

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

PRINTED: 02/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2024	
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO				STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018			
(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			F 000			
F 730 SS=F	The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 02/29/24. Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents and five Certified Nurse Aides (CNA) reviewed for performance evaluations and required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - CNA N, hired 09/30/22, no yearly performance evaluations were provided upon request. - CNA O, hired 08/21/22, no yearly performance evaluations were provided upon request. - CNA P, hired 04/16/22, no yearly performance evaluations were provided upon request. - CNA Q, hired 11/18/21, no yearly performance evaluations were provided upon request.			F 730			

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

TITLE

(X6) DATE

02/29/2024

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 730	Continued From page 1 CNA MM, hired 02/15/21, no yearly performance evaluations were provided upon request. On 02/20/24 at 09:57 AM Administrative Nurse D stated the facility did not complete yearly performance evaluations for their staff. Administrative Nurse D stated she relied on other nursing staff to provide education to their peers on the spot when issues would arise. Administrative Nurse D further stated if an issue required more intervention, the nurses would have notified her, and further intervention or education would have been provided at that time. Administrative Nurse D stated that issues would have been addressed when they arose instead of waiting until a yearly evaluation was done. The facility policy "Required Training, Performance Evaluation and In-Service of Staff" documented performance is evaluated each day through communication with staff leaders and leadership team members. Any performance issues are addressed with staff members and followed up by any additional training needed. The facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.	F 730			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756			

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F 756	Continued From page 2 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of the	F 756			

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F 756	Continued From page 3 required stop date for Resident (R) 30's as-needed (PRN) lorazepam (antianxiety-class of medications that calm and relax people). This placed the resident at risk of receiving unnecessary psychotropic (alters mood or thoughts) medications. Findings included: - R30's Electronic Medical Record (EMR) listed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and dementia (progressive mental disorder characterized by failing memory, and confusion). R30's "Quarterly Minimum Data Set" (MDS) dated 12/05/23 documented R30 had a Brief interview for Mental Status score of four which indicated severe cognitive impairment. The MDS documented R30 had no behaviors. R30 received antianxiety medications, antidepressant (medication used to treat mood disorders), opioids (narcotic medication used to treat pain), and antiplatelet (medication to inhibit blood clotting) medication during the observation period. R30's "Care Plan" dated 07/20/23 documented R30 was at risk for adverse side effects due to medications with Black Box Warnings (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration). R30's "Care Plan" documented R30 had impaired cognitive function related to her dementia (08/04/23). The plan directed staff to provide approaches that maximized R30's involvement in daily decision making such as	F 756			

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F 756	Continued From page 4 limiting choices, using cueing, task segmentation, written lists, and instructions. R30's EMR documented a "Physician's Order" dated 11/23/23 for lorazepam oral tablet, 0.5 milligrams (mg) by mouth every afternoon for anxiety. R30's EMR documented a "Physician's Order" dated 12/30/23 for lorazepam oral tablet, 0.5 mg by mouth every six hours as needed for tremors (uncontrolled shaking or trembling). The order lacked a stop date. A "Behavior Note" dated 12/30/23 at 10:16 AM recorded refused her medications and reported she did not want to take the medication because they were the wrong medications. Staff attempted redirection but it was ineffective. R30 tossed the pills in the trash and reported "These pills make me shake." Staff notified R30's representative who attempted to calm the resident. At the time of the note, R30 sat in her recliner with her call light within reach. Staff provided R30 personal space for her to "recollect herself," and noted if that was ineffective staff would administer PRN Ativan (lorazepam). A review of R30's "Medication Administration Record/Treatment Administration Record " (MAR/TAR) revealed R30 received the PRN lorazepam twice on 12/30/23, on 10 occasions in January 2023, and twice in February 2024 thus far. R30's EMR lacked a 14-day stop order or specified duration with a physician-documented rationale for the extended use of R30's PRN lorazepam. The facility was unable to provide this	F 756			

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F 756	Continued From page 5 documentation as requested on 02/20/24. The CP's "Monthly Medication Review" for February 2024 documented no irregularities were noted and lacked evidence the CP identified the lack of a stop date for R30's PRN lorazepam. On 02/21/24 at 07:21 AM Certified Medication Aid (CMA) S prepared R30's morning medications. R30 sat at the medication cart. CMA S asked R30 if she would like to have her medication in her room or at the medication cart. R30 took her medication without behaviors or concerns. R30's PRN Ativan was not administered during this medication pass due to no anxiety or behaviors displayed. On 02/20/24 at 09:20 AM Licensed Nurse (LN) G stated PRN Ativan medication should include a 14-day stop date unless the medical provider reorders the medications. She stated the medical provider would document the continued use duration on a progress note or order. She stated the pharmacist completed monthly reviews of the medication and reported to Administrative Nurse D. On 02/20/24 at 09:35 AM Administrative Nurse D stated R30's PRN Ativan medication had been ordered for the intended use but was unable to provide a specified duration for the medications PRN use. She stated the pharmacy should have identified the lack of duration on the monthly reviews and reported the concern. The Consultant Pharmacist (CP) was not available for interview on 02//20/24 and 02/21/24. The facility's "Pharmacy Review" policy revised	F 756			

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F 756	Continued From page 6 11/2017 noted the CP will review all residents' records monthly and provide recommendations for clinical guidelines. The policy indicated the medical provider and Director of Nursing would be provided input on recommendations made. The facility failed to ensure the CP identified and reported the lack of the required stop date for R30's PRN lorazepam. This placed the resident at risk of receiving unnecessary psychotropic medications.	F 756			
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	F 758			

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F 758	Continued From page 7 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. §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 41 residents. The sample included 12 residents of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 30 had a stop date for the use of as-needed (PRN) lorazepam (an antianxiety medication that calms and relaxes people). This placed the resident at risk of receiving unnecessary psychotropic (alters mood or thoughts) medications. Findings included: - R30's Electronic Medical Record (EMR) listed diagnoses of generalized anxiety disorder (mental	F 758			

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F 758	Continued From page 8 or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), and dementia (progressive mental disorder characterized by failing memory, and confusion). R30's "Quarterly Minimum Data Set" (MDS) dated 12/05/23 documented R30 had a Brief interview for Mental Status score of four which indicated severe cognitive impairment. The MDS documented R30 had no behaviors. R30 received antianxiety medications, antidepressant (medication used to treat mood disorders), opioids (narcotic medication used to treat pain), and antiplatelet (medication to inhibit blood clotting) medication during the observation period. R30's "Care Plan" dated 07/20/23 documented R30 was at risk for adverse side effects due to medications with Black Box Warnings (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration). R30's "Care Plan" documented R30 had impaired cognitive function related to her dementia (08/04/23). The plan directed staff to provide approaches that maximized R30's involvement in daily decision making such as limiting choices, using cueing, task segmentation, written lists, and instructions. R30's EMR documented a "Physician's Order" dated 11/23/23 for lorazepam oral tablet, 0.5 milligrams (mg) by mouth every afternoon for anxiety. R30's EMR documented a "Physician's Order" dated 12/30/23 for lorazepam oral tablet, 0.5 mg by mouth every six hours as needed for tremors	F 758			

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F 758	Continued From page 9 (uncontrolled shaking or trembling). The order lacked a stop date. A "Behavior Note" dated 12/30/23 at 10:16 AM recorded refused her medications and reported she did not want to take the medication because they were the wrong medications. Staff attempted redirection but it was ineffective. R30 tossed the pills in the trash and reported "These pills make me shake." Staff notified R30's representative who attempted to calm the resident. At the time of the note, R30 sat in her recliner with her call light within reach. Staff provided R30 personal space for her to "recollect herself," and noted if that was ineffective staff would administer PRN Ativan (lorazepam). A review of R30's "Medication Administration Record/Treatment Administration Record " (MAR/TAR) revealed R30 received the PRN lorazepam twice on 12/30/23, on 10 occasions in January 2023, and twice in February 2024 thus far. R30's EMR lacked a 14-day stop order or specified duration with a physician-documented rationale for the extended use of R30's PRN lorazepam. On 02/21/24 at 07:21 AM Certified Medication Aid (CMA) S prepared R30's morning medications. R30 sat at the medication cart. CMA S asked R30 if she would like to have her medication in her room or at the medication cart. R30 took her medication without behaviors or concerns. R30's PRN Ativan was not administered during this medication pass due to no anxiety or behaviors displayed.	F 758			

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F 758	Continued From page 10 On 02/20/24 at 09:20 AM Licensed Nurse (LN) G stated PRN Ativan medication should include a 14-day stop date unless the medical provider reorders the medications. She stated the medical provider would document the continued use duration on a progress note or order. She stated the pharmacist completed monthly reviews of the medication and reported to Administrative Nurse D. On 02/20/24 at 09:35 AM Administrative Nurse D stated R30's PRN Ativan medication had been ordered for the intended use but was unable to provide a specified duration for the medications PRN use. She stated the pharmacy should have identified the lack of duration on the monthly reviews and reported the concern. A review of the facility's "Psychotropic Medication Use" policy revised 11/2017 indicated the facility will provide ongoing psychotropic (alters mood or thoughts) medication monitoring and ensure correct indication of use and appropriate duration. The facility failed to ensure R30 had a stop date for the use of PRN lorazepam. This placed the resident at risk of receiving unnecessary psychotropic (alters mood or thoughts) medications.	F 758			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880			

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F 880	Continued From page 11 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880			

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F 880	Continued From page 12 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 41 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to the implementation of procedures to monitor and prevent Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens. These deficient practices placed the residents at risk for complications related to infectious diseases. Findings Included: - A review of the information provided by the facility on the facility's Water Management program revealed the program lacked text and diagrams specific to the building's water flow	F 880			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175472	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2024
NAME OF PROVIDER OR SUPPLIER HILLSIDE VILLAGE OF DE SOTO			STREET ADDRESS, CITY, STATE, ZIP CODE 33600 WEST 85TH STREET DE SOTO, KS 66018		
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F 880	Continued From page 13 system. The program did not identify building-specific areas at risk for Legionella or identify specific points within the system checked by the water management program team. On 02/20/24 at 10:23 AM Administrative Staff A stated he was unable to locate the facility's water flow system diagram but would contact the maintenance director. On 02/20/24 at 10:35 Maintenance Staff U stated the facility did not have a diagramed flow chart of the facility water system. He stated the team does monitor high-risk areas and ensures areas of standing water are flushed out frequently. A review of the facility's "Water Management" policy (undated) indicated the facility would provide the appropriate precautions for the control of legionella including identifying areas of growth, completing risk assessments, and implementing precautions to provide regular inspections. The policy indicated microbial monitoring, temperature checks, and system flushing. The facility to ensure proper infection control standards were followed related to implementation of procedures to monitor and prevent Legionella disease or other opportunistic waterborne pathogens. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880			
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides.	F 947			

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F 947	Continued From page 14 In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility had a census of 41 residents. The sample included 12 residents and five Certified Nurse Aides (CNA) reviewed for in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education including the required topics per year. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's in-service records revealed the following: CNA N hired 09/30/22: The documentation provided lacked evidence that CNA N completed 12 hours of in-service/education hours in the past 12 months.	F 947			

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F 947	Continued From page 15 CNA O hired 08/21/22: The documentation provided lacked evidence that CNA O had completed 12 hours of in-service/education hours in the past 12 months. CNA P hired 04/16/22: The documentation provided lacked evidence that CNA P had completed 12 hours of in-service/education hours in the past 12 months. CNA Q hired 11/18/21: The documentation provided lacked evidence that CNA Q had completed 12 hours of in-service/education hours in the past 12 months. CNA MM hired 02/15/21: The documentation provided lacked evidence that CNA MM had completed 12 hours of in-service/education hours in the past 12 months. On 02/20/24 at 09:12 AM Administrative Nurse D stated the facility provided education for staff; however, the facility did not have a way to track the hours of education provided for the year. Administrative Nurse D further stated Administrative Staff B assisted her in tracking post-tests for the education that was provided for staff; however, Administrative Nurse D stated she was typically the one responsible for ensuring staff met education requirements. The updated facility policy "Required Training, Performance Evaluation and In-Service of Staff" documented all direct care staff are required to attend 12 hours of continuing education and demonstrate competency annually. The facility failed to ensure five of the five CNA	F 947			

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F 947	Continued From page 16 staff reviewed had the required 12 hours of in-service education including the required topics per year. This placed the residents at risk for inadequate care.	F 947			