

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

PRINTED: 07/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER WESTCHESTER VILLAGE OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 8505 PFLUMM ROAD LENEXA, KS 66215		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Licensure Resurvey and Complaint Investigation #KS00181196.	F 000			
F 656 SS=D	The 2567 was sent electronically on 07/19/23. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656			

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

TITLE

(X6) DATE

07/19/2023

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.

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F 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35. The sample included 12 with 12 reviewed for comprehensive care plans. Based on observation, record review and interview, the facility failed to develop a comprehensive care plan related to preventative wound care for Resident (R)22. This deficient practice placed him at risk for complication related to skin injuries and pressure ulcers due to uncommunicated care needs. Findings Included: - The "Medical Diagnosis" section within R22's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder), restlessness, agitation, reduced mobility, and benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections).	F 656			

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F 656	Continued From page 2 R22's "Quarterly Minimum Data Set (MDS)" completed 06/03/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required extensive assistance from staff for transfers, bed mobility, personal hygiene, toileting, locomotion, dressing, and bathing. The MDS indicated he had frequent bowel and bladder incontinence with no toileting program. The MDs indicated he was at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The MDS indicated no unhealed pressure ulcers at the time of assessment. R22's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 12/21/22 indicated he required extensive assistance from staff for his ADLs due to his medical and prevent injuries and falls. R22's "Urinary Incontinence CAA" completed 12/21/22 indicated he had frequent bladder incontinence due to general weakness and depended on staff for toileting. The MDS indicated most of the time he called staff too late for incontinence assistance. The CAA indicated staff were to assist with transfers, toileting, and peri-care to prevent skin issues. R22's "Pressure Injury CAA" completed 12/21/22 indicated he was a risk for potential skin issues and pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) due to	F 656			

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F 656	Continued From page 3 incontinence and mobility issues. The CAA indicated staff were to assist him to prevent skin issues. R22 "Care Plan" indicated 06/29/22 indicated he required assist from two staff for bed mobility, toileting, transfers, and bathing. The plan noted he used a wheelchair for mobility and sit-to-stand (mechanical lift) for transfers. The plan indicated he was incontinent of bladder and used a portable urinal. The plan indicated he sometimes would spill the urinal. The plan lacked preventative interventions related to his coccyx (small triangular bone at the base of the spine) wound. R22's EMR under "Physician's Orders" revealed an order dated 09/03/22 for weekly skin assessments every Saturday. R22's EMR under "Physician's Orders" revealed an order dated 04/25/23 instructing staff to provide skin treatment for his coccyx area every other day. The order instructed staff to cleanse, pat dry, and apply zinc cream. The order instructed staff to apply an Opti-Foam dressing (silicone bordered adhesive dressing). R22's "Skin Assessment Note" dated 05/20/23 indicated he had continued excoriation (injury to the skin) on his coccyx. R22's EMR indicated a Braden Assessment (scale used to assess the risk of developing pressure ulcers) was completed on 06/29/23. The assessment revealed a score of 14 (Moderate Risk). On 07/11/23 at 10:00AM R22 lay in his bed. R4	F 656			

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F 656	Continued From page 4 had pressure reduction mattress on his bed. His wheelchair had a pressure reduction pad on it. R4 reported he did have incontinence and used a urinal during the nighttime. He reported he had limited range of motion and sometimes spilled his urinal. He reported no concerns related to bathing. On 07/12/23 at 02:27PM Certified Nurse Aide (CNA) M reported all staff had access to the care plans. She stated staff had access to the care plan. She stated skin interventions should be provided for staff in the plans. She stated if a care plan is missing interventions or needs something added she would notify the charge nurse. On 07/12/23 at 02:44PM Licensed Nurse (LN) G reported R22 had frequent incontinence and used a urinal due to mobility issues. She stated his coccyx excoriation went away but came back recently. She stated the care plan should have interventions to prevent it from declining. She stated he had orders. She stated staff should be repositioning him, providing peri-care, and wound care cares weekly to assess him. She stated if the care plan is missing interventions, she would contact Administrative Nurse F. On 07/12/23 at 03:14PM Administrative Nurse F stated care plans haven't been updated as quickly as they should have due to lack of staffing. She stated established care plans should be updated immediately as an issue had been identified. She stated all direct care staff have access to the care plans and should report if information is outdated or missing. A review of the facility's "Pressure Ulcer" revised 07/2017 indicated the facility will identify risk	F 656			

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F 656	Continued From page 5 factors related to pressure injuries and provide preventive skin treatments. The policy indicted the facility will assess and identify interventions and ongoing assessments of residents at risk. The facility failed to develop a comprehensive care plan related to preventative wound care for R22. This deficient practice placed him at risk for complication related to skin injuries and pressure ulcers due to uncommunicated care needs.	F 656			
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35. The sample included 12 residents. Based on interview and record review, the facility failed to provide activities on the weekends which reflected the residents' interests, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life. Findings included: - Review of the facility's activity calendars for April 2023 and May 2023 revealed each Saturday	F 679			

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F 679	Continued From page 6 had activities of snacks and chat, and family visits except for 04/08/23 when an Easter egg hunt and a musical "Yakety Sax Quartet" was provided. The activity calendar for April, May, and June 2023 revealed no activities scheduled on any Sunday except afternoon church services. On 07/11/23 at 03:37 PM, in a confidential interview with the resident council, several residents reported that though the weekday activities were ongoing and fun, the facility did not provide any activities on Sundays. The council reported the facility had church on Sundays, but the rest of the day had no scheduled activities, and Sundays were often boring. On 07/13/2023 at 03:14 PM Activities Staff Z reported that she was at the facility Monday through Friday but usually staff would coordinate activities for Saturday. She stated Sunday was church services. She stated the residents also have computers access, music, and television. The facility did not provide an activities policy. The facility failed to provide activities on the weekends which reflected the residents' interests, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684			

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F 684	Continued From page 7 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 identified a census of 35 residents. The sample included 12 residents with three reviewed for non-pressure related skin conditions. Based on observations, record review, and interviews, the facility failed to implement interventions to identify, treat, and prevent Resident (R)4's traumatic skin injuries. These deficient practices placed R4 at risk for complications related to skin injuries and infections. Findings included: - The "Medical Diagnosis" section within R4's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, dysphagia (swallowing difficulty), myocardial infarction (heart attack), and unsteadiness on feet. R4's "Quarterly Minimum Data Set (MDS)" completed 06/03/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she required extensive assistance from one staff for all activities of daily living (ADLs). The MDS indicated she had one non-injury fall. The MDS noted she weighed 109 pounds (lbs.) and had no weight loss. The MDS indicated she had skin tears noted and used preventative bed and chair devices.	F 684			

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F 684	Continued From page 8 R4's "ADLs Care Area Assessment (CAA)" completed 12/25/22 indicated she required extensive assistance from one staff for ADL's related to her medical diagnoses. R4's "Pressure Injuries CAA" completed 12/25/22 indicated she was at risk for potential skin issues related to her incontinence and mobility issues. The CAA instructed staff to assist with all ADLs to prevent falls and skin injuries. R4's "Care Plan" initiated 06/28/23 indicated she had full thickness traumatic wounds to her right and left legs. The plan instructed staff to identify and resolved causative factors for her wound and monitor for infections. The plan indicated wound care treatments would be carried out by nursing staff per wound care providers orders. The care plan lacked documentation showing the causative factors of the wound and how to prevent further injuries. The plan instructed staff to encourage good nutrition and hydration and provide weekly skin assessments. The plan instructed staff to provide dressing changes per providers orders. The plan indicated she required assistance from one staff for all ADL activities. The plan indicated staff were to use a gait belt for transfers. The plan lacked interventions related to identified injuries caused by R4's wheelchair. R4's EMR under "Wound Care Note" completed on 07/11/23 indicated R4 had three established wounds identified on her treatment plan. The report indicated she had a right anterior lower leg full thickness traumatic wound measuring 3.8 centimeters (cm) in length, 1.8cm in width, and 0.1cm in depth (3.8cm x 1.8cm x 0.1cm). The report indicated she had a right posterior (back)	F 684			

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F 684	Continued From page 9 lower leg traumatic wound measured at 2.2cm in length, 1.2cm in width, and 0.1cm in depth. The report indicated she had a lower lateral (side of leg) traumatic wound measured at 6.7cm in length, 2.7cm in width, and 0.1cm in depth. The report indicated she had a new wound assessed as a full thickness open wound measured at 0.7cm in length, 0.7cm in width, and 0.1cm in depth. The report indicated on 05/16/23 and 05/23/23 R13's wheelchair was identified as rubbing the back of her leg and causing erythema (redness or inflammation of the skin). The report did indicate R4 had a history of taking off her dressing and bandages. On 07/11/23 at 11:14AM Consultant HH and Administrative Nurse E completed wound care for R4. R4 sat in her chair in her room. Staff asked R4 if wound care could be completed before lunch and R4 approved. R4 sat in her chair with her feet on the ground and her foot pedals in the up position. At 11:16AM an unidentified CNA came into the room and pushed R4 from the center of the shared room to her bed causing her feet to drag. The staff member then transferred R4 from her wheelchair to a seated position on her bed without using a gait belt. Upon assessment of R4's wounds, staff identified a new open area below R4's initial right leg's injury and stated it may have been from hitting against her wheelchair. Staff completed wound care and assisted R4 to lunch. On 07/12/23 at 09:34AM Certified Nurse's Aide (CNA) N stated she probably hit her legs during transfer on the foot pedals or the side of the wheelchair. She stated R4 sometimes transfers herself to her bed without asking for help. She stated staff should be using her foot pedals when			F 684			

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F 684	Continued From page 10 pushing her and putting them up when transferring her to her bed. On 07/12/23 at 02:27 Licensed Nurse (LN) G stated the direct care staff should ensure that foot pedals were removed before attempting to transfer R14. She stated staff should have used a gait belt. She stated R4 had very fragile skin and easily could have skin tears but not sure what caused the tears on her legs. On 07/12/23 at 03:41PM Administrative Nurse E reported R4 may have been caused by rubbing of her wheelchair. She stated R4 refused to wear legging and socks and would often take her dressings off. She stated staff were expected to move the foot pedals out of the way before transferring and ensuring she did not attempt to self-transfer. She stated the facility will attempt putting a nylon blocking on her chair over hard parts. A review of the facility's "Safe Handling and Mobility" policy revised 07/2017 indicated the facility will ensure staff follow the correct and safe method of transferring each resident as indicated by the individualized care plan. A review of the facility's "Preventative Skin Care" policy revised 09/2013 indicated the facility will identify, assess, and implement care planned interventions for residents at risk for skin impairments and injuries. The policy indicated the facility will ensure avoidable injuries and hazards are identified to prevent falls, accidents, and infections. The facility failed to implement measures to identify, treat, and prevent R4's traumatic skin	F 684			

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F 684	Continued From page 11	F 684			
F 689 SS=D	injuries. The deficient practice placed R4 at risk for complications related to skin injuries and infections. 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 identified a census of 35 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to ensure adequate interventions were in place to address hazards on Resident (R)4's wheelchair and failed to provide safety provisions, including use of gait belt and foot pedals, for R4. The deficient practice placed R4 at risk for accidents and injuries. Findings included: - The "Medical Diagnosis" section within R4's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, dysphagia (swallowing difficulty), myocardial infarction (heart attack), and unsteadiness on feet. A review of R4's "Quarterly Minimum Data Set (MDS)" completed 06/03/23 noted a Brief	F 689			

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F 689	Continued From page 12 Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she required extensive assistance from one staff for all activities of daily living (ADLs). The MDS indicated she had one non-injury fall. The MDS noted she weighed 109 pounds (lbs.) and had no weight loss. The MDS indicated she had skin tears noted and used preventative bed and chair devices. R4's "ADLs Care Area Assessment (CAA)" completed 12/25/22 indicated she required extensive assistance from one staff for ADL's related to her medical diagnoses and recent COVID-19 (highly contagious viral infection) illness. R4's "Pressure Injuries CAA" completed 12/25/22 indicated she was at risk for potential skin issues related to her incontinence and mobility issues. The CAA instructed staff to assist with all ADLs to prevent falls and skin injuries. R4's "Care Plan" initiated 06/28/23 indicated she had full thickness traumatic wounds to her right and left legs. The plan instructed staff to identify and resolved causative factors for her wound and monitor for infections. The plan indicated wound care treatments would be carried out by nursing staff per wound care providers orders. The care plan lacked documentation showing the causative factors of the wound and how to prevent further injuries. The plan instructed staff to encourage good nutrition and hydration and provide weekly skin assessments. The plan instructed staff to provide dressing changes per providers orders. The plan indicated she required assistance from one staff for all ADL activities. The plan indicated staff were to use a gait belt for transfers. The plan	F 689			

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F 689	Continued From page 13 lacked interventions related to identified injuries caused by R4's wheelchair. R4's EMR under "Wound Care Note" completed on 07/11/23 indicated R4 had three established wounds identified on her treatment plan. The report indicated she had a right anterior lower leg full thickness traumatic wound measuring 3.8 centimeters (cm) in length, 1.8cm in width, and 0.1cm in depth (3.8cm x 1.8cm x 0.1cm). The report indicated she had a right posterior (back) lower leg traumatic wound measured at 2.2cm in length, 1.2cm in width, and 0.1cm in depth. The report indicated she had a lower lateral (side of leg) traumatic wound measured at 6.7cm in length, 2.7cm in width, and 0.1cm in depth. The report indicated she had a new wound assessed as a full thickness open wound measured at 0.7cm in length, 0.7cm in width, and 0.1cm in depth. The report indicated on 05/16/23 and 05/23/23 R13's wheelchair was identified as rubbing the back of her leg and causing erythema (redness or inflammation of the skin). The report did indicate R4 had a history of taking off her dressing and bandages. On 07/11/23 at 11:14AM Consultant HH and Administrative Nurse E completed wound care for R4. R4 sat in her chair in her room. Staff asked R4 if wound care could be completed before lunch and R4 approved. R4 sat in her chair with her feet on the ground and her foot pedals in the up position. At 11:16AM an unidentified CNA came into the room and pushed R4 from the center of the shared room to her bed causing her feet to drag. The staff member then transferred R4 from her wheelchair to a seated position on her bed without using a gait belt. Upon assessment of R4's wounds staff identified a new	F 689			

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F 689	Continued From page 14 opened area below R4's initial right leg injury and stated it may have been from hitting against her wheelchair. Staff completed wound care and assisted her to lunch. On 07/12/23 at 09:34AM Certified Nurse's Aide (CNA) N stated R4 probably hit her legs during transfer on the foot pedals or the side of the wheelchair. She stated R4 sometimes transfered herself to her bed without asking for help. She stated staff should be using her foot pedals when pushing her and putting them up when transferring her to her bed. On 07/12/23 at 02:27 Licensed Nurse (G) stated the direct care staff should ensure that foot pedals were removed before attempting to transfer R4. She stated staff should have used a gait belt. She stated R4 had very fragile skin and easily could have skin tears but not sure what caused the tears on her legs. On 07/12/23 at 03:41PM Administrative Nurse E reported R4 may have been caused by rubbing of her wheelchair. She stated R4 refused to wear legging and socks and would often take her dressings off. She stated staff were expected to move the foot pedals out of the way before transferring and ensuring she did not attempt to self-transfer. She stated the facility will attempt putting a nylon blocking on her chair over hard parts. A review of the facility's "Safe Handling and Mobility" policy revised 07/2017 indicated the facility will ensure staff follow the correct and safe method of transferring each resident as indicated by the individualized care plan.			F 689			

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F 689	Continued From page 15 A review of the facility's "Falls/Accidents Prevention" policy revised 03/2018 indicated the facility will identify and provide interventions resident risks. The policy indicated the facility will ensure each residents environment, medical equipment/devices, and cares is evaluated to minimize the consequences of injuries and accidents. The facility failed implement interventions to prevent injuries caused by R4's wheelchair. The facility additionally failed to safety utilize medical devices (wheelchair foot pedals and gait belt) while providing care to R4. These deficient practices placed R4 at risk for preventable injuries and accidents.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692			

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F 692	Continued From page 16 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 12 residents with three reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)6 was weighed weekly per his physician's orders. This deficient practice placed R6 at risk for complications related to unintended weight loss. Findings included: - The "Medical Diagnosis" section within R6's Electronic Medical Records (EMR) included diagnoses of insomnia (inability to sleep), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling), major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), dysphagia (swallowing difficulty), muscle weakness, and neuropathy (pain caused by nerve damage). R6's "Quarterly Minimum Data Set (MDS)" completed 04/01/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe impaired cognition. The MDS indicated he required extensive assistance from staff for all his activities of daily living (ADLs). The MDS indicated he used a wheelchair for mobility. The MDS indicated he was on hospice services. The MDS indicated he had no weight loss. The MDS indicated he had coughing and choking during swallowing.	F 692			

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F 692	Continued From page 17 R6's "Nutritional Care Area Assessment (CAA)" completed 01/10/23 indicated he was on a puree diet with nectar thick liquids. The CAA indicated he was at risk of weight loss due to his medical diagnoses, decreased mobility, and continued decline. R6's "Care Plan" revised 12/16/22 indicated he was at risk for weight loss related to his dementia diagnosis and diuretic medication. The instructed staff to monitoring his weight weekly and report significant weight loss. R6's EMR under "Physician's Orders" noted an order dated 02/20/23 for staff to weigh R6 every Monday for weight management. R6's "Weight History" and "Medication Administration Report" revealed he was not weighed on six (weekly) occasions as ordered (02/27/23, 03/13/23, 03/27/23, 04/09/23, 04/23/23, and 06/25/23). A review of his EMR revealed no refusals or notes for the missed weights. On 07/11/23 at 12:04PM R6 sat in the dining room with staff. R6 consumed his pureed chicken meal and beans. R6 had thickened juice with his meal. R6 consumed his meal whole meal and drink. R6 reported he enjoyed his meal. On 07/12/23 at 02:27 PM Licensed Nurse (LN) G reported the nurses were responsible for ensuring the weights were reviewed and entered in the EMR. She reported if a resident refused the nurse would attempt to intervene, but the action would be documented in the EMR. She reported R6's weight was closely monitored due to his	F 692			

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F 692	Continued From page 18 medications and cognitive decline. She stated if a weight loss occurred, she would report it to the nurse immediately. On 07/12/23 at 02:34 PM Certified Nurse's Aide (CNA) N stated the nurse provided the daily weight schedule for all residents. She stated each resident is weighed based on their orders. She stated if a resident refused to be weighed it would be noted in the EMR. She stated R6 had never refused his weights or care. She stated R6 was at risk for weight loss due to his dementia. She stated she would report a significant weight loss to Registered Dietician (RD). On 07/12/23 at 03:50PM Administrative Nurse D reported staff were expected to report when weight was not being completed and documented. She stated that if a resident missed being weighed, staff were expected to get the weight the next day. A review of the facility's "Weight Assessment and Intervention" policy revised 03/2022 indicated all residents would be monitored and assessed for the risk of undesirable weight loss. The policy noted the residents will be monitored. The facility failed to ensure R6 was weighed weekly per his physician's orders. This deficient practice placed R6 at risk for complications related to unintended weight loss.	F 692			
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	F 758			

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F 758	Continued From page 19 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 §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.	F 758			

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F 758	Continued From page 20 §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 identified a census of 35 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the physician indicated an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits, for the use of an antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) for Resident (R) 22, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). This placed R22 at risk for administration of unnecessary psychotropic (alters mood or thought) medications and adverse side effects. Findings Included: - The "Medical Diagnosis" section within R22's Electronic Medical Records (EMR) included diagnoses of dementia,, major depressive disorder (major mood disorder), restlessness (the inability to relax), agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), reduced mobility, and benign prostatic hyperplasia (BPH- a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and			F 758			

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F 758	Continued From page 21 urinary tract infections). R22's "Minimum Data Set (MDS)" completed 06/03/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required extensive assistance from staff for transfers, bed mobility, personal hygiene, toileting, locomotion, dressing, and bathing. The MDS indicated he had frequent bowel and bladder incontinence with no toileting program. The MDS indicated he was taking antipsychotic medication. R22's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 12/21/22 indicated he required extensive assistance from staff for his ADLs due to his medical and prevent injuries and falls. R22's "Psychotropic Medication CAA" completed 12/21/22 indicated he took Risperdal (antipsychotic) medication. The CAA instructed staff to monitor R22 for side effects and notify the medical provider of issues. R22's "Care Plan" created initiated 06/29/22 indicated he took antipsychotic medication related to his paranoid personality disorder and behaviors. The plan instructed staff to completed monitoring of side effects and follow the recommended medical providers orders. The plan also instructed staff to monitor for abnormal behaviors or changes in cognitive status. R22's EMR under "Physicians Orders" revealed an order dated 06/26/23 for staff to administer 0.5 milligrams (mg) of Risperdal by mouth two times a day for unspecified dementia.			F 758			

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F 758	Continued From page 22 A review of the Consultant Pharmacist (CP) "Note to Attending Physician" medication regimen review (MRR) dated 12/19/22 documented R22's antipsychotic Risperdal lacked an allowable diagnosis to support its use. A review of the CP 's 01/30/23 MRR for R22 recommended to the physician an allowable diagnosis to support the use of Risperdal. The physician responded on 02/02/23 stating the medication was ordered per psychiatry and marked depression with psychotic features for an appropriate diagnosis. A review 06/19/23 CP's MRR "Note to Attending Physician" stated R22 was currently taking Risperdal with a diagnosis of "restlessness". Per Centers for Medicaid & Medicare Services (CMS) guidelines only approved indications for use were allowed for the continued use of antipsychotics in patients with dementia due to the increased rate of mortality and lack of efficacy when used in patients with dementia-related psychosis. The CP recommended to consider a trial reduction to Risperdal in an attempt to reduce inappropriate antipsychotic use. R22's clinical record lacked a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits. On 07/11/23 at 10:00AM R22 laid in his bed. R22 had pressure reduction mattress on his bed. His wheelchair had pressure reduction mat on it. R22 reported he did have incontinence and used a urinal during the nighttime. He reported he had limited range of motion and sometimes spills his	F 758			

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F 758	Continued From page 23 urinal. On 07/12/23 at 02:15 PM Certified Medication Aide (CMA) R stated she could not say what an appropriate diagnosis or indication for use for Risperdal would be. On 07/12/23 at 02:48 PM Licensed Nurse (LN) H stated a correct diagnosis for Risperdal might be depression, but it should not be given for residents with dementia. On 07/12/23 at 03:58 PM Administrative Nurse D stated they based the order on the physician's order and physician indication for use. Administrative Nurse D stated that dementia was not an appropriate indication for use for R22's Risperdal. The "Psychoactive Drug Monitoring" policy dated 01/21 documented: For deviation from the recommended dosage and dosage reduction criteria, the clinical record contains evidence to support justification for use of a drug not meeting the dosage criteria but considered clinically appropriate. Examples include: A medical or psychiatric consultation or evaluation supporting the physician's conclusion. The physician, nurse, or other health professional documentation that the resident was being monitored for adverse consequences or complications of therapy. The Consultant Pharmacist reviewed and analyzed data related to psychoactive drug use in the facility as part of the quality assurance process. The facility utilizes the data presented by the consultant pharmacist (and others) to formulate and monitor psychoactive drug use improvements plans.			F 758			

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F 758	Continued From page 24 The facility failed to ensure an appropriate indication or appropriate documentation for R22's antipsychotic medication Risperdal. This placed R22 at risk for risk for unnecessary medication administration and adverse side effects.	F 758			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER WESTCHESTER VILLAGE OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 8505 PFLUMM ROAD LENEXA, KS 66215		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 883	Continued From page 25 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 16 residents which five residents reviewed for immunizations. Based on record review and interviews, the facility failed to obtain pneumococcal (pneumonia infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination consents, declinations, or administration information for Residents (R) 7 and R22. This deficient practice placed residents at increased risk for pneumonia and related complications. Findings included - Review of the Electronic Medical Record (EMR)	F 883			

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F 883	Continued From page 26 for R7 and R22 revealed the clinical record lacked documentation indicating that the residents had been offered, consented, refused, or had received the pneumonia vaccination. The facility was unable to provide a consent, declination, or record of administration of pneumonia vaccination for R7 and R22. On 07/12/23 at 03:32 PM Administrative Nurse E stated at the time of admission residents were asked about their immunization status and that information was documented under the "Immunization" tab in the clinical record. Administrative Nurse E stated the admitting nurse would notify her if a resident needed a vaccination after admission. Administrative Nurse E stated she would now start tracking the immunization status of all new admission. On 07/12/23 at 04:02 PM Administrative Nurse D stated the facility was unable to locate the consent, declination, or administration of the pneumonia vaccination for R7 and R22. Administrative Nurse D stated each resident at the time of admission are offered vaccinations or interviewed about their vaccination status and that information would be entered into the clinical record. Administrative Nurse D stated the Infection Preventionist (IP) would be tracking the new admission immunizations and their consent or declination would be placed in the resident's clinical record.. The facility's "Pneumococcal Vaccine" policy last revised August 2016 documented all residents would be offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents	F 883			

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F 883	Continued From page 27 would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, would be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The facility failed to provide pneumococcal vaccinations or informed refusals for R7 and R22. This deficient practice placed the residents at risk for complication related to pneumonia.	F 883			