 01/05/23, documented anti-roll back brakes were installed on her wheelchair. The update, dated 03/10/23, directed staff to not leave the resident unattended in her room while she was in her wheelchair.

The "Nurse's Note," dated 06/28/22 at 10:31 AM, documented R5 had a small laceration over her left eye and stated she fell but had not called for assistance. The note further stated the laceration started bleeding after her shower and the nurse applied steri-strips due to the location of the wound.

The EMR lacked further documentation regarding the laceration or a related fall.

On 03/21/23 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) R placed a gait belt around R5's waist, CNA R and CNA S took ahold of the gait belt and assisted the resident to stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 609	Continued From page 8 up, pivot and sit down on the bed. Further observation revealed CNA R took off the resident's shoes and swung her legs onto the bed, took off R5's glasses, covered her up and attached the call light the R5's blanket. CNA R lowered R5's bed, placed a fall mat next to the bed, placed a motion sensor on the mat, and turned on another motion sensor that was on the wall by the resident's door before leaving the room. On 03/28/23 at 01:30 PM, Administrative Nurse D stated she had not started working at the facility until September and could not find documentation that the laceration was investigated or reported. The facility's "Abuse, Neglect, Exploitation Prevention" policy, undated, documented The Director of Nursing, Administrator or other designated investigating individual would begin their own internal investigation and notify the State of Kansas agency within twenty-four (24) hours of identifying the concern of possible abuse, neglect, or exportation and will fully cooperate with the investigating agency. The risk management committee and Quality Assurance Performance Improvement Committee will analyze occurrences to determine changes to policies and procedures to prevent further occurrences. The facility failed to ensure staff reported an injury of unknown origin to administration for cognitively impaired R5, placing her at risk for further injury and unidentified abuse or mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 610	Continued From page 9	F 610		

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to investigate an injury of unknown origin for one sampled resident, Resident (R) 5, who had a laceration over her left eye. This placed the resident at risk for further injury and unidentified abuse or mistreatment.

Findings Included:

- The Electronic Medical Record (EMR) documented R5 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), epilepsy (brain disorder characterized by repeated seizures), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 610	Continued From page 10	F 610		

dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion).

The "Significant Change Minimum Data Set" (MDS), dated 07/22/22, documented R5 had severely impaired cognition and required limited assistance of two staff for bed mobility, transfers, toileting, and locomotion. The MDS further documented R5 had unsteady balance, occasional bladder incontinence, no functional impairment, and had two or more non-injury falls.

R5's "Quarterly MDS," dated 01/23/23, documented R5 had severely impaired cognition and required extensive assistance with bed mobility, transfers, locomotion, toileting, and personal hygiene. The MDS further documented R5 had unsteady balance, frequent bowel and bladder incontinence, no functional impairment, and had two or more falls.

The "Fall Care Area Assessment [CAA]," dated 07/22/22, documented R5 required a wheelchair for mobility due to increased weakness, increased confusion, and instability.

The "Fall Risk Assessments, " dated 0/23/22, 10/18/22, 11/05/22, 01/16/23, documented the resident was a high risk for falls.

The "Fall Care Plan," dated 11/03/20, documented R5 would have on appropriate footwear and/or nonskid socks during transfers. The update, dated 06/03/22, documented new shoes were ordered for the resident. The update, dated 07/30/22, documented a motion sensor was placed in her room. The update, dated 08/19/22, documented R5 had a high/low bed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 610	Continued From page 11	F 610		

be kept in the lowest position. The update, dated, 08/21/22, directed staff to utilize as needed medication when the resident had increased anxiety. The update, dated 12/29/22, directed staff to place a second motion sensor in her room. The update, dated 01/05/23, documented anti-roll back brakes were installed on her wheelchair. The update, dated 03/10/23, directed staff to not leave the resident unattended in her room while she was in her wheelchair.

The EMR documented falls on these dates: 06/17/22, 06/19/22, 06/28/22, 08/07/22, 08/21/22, 08/26/22, 11/07/22, 11/26/22, 12/29/22, 01/20/23, and 03/01/23. R5's clinical record lacked evidence of resident centered interventions placed after each fall to prevent future falls. The clinical record lacked evidence the facility performed a thorough root cause analysis to attempt to identify R5's needs or reasons she continued to fall.

On 03/21/23 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) R placed a gait belt around R5's waist, CNA R and CNA S took ahold of the gait belt and assisted the resident to stand up, pivot and sit down on the bed. Further observation revealed CNA R took off the resident's shoes and swung her legs onto the bed, took off R5's glasses, covered her up and attached the call light the R5's blanket. CNA R lowered R5's bed, placed a fall mat next to the bed, placed a motion sensor on the mat, and turned on another motion sensor that was on the wall by the resident's door before leaving the room.

On 03/21/23 at 11:30 AM, CNA R stated R5 had the double motion sensor and fall mat because of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 610	Continued From page 12	F 610		

R5's many falls. CNA R stated R5 was very quick and would try to transfer herself and would fall.

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R5 would get up on her own and had a lot of falls and when the team got together, if they did not feel the interventions needed changed, they would keep them the same and it was difficult to always come up with a new intervention. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated the motion detector had been placed in R5's room within the last three months because of all her falls; staff watched her closely because she is quick and when they did not get to her in time, she would fall.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated the resident had a lot of falls and interventions were implemented by the team and nurse's did not update the care plan at this time but may try and work to that at some point.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated she had not started working at the facility until September and could not find documentation that the laceration was investigated or reported.

The facility's "Abuse, Neglect, Exploitation Prevention" policy, undated, documented The Director of Nursing, Administrator or other designated investigating individual would begin their own internal investigation and notify the State of Kansas agency within twenty-four (24)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 610	Continued From page 13 hours of identifying the concern of possible abuse, neglect, or exportation and will fully cooperate with the investigating agency. The risk management committee and Quality Assurance Performance Improvement Committee will analyze occurrences to determine changes to policies and procedures to prevent further occurrences. The facility failed to investigate an injury of unknown origin for cognitively impaired R5, who had a laceration over her left eye. This placed the resident at risk for further injury and unidentified abuse or mistreatment.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 14	F 657		

disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with person-centered interventions for inappropriate sexual behavior for one sample resident, Resident (R) 2, and failed to revise and implement person- centered interventions to prevent falls for R3 and R5, who had multiple falls. This placed the resident at risk for uncommunicated and/or unmet care needs.

Findings Included:

- The Electronic Medical Record (EMR) documented R2 had diagnoses of dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion), inappropriate sexual behaviors, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set" (MDS), date 03/02/23, documented R2 had moderately impaired cognition and required extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 15	F 657		

assistance for transfers, toileting, limited assistance of one staff for bed mobility, and personal hygiene. The MDS further documented R2 had disorganized thinking, inattention, physical behaviors one to three days, and other behaviors one to three days.

The " Behavior/Verbal Aggression Care Plan," dated 02/15/23, documented R2 used inappropriate language, was verbally aggressive, and quick tempered due to poor impulse control, dementia, and his traumatic brain injury (tTBI). The care plan directed staff to administer medication as ordered, analyze key times, triggers, circumstances and what de-escalated behaviors and document. The care plan directed staff to redirect R2's verbal aggression with music, singing, puzzles, group activities, and intervene before behavior escalated. The care plan documented R2 participated in individualized psychotherapy session twice a month with a telemed psychiatric service and to point out signs of positive progress or change in reactions to others when he was upset. The care plan lack direction regarding R2's inappropriate sexual behavior.

The "Mood Care Plan," dated 02/15/23, directed staff to encourage and provide opportunities for activities and encourage him to express feelings appropriately through 1:1 talks, and discuss any concerns, fears, issues regarding health and other subjects as often as he desires. The plan directed staff to monitor and document any anxious, negative statements, or health related complaints, and mental health medication oversight and talk therapy provided by psychiatric services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 16	F 657		

The "Anxiety Care Plan," dated 02/15/23, directed staff to remove R2 to a calm environment and allow to vent and share his feelings, encourage participation in daily care, and honor his requests as much as safely possible.

The "Physician Order," dated 04/23/22, directed staff to administer Cymbalta (an antidepressant medication), 30 milligrams (mg), 1 caplet, by mouth, in the evening and administer Cymbalta, 60 mg, 1 caplet, by mouth in the evening for depression.

The "Nurse's Note," dated 07/13/22 at 04:58 AM, documented R2 was very inappropriate toward staff and stated that he would like to have an underage staff member home with him. The note recorded R2 made comments about younger staff members and how they looked.

The "Nurse's Note," dated 10/19/22 at 08:07 PM, documented R2 told a Certified Medication Aide (CMA) that he wanted to take her to the bathroom and show her a good time. The resident was told that it was very inappropriate to talk to her that way and he needed to apologize. The note further documented R2 was angry at staff and would wheel up behind them and touch staffs' buttocks to get their attention.

The "Nurse's Note," dated 11/19/22 at 11:26 AM, documented R2 sexually touched a CMA's buttocks and he started to laugh when she told him it was not appropriate and to not touch her. The note further documented R2 called the nurses and CMA derogatory names.

The "Nurse's Note," dated 02/06/23 at 11:25 AM, documented R2 sat in his wheelchair behind a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 17	F 657		

CMA staring at her buttocks with a grin on his face. The nurse told him that it was not appropriate and to move along and do something else. The resident laughed and said he was reading something on her pants. The note further documented the nurse told R2 that there was no lettering where he was looking and to finding something else to do.

The "Nurse's Note," dated 02/14/23 at 07:19 PM, documented R2 touched Certified Nurse Aide (CNA)'s buttocks and the nurse told the resident there are consequences for touching others inappropriately.

The "Nurse's Note," dated 02/16/23 at 04:17 PM, documented the psych services recommended adding medroxyprogesterone (hormone medication), 5 mg, by mouth, daily for sexual behaviors.

The "Nurse's Note," dated 02/16/23 at 09:23 PM, documented R2 commented to the CMA that the buttocks of one of the younger CNA's was nice to look at and stated that when he heard her voice, he had dreams of sleeping with her. The note further documented the CNA told staff that she felt very uncomfortable to provide care to the resident and was advised to not provide cares to the resident alone.

R2's clinical record lacked evidence the facility followed up with R2 regarding the sexual behaviors and lacked evidence of ongoing behavioral support services in order to identify triggers and effective redirection methods.

On 03/28/23 at 04:00 PM, observation revealed R2 seated at a table putting a puzzle together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 18	F 657		

On 02/27/23 at 11:30 AM, CNA R stated he had a lot of behaviors some toward resident's and some towards staff. CNA R stated he has one resident he likes to get upset and they try to keep them separate. CNA R stated he has inappropriate sexual behaviors with staff.

On 03/28/23 at 10:09 AM, Administrative Nurse E stated verified there was not a care plan for his inappropriate sexual behaviors and didn't think they could put that in his care plan.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated they work as a team on care plans and right now the nurse's don't put interventions in the care plans and stated the care plan would be updated.

The facility's "Care Plan Revision" undated policy documented the care plan would be revised whenever the behavior or cognition of a resident changed with either a deterioration or an improvement. Any change in the problem, goals, or specific interventions or reasonable time frames would be revised on the resident's plan of care.

The facility failed to revise R2's care plan with interventions when for his inappropriate sexual behavior.

- R3's Electronic Medical Record (EMR) recorded diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), transient ischemic attack (TIA-a temporary disruption in the blood supply to part of the brain), and incontinence (lack of voluntary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 19	F 657		

control over urination).

R3's "Quarterly Minimum Data Set" (MDS), dated 07/29/22, documented moderately impaired cognition and indicated R3 required supervision and set up assistance with toileting, dressing, personal hygiene, and independent with ambulation in her room, bed mobility, and transfers. The MDS further documented R3 had unsteady balance, no functional impairment, and had no falls.

R3's "Annual MDS," dated 02/02/23, documented R3 had moderately impaired cognition and required extensive assistance of one staff for transfers, toileting, ambulation in her room, and limited assistance of one staff for ambulation in corridors, personal hygiene, and dressing. The MDS further documented R3 had unsteady balance, occasional incontinence, no functional impairment, and had one non-injury fall.

The "Fall Care Area Assessment [CAA]," dated 02/02/23, documented R3 had moderately impaired cognition, and ambulated with a walker. R3, at times, would not accept assistance from staff for toileting and dressing. The CAA further documented R3 was alert and oriented, and her mood changed frequently. R3 had episodes of refusing to allow evaluations or assistance and participated in activities of her choice.

The "Fall Assessments," dated 04/18/22, 07/27/22, and 02/02/23, all documented R3 was a high risk for falls.

The "Fall Care Plan," dated 03/31/22, directed staff to ensure R3's call light was within reach and to call for assistance; encourage R3 to participate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 20	F 657		

in activities that promoted exercise, and have therapy evaluate and treat as needed. An update, dated 04/19/22, documented R3 required one staff for assistance with toileting, set up assistance of one staff for dressing, and directed staff to ensure R3 wore appropriate footwear with nonskid soles when she ambulated. An update, dated 08/10/22, directed staff to ensure R3 wore shoes or gripper socks when she ambulated and provide reminders if R3 did not wear shoes. An update, dated 02/21/23, directed staff to ensure R3 wore nonskid slipper socks to bed.

The "Fall Investigation," dated 08/10/22, documented at 03:48 PM, R3 slipped and fell in her room. The investigation documented the fall was unwitnessed, R3 had gait imbalance, and ambulated without staff assistance. The investigation recorded R3 had improper footwear on, and she obtained an abrasion (scrape) to her left elbow.

The "Fall Investigation," dated 10/24/22, documented at 03:25 PM, R3 slipped and fell in her room. The investigation documented the fall was unwitnessed, R3 had gait imbalance, and did not receive any injury.

The "Fall Investigation," dated 02/20/23, documented at 12:42 AM R3 slipped when she lost her balance and scooted to the door to call for assistance. The investigation documented R3 had gait imbalance and improper footwear.

The "Fall Investigation," dated 02/21/22, documented at 08:00 AM, R3 stated she tried to get out of bed to go to the bathroom, was unable to stand, and slid to the floor. The investigation further documented R3 did not have on any socks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 21	F 657		

at the time of the fall, and nonskid socks were applied. The investigation noted R3 did not receive any injury.

The "Nurse's Note," dated 02/21/23 at 04:29 PM, documented R3 reported right breast pain and stated that earlier in the day she heard a "pop" and started to have severe pain. The note further documented R3 stated she often had acid reflux and refused to go to the emergency room for evaluation. The note documented the nurse administered antacid medication (used to treat heartburn) and pain medication.

The "Nurse's Note," dated 02/22/23 at 09:17 AM, documented R3 complained of pain under her right breast and continued to refuse to go to the emergency room for an x-ray (a photograph or digital image of the internal composition of part of the body) or to have the physician evaluate her. The note further documented R3 requested medication for her heart burn and requested to stay in her bed because she was sore.

The "Nurse's Note," dated 02/22/23 at 12:39 PM, documented the nurse contacted the physician due to R3 had extreme discomfort under her right breast. The note further documented R3 did not have any swelling or redness in the area, continued to decline transfer to the emergency room, and did not want the physician notified. The noted documented R3 continued to have heart burn and the physician ordered a scheduled antacid.

The "Nurse's Note," dated 02/25/23 at 08:40 AM, documented R3 complained of severe pain under her right breast that was rated as a 10 out of 10 (a 0 to 10 pain scale with zero as no pain and 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 22	F 657		

representing the worst pain imaginable). The nurse assessed the area under the resident's right breast and did not see any swelling, redness, or bruising. The area was symmetrical (made up of exactly similar parts facing each other) upon palpation on each side of her chest. The note documented R3 winced in pain with each movement. The nurse contacted the emergency room, who suggested R3 be sent to the walk-in clinic. The note documented R3 agreed to go to the clinic for evaluation.

The "Physician Orders," dated 02/25/23, directed staff to administer Aleve (over the counter pain medication), 220 milligrams (mg), by mouth, every eight hours for pain; and Tylenol (medication for minor aches and pains), 650 mg, by mouth, every four hours for five days, for pain. The order further directed staff to apply a heat pack every two hours alternating with an ice pack every two hours as needed. The order directed staff to encourage R3 to deep breath and use an incentive spirometer (a handheld device used to help improve the functioning of lungs) every two hours while awake. The order directed staff to have R3 hold a pillow to her chest when coughing due to R3 had fracture of ribs 3, 4, and 5.

The "Nurse's Note," dated 02/27/23 at 02:38 PM, documented R3 had increased pain and agitation and the current pain medication was not effective for reducing pain.

The "Physician Order's," dated 02/27/23, directed staff to hold the resident's Tylenol and administer Norco (narcotic medication for moderate to severe pain), 5/325 mg, by mouth every four hours as needed for pain, and a Salanpas (pain patch), to the right chest, every 12 hours, as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 23	F 657		

needed for pain.

On 03/28/23 at 09:08 AM, observation revealed R3 had gripper socks on while in bed but Certified Nurse Aide (CNA) R had to adjust them and put one of them back onto her foot. Further observation revealed CNA R assisted R3 to sit on the side of her bed, placed a gait belt around the resident's waist, and CNA R and CNA S had the resident stand up. R3 required extra assistance to stand, she slowly grabbed her walker and slowly walked with staff down the hall to the shower room with just the gripper socks on her feet.

On 03/27/23 at 11:20 AM, CNA R stated R3 had fallen many times due to not calling for assistance. CNA R further stated R3 used to walk without assistance. CNA R stated even though staff remind R3, R3 gets up before staff get to her to assist her.

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R3 refused assistance and would get up on her own because she felt she could still take care of herself. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated R3 was alert and orient and did not feel R3 had cognitive impairment, just behaviors. LN G stated R3 does not like to call for assistance even though they remind her often because she still thinks she can get up on her own.

On 03/28/23 at 1:30 PM, Administrative Nurse D stated the staff tried multiple times to get the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 24	F 657		

resident to go to the emergency room when she fell but she refused.

The facility's "Care Plan Revisions" undated policy documented the care plan would be revised after every fall to include specific instruction to staff based on the causal factors identified at the time of the occurrence and during the fall investigation process to prevent or reduce the possibility fro reoccurrence of falls.

The facility failed to revise R3's care plan with meaningful, resident centered interventions who had falls, placing the resident at risk for further falls.

- The Electronic Medical Record (EMR) documented R5 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), epilepsy (brain disorder characterized by repeated seizures), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus type 2.

The "Significant Change Minimum Data Set" (MDS), dated 07/22/22, documented R5 had severely impaired cognition and required limited assistance of two staff for bed mobility, transfers, toileting, and locomotion. The MDS further documented R5 had unsteady balance, occasional bladder incontinence, no functional impairment, and had 2 or more non-injury falls.

R5's "Quarterly MDS," dated 01/23/23, documented R5 had severely impaired cognition and required extensive assistance with bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 25	F 657		

mobility, transfers, locomotion, toileting, and personal hygiene. The MDS further documented R5 had unsteady balance, frequent bowel and bladder incontinence, no functional impairment, and had two or more falls.

The "Fall Care Area Assessment [CAA]," dated 07/22/22, documented R5 required a wheelchair for mobility due to increased weakness, increased confusion and instability.

The "Fall Risk Assessments, " dated 0/23/22, 10/18/22, 11/05/22, 01/16/23, documented the resident was a high risk for falls.

The "Fall Care Plan," dated 11/03/20, documented R5 would have on appropriate footwear and/or nonskid socks during transfers. The update, dated 06/03/22, documented new shoes were ordered for the resident. The update, dated 07/30/22, documented a motion sensor was placed in her room. The update, dated 08/19/22, documented R5 had a high/low bed to be kept in the lowest position. The update, dated, 08/21/22, directed staff to utilize as needed medication when the resident had increased anxiety. The update, dated 12/29/22, directed staff to place a second motion sensor in her room. The update, dated 01/05/23, documented anti-roll back brakes were installed on her wheelchair. The update, dated 03/10/23, directed staff to not leave the resident unattended in her room while she was in her wheelchair.

The EMR documented falls on these dates: 06/17/22, 06/19/22, 06/28/22, 08/07/22, 08/21/22, 08/26/22, 11/07/22, 11/26/22, 12/29/22, 01/20/23, and 03/01/23. R5's clinical record lacked evidence of resident centered interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 26	F 657		

placed after each fall to prevent future falls. The clinical record lacked evidence the facility performed a thorough root cause analysis to attempt to identify R5's needs or reasons she continued to fall.

On 03/21/23 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) R placed a gait belt around R5's waist, CNA R and CNA S took ahold of the gait belt and assisted the resident to stand up, pivot and sit down on the bed. Further observation revealed CNA R took off the resident's shoes and swung her legs onto the bed, took off R5's glasses, covered her up and attached the call light the R5's blanket. CNA R lowered R5's bed, placed a fall mat next to the bed, placed a motion sensor on the mat, and w turned on another motion sensor that was on the wall by the resident's door before leaving the room.

On 03/21/23 at 11:30 AM, CNA R stated they have the double motion sensor and fall mat because of R5's many falls. CNA R stated R5 was very quick and would try to transfer herself and would fall,

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R5 would get up on her own and had a lot of falls and when the team got together, if they did not feel the interventions needed changed, they would keep them the same and it was difficult to always come up with a new intervention. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 657	Continued From page 27 On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated the motion detector had been placed in her room within the last 3 months because of all her falls, staff watch her closely because she is quick and when they did not get to her in time, she would fall. On 03/28/23 at 01:30 PM, Administrative Nurse D stated the resident had a lot of falls and interventions were implemented by the team and nurse's do not update the care plan at this time but may try and work to that at some point. The facility's "Care Plan Revisions" undated policy documented the care plan would be revised after every fall to include specific instruction to staff based on the causal factors identified at the time of the occurrence and during the fall investigation process to prevent or reduce the possibility for reoccurrence of falls. The facility failed to revise R5's care plan with meaningful, resident centered interventions who had falls, placing the resident at risk for further falls.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 660	Continued From page 28 (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 660	Continued From page 29	F 660		

SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 13 residents. Based on record review and interview, the facility failed to develop a discharge plan to support and accommodate Resident (R) 29's goal of returning to the community. This placed R29 at risk for unmet care needs.

Findings included:

- R29's Electronic Medical Record (EMR) revealed the resident admitted to the facility on 01/10/23, with diagnoses of systemic lupus erythematosus (autoimmune disease in which the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 660	Continued From page 30	F 660		

immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs.), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), muscle weakness, difficulty in walking, history of falls and need for assistance with personal care.

The "Admission Minimum Data Set" (MDS), dated 01/18/23, documented R29 had intact cognition, required set up help, supervision and limited assistance with activities of daily living (ADLD). R29 was not steady but able to stabilize without staff assistance, used a wheelchair or walker for mobility. R29 was always continent of urine and bowel. The MDS further documented R29 expected to be discharged to the community and no active discharge planning had occurred for the resident to return to the community.

The "Return to Community Referral Care Area Assessment" (CAA), dated 01/26/23, documented R29 required stand by assistance and supervision to complete ADL, had a history of falls, reported adequate pain control, intact skin, and received physical therapy. The CAA further documented R29 planned to return to home.

The "Baseline Care Plan", dated 01/10/23, documented R29's discharge goals were unknown at that time, no discharge plan was initiated, and physical, occupational, and speech therapy screens were to be completed.

The "Comprehensive Care Plan", dated 02/06/23, lacked a discharge care plan focus.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 660	Continued From page 31	F 660		

The "Admission Assessment", dated 01/10/23, documented R29 had intact cognition, wanted to try to complete personal hygiene independently, and planned to discharge to home.

The "Progress Note", dated 01/15/23 at 02:39 PM, documented R29 stated "I wonder when I can get out of here. I want to be able to walk without that walker."

The "Progress Note", dated 01/30/23 at 10:53 AM, documented R29 returned to the facility. R29 stayed home over the weekend and tolerated the stay well with no noted complications. R29 stated "it was nice to be home."

The "Progress Note", dated 02/09/23 at 03:27 PM, documented R29 left the facility in wheelchair in the company of a family member and all discharge documentation completed.

On 03/28/23 at 08:51 AM, Social Services X stated she was responsible for discharge planning and care planning for R29's discharge. Social Services X verified the lack of a discharge care plan.

The facility's "Resident Discharge" policy, dated 03/28/23, documented the facility will provide sufficient preparation an orientation to resident and/or surrogate decision makers to ensure safe and orderly transfer or discharge from the facility based on the resident's assessed the needs and ability to this facility to meet those needs.

The facility failed to develop a comprehensive discharge plan that supported R29's discharge to the community placing the resident at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 660	Continued From page 32 unmet care needs.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 13 residents. Based on record review and interview, the facility failed to develop a discharge summary for one resident reviewed	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 661	Continued From page 33	F 661		

for discharge that included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay for Resident (R) 29. This placed the resident at risk for unmet care needs.

Findings included:

- R29's Electronic Medical Record (EMR) revealed the resident admitted to the facility on 01/10/23, with diagnoses of systemic lupus erythematosus (autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs.), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), muscle weakness, difficulty in walking, history of falls and need for assistance with personal care.

The "Admission Minimum Data Set" (MDS), dated 01/18/23, documented R29 had intact cognition, required set up help, supervision and limited assistance with activities of daily living (ADL). R29 was not steady but able to stabilize without staff assistance, used a wheelchair or walker for mobility. R29 was always continent of urine and bowel. The MDS further documented R29 expected to be discharged to the community and no active discharge planning had occurred for the resident to return to the community.

The "Progress Note" dated 01/15/23 at 02:39 PM, documented R29 stated "I wonder when I can get out of here. I want to be able to walk without that walker."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 661	Continued From page 34 The "Progress Note" dated 01/30/23 at 10:53 AM, documented R29 returned to the facility. R29 stayed home over the weekend and tolerated the stay well with no noted complications. R29 stated "it was nice to be home" The "Progress Note" dated 02/09/23 at 03:27 PM, documented R29 left the facility in wheelchair in the company of a family member and all discharge documentation completed. The "Progress Note", dated 02/23/23 at 01:02 PM, documented Social Services X spoke with R29's family member about discharge to home on 02/09/23. R29's EMR lacked a recapitulation of R29's stay. On 03/28/23 at 09:14 AM, Social Services X and Administrative Staff A reported they were unaware of the requirement for a recapitulation of R29's stay. The facility's "Resident Discharge" policy, dated 03/28/23, documented the facility would complete a "Nursing Discharge Summary and Recapitulation" and medication reconciliation will be completed in full and placed in clinical record. The facility failed to develop a discharge summary that included a recapitulation of the resident's stay for R29. This placed the resident at risk for unmet care needs.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 35	F 684		

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 13 residents, with eight reviewed for behaviors. Based on observation, record review, and interview, the facility failed to consistently monitor Resident (R) 3, who had a physician order for hourly suicide checks. This placed the resident at risk for self-injury and death.

Findings included:

- The Electronic Medical Record (EMR) for R3 recorded diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), transient ischemic attack (TIA-a temporary disruption in the blood supply to part of the brain), and incontinence (lack of voluntary control over urination).

The "Annual Minimum Data Set" (MDS), dated 02/02/23, documented R3 had moderately impaired cognition and required extensive assistance of one staff for transfers, toileting, ambulation in her room, and limited assistance of one staff for ambulation in corridors, personal hygiene, and dressing. The MDS further documented R3 had little pleasure doing things 12-14 days, felt down and depressed 12-14 days,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 36	F 684		

had thoughts she would be better off dead or hurting self never or one day, and had rejection of care one to three days.

The "Behavior Care Plan," dated 02/02/23, documented R3 had verbal aggression related to inappropriate coping skills and directed staff to administer medications as ordered and monitor for effectiveness. The care plan further directed staff to analyze key times, triggers, circumstances and what de-escalates behaviors and document, assess coping skills and support systems.

The "Depression Care Plan," dated 02/02/23, documented R3 had a history of difficult relationships and loss of independence and directed staff to administer medication as ordered, discuss with R3 any concerns, fears or issues regarding health. The care plan further documented R3 needed time to talk when she was upset and directed staff to encourage her to express her feelings and provide validation. The update, dated 02/14/23, documented R3 refused telemed psychiatric talk therapy and medications.

The "Physician Order," dated 08/24/22, directed staff to administer Celexa (antidepressant medication), 40 milligrams (mg), by mouth, daily. The order directed staff to place the resident on suicide precautions until she was not suicidal and did not have a plan. The order was discontinued on 09/06/22.

The "Physician Order," dated 08/24/22, directed staff to place the resident on one hour suicide checks, be as unobtrusive as possible every hour for suicidal ideation. The order was discontinued on 09/06/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 37	F 684		

The "Treatment Administration Record," dated August 2022 lacked documentation staff observed R3 hourly on the following days and times:
08/27/22 05:00 AM
08/27/22 06:00 AM
08/28/22 06:00 AM
08/29/22 06:00 AM
08/30/22 12:00 AM through 06:00 AM
08/31/22 12:00 AM through 06:00 AM

The "Treatment Administration Record," dated September 2022 lacked documentation staff observed R3 hourly on the following days and times:
09/01/22 06:00 PM
09/02/22 06:00 AM and 11:00 PM
09/03/22 04:00 AM, 05:00 AM, 06:00 AM, 03:00 PM, 04:00 PM, 05:00 PM, and 06:00 PM
09/04/22 05:00 AM and 06:00 AM

The "Physician Order," dated 02/22/23, directed staff to administer Celexa, 20 mg, by mouth, daily for depression with psychotic features for 2 weeks. The Celexa was discontinued on 03/08/23.

The "Physician Order," dated 02/22/23, directed staff to administer Effexor (antidepressant medication), 75 mg, by mouth, daily, for depression and discontinue in two weeks. The medication was discontinued on 03/08/23.

The "Physician Order," dated, 03/08/23, directed staff to administer Effexor ER (extended release), 75 mg, by mouth, daily, for depression.

The "Nurse's Note," dated 08/24/22 at 06:53 PM, documented R3 stated she was tired of living and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 38	F 684		

just wanted to die. The note further documented she wanted assistance with dying and told the nurse that she was looking around the room for something to hang herself with.

The "Nurse's Note," dated 08/25/22 at 11:29 AM, documented the facility spoke with R3's family regarding the resident and family stated they knew she had bad days, was trying to find was to take the resident out of the facility more often, and instructed the facility to engage her in more activities and mealtimes to help with the adjustment.

The "Nurse's Note," dated 09/05/22 at 04:02 PM, documented the resident continued to express a wish to die but was not describing how she would do it or stating she had any plan to commit suicide.

The "Nurse's Note," dated 09/08/22 at 04:37 PM, documented R3's family in to visit and the resident stated she was in good spirits.

The "Nurse's Note, dated 02/21/23 at 11:10 AM, documented R3 stated death was beautiful and staff asked her if she had a plan. R3 stated she did not have anything to hang herself with. The note further documented staff contacted the physician for further instructions.

The "Nurse's Note, dated 02/21/23 at 11:31 AM, documented R3 stated she felt down and did not have a plan to hurt herself or any desires to commit suicide at this time. The note further documented staff told the resident they had called the physician to report her symptoms of depression and further orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 39	F 684		

R3's clinical record lacked evidence of social service support provided to the resident.

On 03/22/23 at 09:30 AM, observation revealed R3 sat in her recliner, stated she was having a good day.

On 03/27/23 at 11:20 AM, Certified Nurse Aide (CNA) R stated R3 had been on suicide watch many times and she usually got depressed when her family was not coming to visit her. CNA R further stated if R3 ever told her she wanted to harm herself, she would go tell the nurse.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated R3 had verbalized she wanted to harm herself and LN G contacted the Director of Nursing (DON) as well as R3's physician. LN G further stated after he had told the DON, R3 changed her mind but the physician changed her medications.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated she was not working at the facility at the time of the suicide watch but felt they probably looked in on R3 but just did not document.

The facility's "Suicide Precautions" undated policy, documented once suicide precautions are implemented and ordered, the specific precautions woul be added to the physician order sheet and the individualized comprehensive care plan and the specific orders would be communicated to all staff members. The policy further documented, constant direct observation for suicide precautions may be implemented in any neighborhood or area of this facility and would remain in place until discontinued by the psychiatrist or physician or ordered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 684	Continued From page 40 precautions. The facility failed to consistently monitor R3, who had physician ordered hourly suicide checks. This placed the resident at risk for injury or death.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 13 residents, with four reviewed for falls. Based on observation, record review, and interview, the facility failed to implement the care planned interventions for Resident (R) 3, who had multiple falls related to inappropriate footwear, with one fall resulting in rib fractures (broken bones). The facility further failed to identify and implement interventions to prevent falls for R5, who had multiple falls. This placed the resident at risk for further falls and avoidable injury. Findings included: - R3's Electronic Medical Record (EMR) recorded diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), transient ischemic attack (TIA-a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 41	F 689		

temporary disruption in the blood supply to part of the brain), and incontinence (lack of voluntary control over urination).

R3's "Quarterly Minimum Data Set" (MDS), dated 07/29/22, documented moderately impaired cognition and indicated R3 required supervision and set up assistance with toileting, dressing, personal hygiene, and independent with ambulation in her room, bed mobility, and transfers. The MDS further documented R3 had unsteady balance, no functional impairment, and had no falls.

R3's "Annual MDS," dated 02/02/23, documented R3 had moderately impaired cognition and required extensive assistance of one staff for transfers, toileting, ambulation in her room, and limited assistance of one staff for ambulation in corridors, personal hygiene, and dressing. The MDS further documented R3 had unsteady balance, occasional incontinence, no functional impairment, and had one non-injury fall.

The "Fall Care Area Assessment [CAA]," dated 02/02/23, documented R3 had moderately impaired cognition, and ambulated with a walker. R3, at times, would not accept assistance from staff for toileting and dressing. The CAA further documented R3 was alert and oriented, and her mood changed frequently. R3 had episodes of refusing to allow evaluations or assistance and participated in activities of her choice.

The "Fall Assessments," dated 04/18/22, 07/27/22, and 02/02/23, all documented R3 was a high risk for falls.

The "Fall Care Plan," dated 03/31/22, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 42	F 689		

staff to ensure R3's call light was within reach and to call for assistance; encourage R3 to participate in activities that promoted exercise, and have therapy evaluate and treat as needed. An update, dated 04/19/22, documented R3 required one staff for assistance with toileting, set up assistance of one staff for dressing, and directed staff to ensure R3 wore appropriate footwear with nonskid soles when she ambulated. An update, dated 08/10/22, directed staff to ensure R3 wore shoes or gripper socks when she ambulated and provide reminders if R3 did not wear shoes. An update, dated 02/21/23, directed staff to ensure R3 wore nonskid slipper socks to bed.

The "Fall Investigation," dated 08/10/22, documented at 03:48 PM, R3 slipped and fell in her room. The investigation documented the fall was unwitnessed, R3 had gait imbalance, and ambulated without staff assistance. The investigation recorded R3 had improper footwear on, and she obtained an abrasion (scrape) to her left elbow.

The "Fall Investigation," dated 10/24/22, documented at 03:25 PM, R3 slipped and fell in her room. The investigation documented the fall was unwitnessed, R3 had gait imbalance, and did not receive any injury.

The "Fall Investigation," dated 02/20/23, documented at 12:42 AM R3 slipped when she lost her balance and scooted to the door to call for assistance. The investigation documented R3 had gait imbalance and improper footwear.

The "Fall Investigation," dated 02/21/22, documented at 08:00 AM, R3 stated she tried to get out of bed to go to the bathroom, was unable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 43	F 689		

to stand, and slid to the floor. The investigation further documented R3 did not have on any socks at the time of the fall, and nonskid socks were applied. The investigation noted R3 did not receive any injury.

The "Nurse's Note," dated 02/21/23 at 04:29 PM, documented R3 reported right breast pain and stated that earlier in the day she heard a "pop" and started to have severe pain. The note further documented R3 stated she often had acid reflux and refused to go to the emergency room for evaluation. The note documented the nurse administered antacid medication (used to treat heartburn) and pain medication.

The "Nurse's Note," dated 02/22/23 at 09:17 AM, documented R3 complained of pain under her right breast and continued to refuse to go to the emergency room for an x-ray (a photograph or digital image of the internal composition of part of the body) or to have the physician evaluate her. The note further documented R3 requested medication for her heart burn and requested to stay in her bed because she was sore.

The "Nurse's Note," dated 02/22/23 at 12:39 PM, documented the nurse contacted the physician due to R3 had extreme discomfort under her right breast. The note further documented R3 did not have any swelling or redness in the area, continued to decline transfer to the emergency room, and did not want the physician notified. The noted documented R3 continued to have heart burn and the physician ordered a scheduled antacid.

The "Nurse's Note," dated 02/25/23 at 08:40 AM, documented R3 complained of severe pain under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 44	F 689		

her right breast that was rated as a 10 out of 10 (a 0 to 10 pain scale with zero as no pain and 10 representing the worst pain imaginable). The nurse assessed the area under the resident's right breast and did not see any swelling, redness, or bruising. The area was symmetrical (made up of exactly similar parts facing each other) upon palpation on each side of her chest. The note documented R3 winced in pain with each movement. The nurse contacted the emergency room, who suggested R3 be sent to the walk-in clinic. The note documented R3 agreed to go to the clinic for evaluation.

The "Physician Orders," dated 02/25/23, directed staff to administer Aleve (over the counter pain medication), 220 milligrams (mg), by mouth, every eight hours for pain; and Tylenol (medication for minor aches and pains), 650 mg, by mouth, every four hours for five days, for pain. The order further directed staff to apply a heat pack every two hours alternating with an ice pack every two hours as needed. The order directed staff to encourage R3 to deep breath and use an incentive spirometer (a handheld device used to help improve the functioning of lungs) every two hours while awake. The order directed staff to have R3 hold a pillow to her chest when coughing due to R3 had fracture of ribs 3, 4, and 5.

The "Nurse's Note," dated 02/27/23 at 02:38 PM, documented R3 had increased pain and agitation and the current pain medication was not effective for reducing pain.

The "Physician Order's," dated 02/27/23, directed staff to hold the resident's Tylenol and administer Norco (narcotic medication for moderate to severe pain), 5/325 mg, by mouth every four

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 45	F 689		

hours as needed for pain, and a Salanpas (pain patch), to the right chest, every 12 hours, as needed for pain.

On 03/28/23 at 09:08 AM, observation revealed R3 had gripper socks on while in bed but Certified Nurse Aide (CNA) R had to adjust them and put one of them back onto her foot. Further observation revealed CNA R assisted R3 to sit on the side of her bed, placed a gait belt around the resident's waist, and CNA R and CNA S had the resident stand up. R3 required extra assistance to stand, she slowly grabbed her walker and slowly walked with staff down the hall to the shower room with just the gripper socks on her feet.

On 03/27/23 at 11:20 AM, CNA R stated R3 had fallen many times due to not calling for assistance. CNA R further stated R3 used to walk without assistance. CNA R stated even though staff remind R3, R3 gets up before staff get to her to assist her.

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R3 refused assistance and would get up on her own because she felt she could still take care of herself. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated R3 was alert and orient and did not feel R3 had cognitive impairment, just behaviors. LN G stated R3 does not like to call for assistance even though they remind her often because she still thinks she can get up on her own.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 46	F 689		

On 03/28/23 at 1:30 PM, Administrative Nurse D stated the staff tried multiple times to get the resident to go to the emergency room when she fell but she refused.

The facility's "Fall Prevention Protocol" policy, undated, documented the facility provided care and services that ensured the elders environment remained as free from accident hazards as was possible and each elder received adequate supervision and assistive devices to prevent accidents. Each elder would be assessed for the causal risk factors for falling at the time of admission, upon return from a health facility, ad after every fall in the facility. The team would develop a plan for service to improve or maintain the elders standing and sitting balance and other interventions to reduce the elder's risk for falls, the plan would include specific individualized information about the elder's routine and personal habits that may place the elder at risk for falls and every team member was responsible for checking the care plan who are at risk for falls.

The facility failed to ensure R3, who had multiple falls related to lack of appropriate footwear, had adequate staff supervision and assistance with footwear leading to a fall which resulted in three rib fractures and pain.

- The Electronic Medical Record (EMR) documented R5 had diagnoses of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), epilepsy (brain disorder characterized by repeated seizures), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 47	F 689		

and confusion), and diabetes mellitus type 2.

The "Significant Change Minimum Data Set" (MDS), dated 07/22/22, documented R5 had severely impaired cognition and required limited assistance of two staff for bed mobility, transfers, toileting and locomotion. The MDS further documented R5 had unsteady balance, occasional bladder incontinence, no functional impairment, and had two or more non-injury falls.

R5's "Quarterly MDS," dated 01/23/23, documented R5 had severely impaired cognition and required extensive assistance with bed mobility, transfers, locomotion, toileting, and personal hygiene. The MDS further documented R5 had unsteady balance, frequent bowel and bladder incontinence, no functional impairment, and had two or more falls.

The "Fall Care Area Assessment [CAA]," dated 07/22/22, documented R5 required a wheelchair for mobility due to increased weakness, increased confusion and instability.

The "Fall Risk Assessments, " dated 0/23/22, 10/18/22, 11/05/22, 01/16/23, documented the resident was a high risk for falls.

The "Fall Care Plan," dated 11/03/20, documented R5 would have on appropriate footwear and/or nonskid socks during transfers. The update, dated 06/03/22, documented new shoes were ordered for the resident. The update, dated 07/30/22, documented a motion sensor was placed in her room. The update, dated 08/19/22, documented R5 had a high/low bed to be kept in the lowest position. The update, dated, 08/21/22, directed staff to utilize as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 48	F 689		

medication when the resident had increased anxiety. The update, dated 12/29/22, directed staff to place a second motion sensor in her room. The update, dated 01/05/23, documented anti-roll back brakes were installed on her wheelchair. The update, dated 03/10/23, directed staff to not leave the resident unattended in her room while she was in her wheelchair.

The EMR documented falls on these dates: 06/17/22, 06/19/22, 06/28/22, 08/07/22, 08/21/22, 08/26/22, 11/07/22, 11/26/22, 12/29/22, 01/20/23, and 03/01/23. R5's clinical record lacked evidence of resident centered interventions placed after each fall to prevent future falls. The clinical record lacked evidence the facility performed a thorough root cause analysis to attempt to identify R5's needs or reasons she continued to fall.

On 03/21/23 at 11:20 AM, observation revealed Certified Nurse Aide (CNA) R placed a gait belt around R5's waist, CNA R and CNA S took ahold of the gait belt and assisted the resident to stand up, pivot and sit down on the bed. Further observation revealed CNA R took off the resident's shoes and swung her legs onto the bed, took off R5's glasses, covered her up and attached the call light the R5's blanket. CNA R lowered R5's bed, placed a fall mat next to the bed, placed a motion sensor on the mat, and turned on another motion sensor that was on the wall by the resident's door before leaving the room.

On 03/21/23 at 11:30 AM, CNA R stated R5 had the double motion sensor and fall mat because of R5's many falls. CNA R stated R5 was very quick and would try to transfer herself and would fall,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 49	F 689		

On 03/28/23 at 10:09 AM, Administrative Nurse E stated R5 got up on her own and had a lot of falls and when the team got together, if they did not feel the interventions needed changed, they kept them the same and it was difficult to always come up with a new intervention. Administrative Nurse E stated after a fall, the team would meet to discuss the fall and would try to come up with new interventions and verified she would not get the new intervention into the computer right away.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated the motion detector had been placed in R5's room within the last three months. LN G said because of all R5's falls, staff watched R5 closely because she was quick and when they did not get to her in time, she would fall.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated the resident had a lot of falls and interventions were implemented by the team. Administrative Nurse D stated the nurses do not update the care plan at that time but may try and work to that at some point.

The facility's "Fall Prevention Protocol" policy, undated, documented the facility provided care and services that ensured the elders environment remained as free from accident hazards as was possible and each elder received adequate supervision and assistive devices to prevent accidents. Each elder would be assessed for the causal risk factors for falling at the time of admission, upon return from a health facility, ad after every fall in the facility. The team would develop a plan for service to improve or maintain the elders standing and sitting balance and other interventions to reduce the elder's risk for falls,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 50 the plan would include specific individualized information about the elder's routine and personal habits that may place the elder at risk for falls and every team member was responsible for checking the care plan who are at risk for falls. The facility failed to identify causative factors and implement person centered interventions to prevent falls for cognitively impaired R5, who had a multiple falls. This placed the resident at risk for further falls and injury.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility had a census 30 residents. Based on record review and interview, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week placing all resident who reside in the facility at risk of lack of assessments and inappropriate care. Findings included:	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 727	Continued From page 51 - Upon review of the "Payroll Based Journal" (PBJ- a required detailed information submitted by nursing homes of staffing required from the Centers of Medicare and Medicaid Service), the facilty lacked RN eight-hour coverage on 02/12/22, 03/28/22, 05/07/22, 05/08/22, and 05/29/22. On 03/27/23 at 09:00 AM, Social Worker X, who assisted with facility nursing staff with scheduling, verified the lack of RN coverage on the above five days. On 03/28/23 at 04:00 PM, Administrative Nurse D stated she was not employed by the facility at the time of the missing dates of RN coverage and said she was currently in the process of hiring more RN. The facility's "Sufficient Nursing Staff" policy, dated 03/28/23, documented a RN will be available in the health center for at least eight/twelve hours each day seven days a week. The facility failed to provide RN coverage eight consecutive hours a day, seven days a week placing the residents who resided in the facility at risk of lack of assessment and inappropriate care.	F 727		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 52	F 745		

by:
The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to identify and provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three sampled residents, Resident (R) 2, who had inappropriate sexual behaviors; R3, who had stated she wanted to harm herself twice in the last six months; and R5, who had behaviors. This placed the residents at risk for further decline of their emotional and mental well-being,

Findings included:

- The Electronic Medical Record (EMR) documented R2 had diagnoses of dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion), inappropriate sexual behaviors, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set" (MDS), date 03/02/23, documented R2 had moderately impaired cognition and required extensive assistance for transfers, toileting, limited assistance of one staff for bed mobility, and personal hygiene. The MDS further documented R2 had disorganized thinking, inattention, physical behaviors one to three days, and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 53	F 745		

behaviors one to three days.

The "Behavior/Verbal Aggression Care Plan," dated 02/15/23, documented R2 used inappropriate language, was verbally aggressive, and quick tempered due to poor impulse control, dementia, and his traumatic brain injury (TBI). The care plan directed staff to administer medication as ordered, analyze key times, triggers, circumstances and what de-escalated behaviors and document. The care plan directed staff to redirect R2's verbal aggression with music, singing, puzzles, group activities, and intervene before behavior escalated. The care plan documented R2 participated in individualized psychotherapy session twice a month with a telemed psychiatric service and directed staff to point out signs of positive progress or change in reactions to others when R2 was upset. The care plan lack direction or interventions regarding R2's inappropriate sexual behavior.

R2's "Mood Care Plan," dated 02/15/23, directed staff to encourage and provide opportunities for activities and encourage him to express feelings appropriately through 1:1 talks, and discuss any concerns, fears, issues regarding health and other subjects as often as he desired. The plan directed staff to monitor and document any anxious, negative statements, or health related complaints, and mental health medication oversight and talk therapy provided by psychiatric services.

The "Anxiety Care Plan," dated 02/15/23, directed staff to remove R2 to a calm environment and allow him to vent and share his feelings, encourage participation in daily care, and honor his requests as much as safely possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 54	F 745		

The "Physician Order," dated 04/23/22, directed staff to administer Cymbalta (an antidepressant medication), 30 milligrams (mg), 1 caplet, by mouth, in the evening and administer Cymbalta, 60 mg, 1 caplet, by mouth in the evening for depression.

The "Nurse's Note," dated 07/13/22 at 04:58 AM, documented R2 was very inappropriate toward staff and stated that he would like to have an underage staff member home with him. The note recorded R2 made comments about younger staff members and how they looked.

The "Nurse's Note," dated 10/19/22 at 08:07 PM, documented R2 told a Certified Medication Aide (CMA) that he wanted to take her to the bathroom and show her a good time. Staff infomred the resident that it was very inappropriate to talk to the CMA that way and he needed to apologize. The note further documented R2 was angry at staff and wheeled up behind them and touched staffs' buttocks to get their attention.

The "Nurse's Note," dated 11/19/22 at 11:26 AM, documented R2 sexually touched a CMA's buttocks and he started to laugh when she told him it was not appropriate and asked him not to not touch her. The note further documented R2 called the nurses and the CMA derogatory names.

The "Nurse's Note," dated 02/06/23 at 11:25 AM, documented R2 sat in his wheelchair behind a CMA staring at her buttocks with a grin on his face. The nurse told him that it was not appropriate and to move along and do something else. The resident laughed and said he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 55	F 745		

reading something on her pants. The note further documented the nurse told R2 that there was no lettering where he was looking and to finding something else to do.

The "Nurse's Note," dated 02/14/23 at 07:19 PM, documented R2 touched a Certified Nurse Aide (CNA)'s buttocks and the nurse told the resident there are consequences for touching others inappropriately.

The "Nurse's Note," dated 02/16/23 at 04:17 PM, documented the psychiatric services recommended adding medroxyprogesterone (hormone medication), 5 mg, by mouth, daily for sexual behaviors.

The "Nurse's Note," dated 02/16/23 at 09:23 PM, documented R2 commented to the CMA that the buttocks of one of the younger CNA's was nice to look at and stated that when he heard her voice, he had dreams of sleeping with her. The note further documented the CNA told staff that she felt very uncomfortable to provide care to the resident and was advised to not provide cares to the resident alone.

R2's clinical record lacked evidence the facility followed up with R2 regarding the sexual behaviors and lacked evidence of ongoing behavioral support services in order to identify triggers and effective redirection methods.

On 03/28/23 at 04:00 PM, observation revealed R2 sat at a table putting a puzzle together.

On 02/27/23 at 11:30 AM, CNA R stated R2 had a lot of behaviors, some toward residents and some towards staff. CNA R stated R2 had one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 56	F 745		

resident he got upset with so staff tried to keep them separated. CNA R stated R2 had inappropriate sexual behaviors with staff.

On 03/28/23 at 08:22 AM, Social Services X stated she talked to the resident all the time about his inappropriate behaviors and often brought him into her office where he was able to express his feelings but stated she did not document all her interactions with the resident. Social Services X further stated R2 received psychiatric services monthly for his behavior. Social Services X stated she had trained herself for her position; she tried to reach out to other social services designees for knowledge but has not had a lot of luck. She stated she does not have a licensed social worker helping her.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated R2 received services for his behaviors and agreed there should be more documentation related to any interaction with the resident and as extra support for the resident.

The facility's " Social Services" policy, undated, documented social service staff would provide social services or obtain needed services from outside entities with expressions or indications of distress that affect the resident's mental and psychosocial wellbeing resulting from depression, chronic disease, Alzheimer's or other dementia related diseases, difficulty with personal interaction, socialization skills and resident to resident interactions. The social service staff would help with difficulty coping with change or loss and a need for emotional support.

The facility failed to identify and provided medically-related social services to attain or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 57	F 745		

maintain the highest practicable physical, mental, and psychosocial well-being for R2, who has inappropriate sexual behaviors.

- R3's Electronic Medical Record (EMR) recorded diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), transient ischemic attack (TIAa temporary disruption in the blood supply to part of the brain), and incontinence (lack of voluntary control over urination).

The "Annual Minimum Data Set" (MDS), dated 02/02/23, documented R3 had moderately impaired cognition and required extensive assistance of one staff for transfers, toileting, ambulation in her room, and limited assistance of one staff for ambulation in corridors, personal hygiene, and dressing. The MDS further documented R3 had little pleasure doing things 12-14 days, felt down and depressed 12-14 days, had thoughts she would be better off dead or hurting self never or one day, and had rejection of care one to three days.

The "Behavior Care Plan," dated 02/02/23, documented R3 had verbal aggression related to inappropriate coping skills and directed staff to administer medications as ordered and monitor for effectiveness. The care plan further directed staff to analyze key times, triggers, circumstances and what de-escalates behaviors and document, assess coping skills and support systems.

The "Depression Care Plan," dated 02/02/23, documented R3 had a history of difficult relationships and loss of independence and directed staff to administer medication as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 58	F 745		

ordered, discuss with R3 any concerns, fears or issues regarding health. The care plan further documented R3 needed time to talk when she was upset and directed staff to encourage her to express her feelings and provide validation. The update, dated 02/14/23, documented R3 refused telemed psychiatric talk therapy and medications.

The "Physician Order," dated 08/24/22, directed staff to administer Celexa (antidepressant medication), 40 milligrams (mg), by mouth, daily. The order directed staff to place the resident on suicide precautions until she was not suicidal and did not have a plan. The order was discontinued on 09/06/22.

The "Physician Order," dated 08/24/22, directed staff to place the resident on one hour suicide checks, be as unobtrusive as possible every hour for suicidal ideation. The order was discontinued on 09/06/22.

The "Treatment Administration Record," dated August 2022 lacked documentation staff observed R3 hourly on the following days and times:
08/27/22 05:00 AM
08/27/22 06:00 AM
08/28/22 06:00 AM
08/29/22 06:00 AM
08/30/22 12:00 AM through 06:00 AM
08/31/22 12:00 AM through 06:00 AM

The "Treatment Administration Record," dated September 2022 lacked documentation staff observed R3 hourly on the following days and times:
09/01/22 06:00 PM
09/02/22 06:00 AM and 11:00 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 59	F 745		

09/03/22 04:00 AM, 05:00 AM, 06:00 AM, 03:00 PM, 04:00 PM, 05:00 PM, and 06:00 PM
09/04/22 05:00 AM and 06:00 AM

The "Physician Order," dated 02/22/23, directed staff to administer Celexa, 20 mg, by mouth, daily for depression with psychotic features for 2 weeks. The Celexa was discontinued on 03/08/23.

The "Physician Order," dated 02/22/23, directed staff to administer Effexor (antidepressant medication), 75 mg, by mouth, daily, for depression and discontinue in two weeks. The medication was discontinued on 03/08/23.

The "Physician Order," dated, 03/08/23, directed staff to administer Effexor ER (extended release), 75 mg, by mouth, daily, for depression.

The "Nurse's Note," dated 08/24/22 at 06:53 PM, documented R3 stated she was tired of living and just wanted to die. The note further documented she wanted assistance with dying and told the nurse that she was looking around the room for something to hang herself with.

The "Nurse's Note," dated 08/25/22 at 11:29 AM, documented the facility spoke with R3's family regarding the resident and family stated they knew she had bad days and were trying to find a way to take the resident out of the facility more often. The note recorded the facility should engage R3 in more activities and mealtimes to help with the adjustment.

The "Nurse's Note," dated 09/05/22 at 04:02 PM, documented R3 continued to express a wish to die but was not describing how she would do it or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 60	F 745		

stating she had any plan to commit suicide.

The "Nurse's Note," dated 09/08/22 at 04:37 PM, documented R3's family was in to visit and the resident stated she was in good spirits.

The "Nurse's Note, dated 02/21/23 at 11:10 AM, documented R3 stated death was beautiful and staff asked her if she had a plan. R3 stated she did not have anything to hang herself with. The note further documented staff contacted the physician for further instructions.

The "Nurse's Note, dated 02/21/23 at 11:31 AM, documented R3 stated she felt down and did not have a plan to hurt herself or any desires to commit suicide at this time. The note further documented staff told the resident they had called the physician to report her symptoms of depression and further orders.

R3's clinical record lacked evidence of social service support provided to the resident.

On 03/22/23 at 09:30 AM, observation revealed R3 sat in her recliner, and stated she was having a good day.

On 03/27/23 at 11:20 AM, Certified Nurse Aide (CNA) R stated R3 had been on suicide watch many times and she usually got depressed when her family was not coming to visit her. CNA R further stated if R3 ever told her she wanted to harm herself, she would go tell the nurse.

On 03/28/23 at 08:23 AM, Social Services X stated R3 did not want any therapy but she would try to visit with the resident regularly and verified she had not documented the conversations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 61	F 745		

Social Services X stated she had trained herself for her position; she tried to reach out to other social services designees for knowledge but has not had a lot of luck. She stated she does not have a licensed social worker helping her.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G stated R3 verbalized she wanted to harm herself and LN G contacted the Director of Nursing (DON) as well as R3's physician. LN G further stated after he had told the DON, R3 changed her mind but the physician changed her medications.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated there should be better documentation by staff regarding interactions they had with R3 and how R3 was feeling.

The facility's " Social Services" policy, undated, documented social service staff would provide social services or obtain needed services from outside entities with expressions or indications of distress that affect the resident's mental and psychosocial wellbeing resulting from depression, chronic disease, Alzheimer's or other dementia related diseases, difficulty with personal interaction, socialization skills and resident to resident interactions. The social service staff would help with difficulty coping with change or loss and a need for emotional support.

The facility failed to identify and provided medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R3, who stated she wanted to harm herself twice within a six-month period. This placed the resident at risk for further decline of her emotional and mental well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 62	F 745		

- R5's Electronic Medical Record (EMR) recorded diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), adjustment disorder with anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 01/21/23, documented R5 had severe cognitive impairment, had inattention and disorganized behavior which fluctuated, required extensive assistance of one or two staff for activities of daily living, had inattention and disorganized thinking, and no behaviors. The MDS further documented R5 received daily antianxiety, antidepressant (medication used to treat depression), and diuretic (medication to promote the formation and excretion of urine).

The "Behavior Care Plan," dated 02/01/23, documented R5 was verbally aggressive and made inappropriate comments to staff and other residents. The care plan directed staff to administer medication as orders, analyze key times, triggers, circumstances and what de-escalates behaviors and document., educated R5 on therapeutic breathing, offer active listening, validation of thoughts and feelings, and educate R5 on socially acceptable behaviors and ask her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 63	F 745		

to refrain from vulgar speech directed at others. The care plan directed staff to offer listening to music, play bingo, animal and pet therapy, drink coffee with friends, and offer activities.

The "Anxiety Care Plan", dated 02/01/23, documented R5 had an actual psychosocial well-being problem related to anxiety and lack of acceptance to her current condition. The care plan directed staff to acknowledge R5's anxiety, maintain a calm demeanor while interacting with her, allow R5 time to answer questions she may have without compromising the privacy of others, and to verbalize feelings perceptions, and fears as her anxiety levels fluctuate throughout the day. The care plan directed staff to take R5 to one of the administration offices when appropriate to decrease anxiety.

The "Physician Order," dated 12/05/22, directed staff to administer lorazepam (antianxiety medication), 1 milligram (mg), py mouth, twice a day, for anxiety and agitation.

The "Physician Order," dated 12/06/22, directed staff to administer fluoxetine (antidepressant medication), 20 mg, by mouth, daily, for depression with severe psychotic symptoms.

The "Physician Order" dated 01/09/23, directed staff to administer lorazepam 2 milligrams (mg)/1 milliliter (ml) to give 0.5 mg by mouth every one hour as needed for agitation, give 0.25 ml-0.5 ml. The order lacked a stop date.

The "Nurse's Note," dated 01/16/23 at 10:14 AM, documented R5 became agitated and called everyone vulgar names and used foul language.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 64	F 745		

The "Nurse's Note, dated 01/18/23 at 01:18 PM, documented R5 used foul language and called nursing staff and residents a vulgar name.

The "Nurse's Note, dated 01/23/23 at 08:34 AM, documented R5 wandered up and down the halls, used foul language and yelled at residents.

The "Nurse's Note," dated 02/22/23 at 04:39 PM, documented R5 was very restless and anxious throughout the shift and used foul language and called residents and staff vulgar names. The note further documented R5 wandered in and out of other resident's rooms; staff attempted to intervene with music and puzzles but R5 hollered and told them to get away and called them a vulgar name.

The "Nurse's Note", dated 03/04/23 at 09:58 AM, documented R5 roamed the facility in a wheelchair, cursed at others and turned the ice machine and flooded the counter and floor. Staff took R5 to the dementia unit for observation.

R5's clinical record lacked evidence of social service support provided to the resident.

On 03/20/23 at 03:17 PM, observation revealed R5 told a male resident to go home and proceeded to call him a vulgar name. Further observation revealed the male resident called R5 a vulgar name as he went by her.

On 03/25/23 at 11:30 AM, Certified Nurse Aide (CNA) R reported R5 had a lot of behaviors, was very verbal to residents, and staff tried giving R5 her baby doll to help when she had behaviors.

On 03/28/23 at 08:23 AM, Social Services X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 65	F 745		

stated she did try to visit with the resident and often got the R5's baby doll for her when she was agitated. Social Services X verified she does not document her interactions with the resident. She stated R5 used to receive psychiatric services but R5 was on hospice now and the services stopped. Social Services X stated she had trained herself for her position; she tried to reach out to other social services designees for knowledge but has not had a lot of luck. She stated she does not have a licensed social worker helping her.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G reported R5 had behaviors with another resident and did not know about the stop date for the as needed lorazepam order.

On 03/28/23 at 01:30 PM, Administrative Nurse D stated staff try to redirect the resident and administration staff take her into their offices when R5 gets agitated.

The facility's " Social Services" policy, undated, documented social service staff would provide social services or obtain needed services from outside entities with expressions or indications of distress that affect the resident's mental and psychosocial wellbeing resulting from depression, chronic disease, Alzheimer's or other dementia related diseases, difficulty with personal interaction, socialization skills and resident to resident interactions. The social service staff would help with difficulty coping with change or loss and a need for emotional support.

The facility failed to identify and provided medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R5, who had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 745	Continued From page 66 behaviors. This placed the resident at risk for further decline of her emotional and mental well-being.	F 745		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 758	Continued From page 67	F 758		

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)5's as needed (PRN) lorazepam (antianxiety medication) had a stop date as required, placing the resident at risk for adverse side effects related to psychotropic (altering mood and mind) medication use.

Findings included:

- R5's Electronic Medical Record (EMR) recorded diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), adjustment disorder with anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 758	Continued From page 68	F 758		

characterized by exaggerated feelings of sadness, worthlessness and emptiness), and dementia(progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 01/21/23, documented R5 had severe cognitive impairment, had inattention and disorganized behavior which fluctuated. R5 required extensive assistance of one or two staff for activities of daily living, and had two or more non-injury falls. The MDS further documented R5 received daily antianxiety, antidepressant (medication used to treat depression), and diuretic (medication to promote the formation and excretion of urine).

The "Anxiety Care Plan," dated 02/01/23, documented R5 had an actual psychosocial well-being problem related to anxiety and lack of acceptance to her current condition. The care plan directed staff to acknowledge R5's anxiety, maintain a calm demeanor while interacting with her, allow R5 time to answer questions she may have without compromising the privacy of others, and to verbalize feelings perceptions, and fears as her anxiety levels fluctuate throughout the day.

The "Physician Order" dated 01/09/23, directed staff to administer lorazepam 2 milligrams (mg)/1 milliliter (ml) to give 0.5 mgs by mouth every one hour as needed for agitation, give 0.25 ml-0.5 ml. The order lacked a stop date.

The "Electronic Medication Administration Record" (EMAR), documented R5 received the PRN lorazepam on 02/16/23, twice on 02/17/23, 03/10/23, 03/17/23 and 03/21/23.

The "Progress Note," dated 03/04/23 at 09:58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 758	Continued From page 69	F 758		

AM, documented R5 roamed the facility in a wheelchair, cursed at others, turned the ice machine and flooded the counter and floor. Staff took R5 to the dementia unit for observation.

On 03/25/23 at 11:30 AM, Certified Nurse Aide (CNA) R reported R5 had a lot of behaviors, was very verbal to residents. CNA R said staff tried giving R5 her baby doll to help when she has behaviors.

On 03/28/23 at 12:00 PM, Licensed Nurse (LN) G reported R5 had behaviors with another resident and did not know about the stop date for the as needed lorazepam order.

On 03/28/23 at 01:30 PM, Administrative Nurse D verified the as needed lorazepam did not have a stop date and said she fixed the order with a stop date.

The facility's "Psychotropic Medication Monitoring" policy, documented orders for as needed psychotropic medication will be limited to fourteen (14) days or less and only for specific clearly documented circumstances. An antianxiety medication order on as needed bases for mood stabilization may be reordered at the end of 14 days after the ordering practitioner has evaluated the resident for continued need and the provide a rationale for continuation of the as needed medication rational and risk/benefit statement with a specific duration for the continuation of the order not to exceed six months.

The facility failed to ensure R5's as needed psychotropic medication had the required stop date placing the resident at risk for adverse side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175471	A. BUILDING _____ B. WING _____	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 758	Continued From page 70 effects.	F 758		