STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigatios KS00193810, KS00193486, KS00193734, and KS00192956. The 2567 was electronically sent on 03/31/25.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. The sample included 18 residents, with two residents sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 24's call light was within her reach and further failed to provide foot pedals for R25 while pushing her in the hall. This deficient practice left R24 vulnerable to unmet care needs due to the inability to call for staff assistance and placed R25 at an increased risk for preventable falls and injuries. Findings Included: - R24's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of heart failure (a condition with low heart output), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral	F 558		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 1	F 558		

infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), effecting the left nondominant side, muscle weakness hypertension (high blood pressure), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Quarterly Minimum Data Set" (MDS) dated 02/24/25 documented a Brief Interview of Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R24 was dependent on staff for bathing and toileting. The MDS documented R24 had not had a fall during the observation period.

The "Significant MDS" dated 05/24/24 documented a BIMS score of one which indicated severely impaired cognition. The MDS documented R24 was dependent on staff for bathing and toileting. The MDS documented R24 had a non-injury fall during the look-back period.

R24's "Falls Care Area Assessment" (CAA) dated 05/24/24 documented R24 was at risk for falls and was dependent on staff for activities of daily living (ADL) and transfers. R24 CAA documented she had weakness due to hemiparesis/hemiplegia, was incontinent of bowel, had a Foley catheter, and had confusion.

R24's "Care Plan" dated 03/05/21 documented R24 was at risk for falls, staff were to place a Dycem (non-slip mat used for stabilization and

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	175218	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 2	F 558		

gripping to prevent slipping) in her recliner and wheelchair to help prevent slipping. R24's plan of care dated 12/26/24 documented staff were to ensure that R24 was positioned away from the edge of the bed and staff were to ensure her call light was within reach and encourage the resident to use it for assistance as needed.

On 03/03/25 at 07:25 AM, R24 laid on her bed asleep. R24's call light was placed at the back of her legs; the call light was out of her reach.

On 03/05/25 at 12:25 PM, Certified Nurse's Aide (CNA) M stated call lights should always be placed on a resident's side, clipped to their clothing, and always within their reach.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated all nursing staff checked to ensure residents' call lights were within the residents' reach. He stated some of the residents had specific places they liked the light placed.

On 03/05/24 at 01:16 PM, Administrative Nurse D stated call lights should be within the resident's reach.

The facility failed to provide an accommodations of needs policy.

The facility failed to ensure R24's call light was within her reach. This deficient practice left R24 vulnerable to unmet care needs due to the inability to call for staff assistance.
- The "Medical Diagnosis" section within R25's Electronic Medical Records (EMR) included diagnoses of acute respiratory failure, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 558	Continued From page 3	F 558		

moods), need for assistance with personal cares, unsteadiness of feet, and catatonic disorder (rare mental disorder that caused immobility, inability to communicate, and abnormal movements).

R4's "Admission Minimum Data Set (MDS)" dated 12/16/24 noted a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance from staff for toileting, bathing, dressing, bed mobility, and bathing. The MDS was unable to determine if she had a history of falls.

R4's "Falls Care Area Assessment (CAA)" completed 12/03/24 indicated she was at risk for falsl related to her impaired gait and cognitive impairment. The CAA noted she used a wheelchair but could ambulate without assistance. The CAA noted a care plan was implemented to address her risks.

R4's "Care Plan" initiated 12/15/24 indicated she was at risk for falls related to her impaired balance and poor safety awareness. The plan noted she required staff assistance with transfers, dressing, bed mobility, bathing, and toileting. The plan noted she had limited mobility and weakness. The plan noted she used a wheelchair for mobility but required staff assistance while walking. The plan noted she had one non-injury fall related to her being dizzy.

On 03/03/25 at 08:10 AM, R4 sat in her wheelchair in the hallway next to her room. R4 wheelchair had no foot pedals. R4 had tan rubber-soled shoes on her feet. At 08:11 AM unidentified staff pushed R4 from the hallway to the dining hall table next to the kitchen's drink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR DERBY, KS 67037

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F 558	Continued From page 4 station. R4's feet slid on the floor as staff pushed her. On 03/03/25 09:30 AM, R4 was moved away from the dining room to her room for toileting assistance. R4's feet slid on the floor as staff pushed her to her room. On 03/05/25 at 11:30 AM, Certified Medication Aide (CMA) R stated some of the residents preferred not to have foot pedals on their wheelchairs, but their feet should never touch the ground while being pushed. She stated cognitively impaired resident must have foot pedals on to prevent falls during motion. On 03/05/25 at 01:16 PM, Administrative Nurse D stated staff were expected to put the foot pedals on before pushing the residents. The facility's "Fall Prevention" policy (undated) indicated the facility was to implement and provide preventative interventions to prevent potential accidents. The policy indicated the facility was to promote a safe environment to ensure resident safety. The facility failed to ensure the use of wheelchair foot pedals for R4 while being pushed in her wheelchair. This placed the resident at risk for preventable accidents and injuries.	F 558		
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for	F 571		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 571	Continued From page 5	F 571		

applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:
(A) Nursing services as required at §483.35.
(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
(F) Medically-related social services as required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 571	Continued From page 6 at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by	F 571		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 571	Continued From page 7	F 571		

§483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.
(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.
(iii) Requests for items and services.
(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.
(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 69 residents. The sample included 18 residents, with one reviewed for personal funds. Based on record review, interviews, and observations, the facility failed to prevent unnecessary charges to Resident (R) 218 bank account resulting in multiple charges to his bank account. This deficient practice placed R218 at risk for misappropriation of funds.

Findings Included:

- The "Medical Diagnosis" section within R57's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 571	Continued From page 8	F 571		

Electronic Medical Records (EMR) included diagnoses of Chronic obstructive pulmonary disorder (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), senile degeneration of the brain, and dementia (a progressive mental disorder characterized by failing memory and confusion).

R218's EMR indicated he was admitted to the facility on 09/06/25.

R218's "Admission Minimum Data Set (MDS)" completed 09/19/24 noted a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS noted he was admitted to the facility for hospice services.

R218's "Dementia Care Area Assessment (CAA)" completed 09/22/24 indicated he had severe cognitive impairments and communication issues. The CAA noted a care plan will be implemented to address his needs.

R218's EMR indicated he was discharged from the facility on 09/25/25.

R218's "Care Plan" initiated on 09/12/24 indicated he was admitted to the facility and wished to remain in the long-term care unit.

R218's EMR under "Census" revealed his payor source was private pay.

R218's EMR under "Miscellaneous" revealed R218's "Admission Agreement" indicated that the facility was aware he received Medicaid/Medicare services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 571	Continued From page 9	F 571		

A review of the facility's "Service Invoice" (dated 09/30/24) for R218's services revealed his bank account was successfully charged $1850.00 on 09/09/24 for his services in September 2025.

A review of the facility's "Service Invoice" (dated 11/30/24) for R218's services revealed his bank account was billed $2,494.73.00 for his services in September 2024.

A review of the facility's "Service Invoice" (dated 12/15/24) for R218's services revealed his bank account was billed $215.27 for his services in September 2024.

A review of the facility's "Service Invoice" (dated 02/28/25) for R218's services revealed his bank account was charged $2,279.46 on 02/10/25 but was declined due to insufficient funds.

On 03/04/25 at 10:01 AM, R218's representative reported the facility charged his personal account $1650.00 in September 2024. She reported the facility then attempted to withdraw $2400.00 but the transaction was declined due to insufficient funds. She reported the facility debited $293.00 in December 2024. She reported the facility attempted to debit his account $2200.00 in January 2024 but the transaction was declined due to insufficient funds. R218's representative stated she reported the transactions to the state agency in February 2025. R218 representative stated she informed the facility. R218 was admitted to the facility on Medicaid under hospice services. She stated the services should have been covered under Medicaid/Medicare services. She stated she provided the facility with a copy of his Medicaid/Medicare eligibility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 571	Continued From page 10 On 03/05/25 at 10:22 AM, Administrative Staff B stated that R218's billing code was set up incorrectly which resulted in the inappropriate charging of his bank account. She stated the facility would reimburse R218's accounts for the error. On 03/05/25 at 01:34 PM, Administrative Staff A stated R218 was admitted on both hospice pay and private pay at the facility. Administrative Staff A stated that may have caused him to be billed incorrectly. The facility failed to provide a policy related to resident personal funds as requested on 03/05/25. The facility failed to prevent unnecessary charges to the R218 bank account resulting in multiple charges to his bank account. This deficient practice placed R218 at risk for misappropriation of funds.	F 571		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 582	Continued From page 11	F 582		

changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 582	Continued From page 12	F 582		

The facility identified a census of 69 with 18 residents included in the sample. The facility identified 12 residents who were discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Skilled Nursing Facility Advance Beneficiary Notification (SNF ABN) form 10055 (the form used to notify Medicare A participants of potential financial liability when a Medicare Part A episode ends) for Resident (R) 63. This failure placed the residents at risk for decreased autonomy and impaired decision-making.

Findings included:

- Review of R63's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 11/13/24 and ended on 012/06/24. R12 remained in the facility for custodial care. The facility was unable to provide evidence that staff issued the SNF ABN 10055.

On 03/02/25 at 11:25 AM, Social Service X stated she had never given an SNF ABN for residents ending Medicare part that were staying in the facility. She stated she was not trained to give SNF ABN.

The facility's "Skilled Nursing Facility Advanced Beneficiary Notice" undated policy documented The SNF ABN provides information to the patient to enable the patient to decide whether to get that care that may not be paid for by Medicare and assume financial responsibility.

The facility failed to ensure the forms provided at the end of skilled services contained the required information for the residents to make informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 13 choices and appeal the non-coverage decisions. This failure placed the residents at risk for decreased autonomy and impaired decision-making.	F 582		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 583	Continued From page 14	F 583		

administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 69 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to keep Resident (R) 38's protected health information (PHI) private on a medication cart parked in the main dining room. This deficient practice placed R38 at risk for impaired privacy.

Findings included:

- On 03/04/25 at 10:02 AM, an observation revealed a medication cart parked in the 400 hallway with a laptop computer sitting on the top, the computer screen was unlocked and open, and R38's PHI was on the screen visible to all who passed by the medication cart. The information visualized included R38's medications, date of birth, allergy information, and code status. No nursing staff were in view of the medication cart. Certified Medication Aide (CMA) R agency exited another room into the hallway.

On 03/04/25 at 10:05 AM, CMA R stated she had just walked away from the medication cart for just a minute. CMA R stated she should not leave the computer open and R38's PHI.

On 03/05/25 at 12:50 PM, Licensed Nurse (LN) G stated the laptop should be closed.

On 03/05/25 at 01:17 PM, Administrative Nurse D stated she expected the laptop on the medication cart to be locked or closed. On Administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 583	Continued From page 15 Nurse D stated the resident's PHI should not be available to just anyone. The facility's "Electronic Medical Records" policy dated 12/2025 documented electronic records are an acceptable form of medical record management. Only authorized persons who have been issued a password and user ID code would be permitted access to the electronic medical records system. The facility would make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure. The facility failed to maintain R38's privacy regarding PHI. This deficient practice placed the resident at risk for impaired privacy.	F 583		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. The sample included 18 residents, with eight residents reviewed for activities of daily living (ADL) for dependent residents. Based on observation, record review, and interviews, the facility failed to ensure a shower/bath was provided for Resident (R) 11, R34, R14, and R15 who were dependent on staff assistance with ADLs. This deficient practice had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 16	F 677		

psychosocial well-being.

Findings included:

- R11's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of muscle weakness, need for assistance with personal care, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Annual Minimum Data Set" (MDS) dated 11/23/24 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R11 was dependent on staff assistance for transfers and required substantial assistance from staff for showering/bathing.

The "Quarterly MDS" dated 12/16/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R11 had limited range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension) on her upper extremity on one side. The MDS documented R11 required substantial to maximum staff assistance for bathing and was dependent on staff assistance for transfers during the observation period.

R11's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 11/30/24 documented she required one staff member's assistance with her ADLs.

R11's "Care Plan" dated 03/17/24 documented she preferred to be offered showers or bed baths twice weekly and as needed. The plan of care documented R11 occasionally refused her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 17	F 677		

showers.

R11's EMR under the "Reports" tab and "Bathing" task was reviewed for the following dates 01/01/25 to 03/03/25 (61 days). The EMR documented one "Shower" (SH) or "Baths" (B) on 01/11/25 and one "Resident Refused" (98 resident refused) on 01/01/25. R11's clinical record lacked evidence she was offered or refused care during the 61 days reviewed. The facility had reported there were bath sheets that were not part of R11's medical record. The facility did not provide the bath sheets for R11.

On 03/05/25 at 10:26 AM, R11 laid on her bed with the head of her bed elevated. R11's hair appeared oily and uncombed. R11 had reported she had not received a bath/shower yet this week. R11 stated she felt dirty and neglected when she did not receive her scheduled bath. R11 stated the facility still charged her full price for care.

On 03/05/24 at 12:24 PM, Certified Nursing Aide (CNA)M stated residents pick the days of the week they prefer bathing. She stated if the facility staff was unable to give bathing due to staffing, the resident would be scheduled the following day. CNA M stated if a resident refuses the shower, the CNA should ask a second time, and report the refusal to the nurse. CNA M stated staff would offer a bed bath or sponge bath. CNA M stated the bath aide documents bathing on a bath sheet, which is given to the director of nursing after the bath sheet was filled out.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated bathing was done by a bath aide twice a week. LN G stated if a resident refused the CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 18	F 677		

would let the nurse know. The LN would visit with the resident and offer a sponge bath or bed bath. LN G stated bathing was documented in the residents' EMR.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated residents were offered two showers a week. She stated if a resident did not get their scheduled shower on the day the shower was scheduled, the nurse would visit with the resident and set up a time on a different day. Administrative Nurse D stated if a resident had not received a shower for multiple days or refused bathing consistently that information would be directed to the director of nursing. Administrative Nurse D stated the bath aide fills out a bath sheet, the sheets are given to the director of nursing to review. She stated nursing was to chart refusals. The CNA would chart showers given and refusals in the residents' EMR. Administrative Nurse D stated she was aware of a few residents' showers not being given due to refusals.

The facility's "Activities of Daily Living" policy undated documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff would ensure each resident's abilities in activities of daily living to not diminish unless circumstances of the resident clinical condition demonstrate that the decline was unavoidable, including bathing, dressing grooming transferring, locomotion, ambulation, toileting, eating, and communication.

The facility failed to provide consistent bathing for R11. This deficient practice had the risk of poor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 19	F 677		

hygiene and decreased self-esteem and dignity.
- The "Medical Diagnosis" section within R15's Electronic Medical Records (EMR) included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), morbid obesity (excessive body fat), and type two diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).

R15's "Quarterly Minimum Data Set (MDS)" dated 01/03/25 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she required substantial to maximal assistance with toileting, transfers, bed mobility, dressing, and bathing. The MDS noted she was frequently incontinent of the bladder and always incontinent of the bowel. The MDS noted she had moisture-associated skin damage (MASD).

R15's "Functional Abilities Care Area Assessment (CAA)" completed 04/03/24 indicated she was dependent on two staff for assistance with her activities of daily living (ADL). The plan noted she would work with therapy to improve her strength and transfer abilities.

R15's "Urinary Incontinence CAA" completed 04/03/24 indicated she was at risk for impaired skin and pressure injuries related to her immobility and incontinence. The plan noted that the staff was to provide peri-care after each incontinent episode.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 20	F 677		

R15's "Care Plan" initiated 07/21/22 indicated she had an ADLs deficiency related to her medical diagnoses. The plan noted she was dependent on staff assistance for bathing, toileting, dressing, personal hygiene, bed mobility, and transfers (07/21/22). The plan noted she refused all her treatments, therapies, and care (11/08/22). The plan noted that R15 had chronic moisture-associated skin damage due to her immobility and medical diagnoses (12/19/24).

R15's "Documentation Survey Report" revealed her last documented bathing opportunity occurred on 02/01/25.

R15's EMR under "Tasks" revealed no bathing opportunities occurred within the last 30 days reviewed.

R15's "Progress Notes" under "Alert Note" revealed a note dated 01/24/25. The note revealed she was provided a bed bath by two staff members. No other progress notes revealed bathing.

On 03/03/25 at 09:00 AM, R15 lay in her bed. Her bed was in the low position with her bedside table pulled to her left side. R15's hair and skwere greasy. Her hair uncombed. Her room smelled of body odor. R15 reported she felt dirty and unclean due to the facility not providing her bathing for the last month. She stated staff would provide peri-care but would not get her up for showering or bathing. She stated she had no current skin issues but has in the past due to not being bathed properly.

On 03/05/24 at 12:24 PM, Certified Nursing Aide (CNA) M stated residents pick the days of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 21	F 677		

week they prefer bathing. She stated if the facility staff were unable to complete bathing due to staffing, the resident would be scheduled the following day. CNA M stated if a resident refused the shower, the CNA should ask a second time, and report the refusal to the nurse. CNA M stated staff would offer a bed bath or sponge bath. CAN M stated the bath aide documents bathing on a bath sheet, which was given to the director of nursing after the bath sheet was filled out.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated bathing was done by a bath aide twice a week. LN G stated if a resident refused the CNA would let the nurse know. The LN would visit with the resident and offer a sponge bath or bed bath. LN G stated bathing was documented in the resident's EMR.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated residents were offered showers twice a week. She stated if a resident had not gotten their scheduled shower on the day the shower was scheduled, the nurse would visit with the resident and set up a time on a different day. Administrative Nurse D stated if a resident does not receive a shower for multiple days or refuses bathing consistently that information would be directed to the director of nursing. Administrative Nurse D stated the bath aide fills out a bath sheet, the sheets are given to the director of nursing to review. She stated nursing was to chart refusals. The CNA would chart showers given and refusals in the residents' EMR. Administrative Nurse D stated she was aware of a few residents' showers not being given due to refusals.

The facility's "Activities of Daily Living" policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 22	F 677		

(undated) documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff would ensure each resident's abilities in activities of daily living do not diminish unless circumstances of the resident clinical condition demonstrate that the decline was unavoidable, including bathing, dressing grooming transferring, locomotion, ambulation, toileting, eating, and communication.

The facility failed to provide consistent bathing opportunities for R15. This deficient practice placed R15 at risk for impaired psycho-social well-being and skin breakdown.
- The "Diagnosis" tab of R14's Electronic Medical Record (EMR) documented diagnoses of obesity (excessive body fat), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hemiplegia (paralysis of one side of the body), affecting left nondominant side, muscle weakness, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), lack of coordination, need for assistance with personal care, cellulitis (bacterial infection of the skin and underlying tissues), and abnormalities of gait and mobility.

The " Quarterly Minimum Data Set (MDS)" dated 01/12/25, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R14 required substantial to maximum assistance for bathing and dressing; and was dependent of staff for toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23	F 677		

The" Annual MDS" dated 07/12/24 documented a BIMS of 15 which indicated intact cognition. The MDS documented R14 had impairment of one side of her body. The MDS documented R14 needed substantial to maximum assistance for bathing and dressing.

R14's "Care Plan" revised on 11/17/24 documented R14 had an activity of daily living (ALD) self-care deficit. R14's plan of care documented she was totally dependent on staff to provide bathing. R14 preferred to receive two showers per week in the daytime, and R14 required one to two staff assistance with her bath.

R14's medical record documented R14 did not consistently receive bathing twice weekly from 01/16/25 to 3/2/25 per her choice.

On 03/03/25 at 09:24 AM, R14 laid in her bed on her back, with the head of bed raised. R14's room had a distinct urine odor.

On 03/03/25 at 09:24 AM, R14 stated she had not gotten a shower for 15 days and was supposed to get a shower on 03/03/25. R14 stated she knew she knew she smelt of urine, and not getting a shower made her feel bad. R14 stated showers get cut when staff was short.

On 03/03/25 at 09:24 AM, R14 laid in her bed on her back, with the head of bed raised. R14's room had a distinct urine odor.

On 03/05/24 at 12:24 PM, Certified Nursing Aide (CNA) M stated residents pick the days of the week they prefer bathing. She stated if the facility staff was unable to give bathing due to staffing, the resident would be scheduled the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 24	F 677		

day. CNA M stated if a resident refuses the shower, the CNA should ask a second time, and report the refusal to the nurse. CNA M stated staff would offer a bed bath or sponge bath. CNA M stated the bath aide documents bathing on a bath sheet, which is given to the director of nursing after the bath sheet was filled out.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated bathing was done by a bath aide twice a week. LN G stated if a resident refused the CNA would let the nurse know. The LN would visit with the resident and offer a sponge bath or bed bath. LN G stated bathing was documented in the residents EMR.

On 03/05/25 at 01:16 PM Administrative Nurse D stated residents were offered two showers a week. She stated if a resident did not get their scheduled shower, on their shower day, the nurse would visit with the resident and set up a time on a different day. Administrative Nurse D stated if a resident does not receive or shower for multiple days or refuses bathing consistently that information would be directed to the director of nursing. Administrative Nurse D stated the bath aide feels out a bath sheet, the sheets are given to the director of nursing to review. She stated nursing was to chart refusals, and the CNA would chart showers given and refusals in the resident's EMR.

The facility's "Activities of Daily Living" policy undated documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff would ensure each resident's abilities in activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 25	F 677		

daily living to not diminish unless circumstances of the resident clinical condition demonstrate that the decline was unavoidable, including bathing, dressing grooming transferring, locomotion, ambulation, toileting, eating, and communication.

The facility failed to provide consistent bathing for R14 who required assistance with bathing. This deficient practice placed R14 at risk for complications related to poor hygiene and impaired dignity.

- R34's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (high blood pressure), muscle weakness, abnormalities of gait and mobility, weakness, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and dysphagia (swallowing difficulty).

The "Quarterly Minimum Data Set" (MDS) dated 01/16/25 documented a Brief Interview of Mental Status (BIMS) score of three which indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 26	F 677		

severely impaired cognition. The MDS documented R34 required substantial to maximum assistance from staff for oral hygiene, toileting, dressing, and showers. The MDS documented R34 required staff touching and cueing for eating.

The "Admission MDS dated 04/15/24 documented a BIMS score of one which indicated severely impaired cognition. The MDS documented R34 needed substantial to maximum assistance from staff for bathing and toileting and was independent with eating.

R34's "Cognitive and Dementia Care Area Assessment" (CAA) dated 04/15/24 for R34 had a BIMS score of one, due to a diagnosis of vascular dementia. R34 requires assistance with ADLs and transfers. R34 had a poor appetite.

R34's "Care Plan" dated 04/02/24 documented R34 required the assistance of one staff for participation with bathing. Staff were to offer R34 a shower two times a week and as needed in the evening. R34's plan of care documented she refuses showers occasionally, and bed baths could be offered as an alternative to showers.

R34's medical record lacked documentation of any shower given from 01/07/25 to 03/03/25.

R34's medical record documented not applicable or refusals for all bathing days from 01/0725 to 03/03/25.

On 03/03/25 at 08:28 AM R34 sat in her armed chair. R34 hair was matted on the left side of her head, and ungroomed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 677	Continued From page 27	F 677		

On 03/03/25 at 8:55 AM, R34 sat in her armed chair. R34's hair was ungroomed and appeared tangled on the back of her head.

On 03/05/24 at 12:24 PM, Certified Nursing Aide (CNA) M stated residents pick the days of the week they prefer bathing. She stated if the facility staff was unable to give bathing due to staffing, the resident would be scheduled the following day. CNA M stated if a resident refuses the shower, the CNA should ask a second time, and report the refusal to the nurse. CNA M stated staff would offer a bed bath or sponge bath. CAN M stated the bath aide documents bathing on a bath sheet, which is given to the director of nursing after the bath sheet was filled out.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated bathing was done by a bath aide twice a week. LN G stated if a resident refused the CNA would let the nurse know, and the LN would visit with the resident and offer a sponge bath or bed bath. LN G stated bathing was documented in the residents ' EMR.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated residents were offered two showers a week. She stated if a resident did not get their scheduled shower on the day the shower was scheduled, the nurse would visit with the resident and set up a time on a different day. Administrative Nurse D stated if a resident does not receive a shower for multiple days or refuses bathing consistently that information would be directed to the director of nursing. Administrative Nurse D stated the bath aide fills out a bath sheet, the sheets are given to the director of nursing to review. She stated nursing was to chart refusals. The CNA would chart showers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 28 given and refusals in the residents ' EMR. Administrative Nurse D stated she was aware of a few residents ' showers not being given due to refusals. The facility ' s "Activities of Daily Living" policy undated documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident ' s comprehensive assessment, facility staff would ensure each resident's abilities in activities of daily living to not diminish unless circumstances of the resident clinical condition demonstrate that the decline was unavoidable, including bathing, dressing grooming transferring, locomotion, ambulation, toileting, eating, and communication. The facility failed to provide bathing and grooming for R34, who required assistance with bathing and grooming. This deficient practice placed R14 at risk for complications related to poor hygiene and impaired dignity.	F 677		
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	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 29	F 679		

by:
The facility identified a census of 69 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to provide resident directed, interactive activities based on resident preferences for the residents on the weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation.

Findings Included:

- A review of the facility's "Activity Calendars" for December 2024, January 2025, and February 2025 was completed. The calendars revealed the residents were provided church related services via television or internet on Sundays. The calendar revealed movies were played for the residents at 02:30 PM and the evening news at 06:00 PM on Sundays. The calendars lacked engaging staff-led activities for Sundays.

On 03/04/25 at 10:30 AM, the facility provided music and exercise group for the residents in the dining hall area.

On 03/04/25 at 11:00 AM, the facility's Resident Council reported the facility rarely provided activities on weekends. The council reported very little occurred on Sundays. The council reported staff would put on a movie for the residents to watch but would not provide engaging activities. The council reported activities were inconsistent on Saturdays. The council reported sometimes outings occurred on Saturdays, but not all residents could go out due to the limited space in transportation. The council reported if you had to sign up and hope you could get a spot to go. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 679	Continued From page 30 council reported the facility did not provide an alternative activity for residents who could not go on the outing. The council reported that weekends were often boring due to the lack of engaging activities. On 03/05/25 at 11:12 AM, Certified Medication Aide (CMA) R stated staff were expected to complete the activities on weekends. She stated the facility had outings and religious services come in on Sundays. She stated staff could also provide coloring pages for the residents to turn in to win a prize. On 03/05/25 at 12:47 PM, Activity Staff Z stated staff were expected to complete the scheduled activities on weekends. She stated the activities were not assigned staff to hold the activities, but staff would provide the scheduled activities. She stated the facility did not document what activities were provided or which residents attended. She stated the facility also had an activity basket for the weekends with puzzles, coloring pages, and games. She stated staff could give them to the residents. The facility failed to provide a policy related to activities as requested on 03/05/25. The facility failed to provide consistent activities on the weekends which reflected the residents' interests, and preferences. This placed the affected residents at risk for boredom, isolation, and decreased quality of life.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31	F 686		

§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The sample included 18 residents, with three residents reviewed for treatment/services to prevent/heal 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). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 24's heels were offloading, heel protectors were applied to both heels and further failed to monitor R24's low air loss mattress. This placed R24 at increased risk for developing pressure ulcers.

Findings Included:

- R24's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of heart failure (a condition with low heart output), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 32	F 686		

flow to the brain by blockage or rupture of an artery to the brain), effecting the left no-dominant side, muscle weakness hypertension (high blood pressure), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Quarterly Minimum Data Set" (MDS) dated 02/24/25 documented a Brief Interview of Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R24 was not at risk for developing pressure ulcers. The MDS documented R24 had a pressure-reducing device in her chair, a pressure-reducing device in her bed, nutritional and hydration interventions to manage skin problems, moisture-associated skin damage, and application of ointment or dressing to feet.

The "Significant MDS" dated 05/24/24 documented a BIMS score of one which indicated severely impaired cognition. The MDS documented R24 was not at risk for developing pressure ulcers. The MDS documented R24 had a pressure-reducing device in her chair, a pressure-reducing device in her bed, nutritional and hydration interventions to manage skin problems, moisture-associated skin damage, and application of ointment or dressing to feet.

R24's "Pressure Ulcer/ Injury Care Area Assessment " dated 05/24/24 documented R24 had a risk for pressure due to impaired mobility, needing assistance to reposition has a Foley catheter (a tube inserted into the bladder to drain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 33	F 686		

urine into a collection bag), pain, depression, dementia, and end of life care. R24's pressure injury would be addressed in the care plan.

R24's "Care Plan" revised 02/08/21 documented R24 had potential impairment to skin integrity. Staff were to monitor and document the location, size, and treatment of skin injury, and report abnormalities of skin. R24's plan of care lacked documentation for staff to monitor R24's low air loss mattress.

R24's "Braden Scale for Prediction Pressure Sore Risk" dated 02/23/25 documented a score of 13 indicating a moderate risk for pressure ulcers.

R24's EMR under the "Vitals and Weights" tab documented a weight of 116.00 on 02/01/25.

R24's low air loss mattress "Drive" manufactures recommendation indications document low air mattress should be set at person's weight.

R24's "Weekly Wound Assessment" dated 03/02/24 documented R24 had no skin issues.

R24's physician's orders under the "Orders" tab revealed the following orders:
Barrier cream to bottom areas every shift for preventative care dated 01/06/25.
Left lateral malleolus (and expanded projection at the distal end of the fibula or tibia at the level of the ankle) apply Skin-prep (liquid skin protectant) twice daily related to redness and preventative 11/13/12.
Heel protectors worn to bilateral feet while in bed daily as tolerated every shift while in bed 11/05/24.
Offload heels daily while in bed every shift while

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 34	F 686		

in bed for redness dated 11/05/24.

On 03/03/25 at 07:25 AM, R24 laid on her bed, R24's Low air loss mattress was set at 350 pounds. R24's heels laid directly on the mattress. R24's heels were not floated, and she did not have heel protectors.

On 03/05/25 at 12:25 PM, Certified Nurse's Aide (CNA) M stated it would be all nursing duties to ensure residents' heels are floated or boots applied to heels. She stated staff ensured the mattress was plugged in. CNA M stated she was unsure what the mattress dial should be set on.

On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated all nursing staff check to ensure the mattresses are plugged in. LN G stated he does not monitor the mattress and was unsure what the mattress should be set at. He stated when the mattresses were put in place, the mattress was set, and nursing staff ensured the mattress was working. LN G stated nurses ensured residents had their heels floated.

On 03/05/24 at 01:16 PM Administrative Nurse D stated she was unsure how low air loss mattresses were set. Administrative Nurse D stated it was all nursing staff's responsibility to ensure residents' heels are floated. She stated heels to be floated should be on the care plan, and orders should be on the "Treatment Administration Record" (TAR).

The facility's "Pressure Injury Prevention" policy revised 02/22 documented the facility would implement and develop a plan to meet the needs of each resident. The facility would include the consideration of mechanical support surfaces,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 35 nutrition, hydration, positioning, mobility continence, skin condition, and overall clinical condition of the resident. The goal would be for the resident to be free of preventable pressure ulcers and injuries. The facility failed to ensure R24's heels were offloading, and heel protectors were applied to both heels and further failed to monitor R24's low air loss mattress. This placed R24 at increased risk for developing pressure ulcers.	F 686		
F 689 SS=E	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 69 residents. The sample included 18 residents, with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to secure areas containing hazardous materials out of reach of seven cognitively impaired /independently mobile residents in the secured unit. The facility further failed to implement interventions related to Resident (R)28's falls. This deficient practice placed the affected residents at risk for preventable injuries and accidents. Findings Included:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36	F 689		

- The facility identified that Residents (R) 5, R16, R22, R30, R42, R53, and R60 were cognitively impaired and independently mobile within the facility.

On 03/03/25 at 07:03 AM, a walkthrough of the facility was completed. Upon inspection of the facility's supplemental oxygen storage room revealed the entry door was unlocked. An inspection of the room revealed 46 fully charged supplemental oxygen cylinder tanks. At 07:05 AM Licensed Nurse (LN) G secured the oxygen room door and stated the room should have been locked. He stated staff may have forgotten to check the door before exiting the room. He stated the residents should not have access to areas with potential hazards.

On 03/03/25 at 07:10 AM, an inspection of the 400 hall revealed the shower room was propped open. The shower contained unsecured two containers of Micro-kill bleach wipes and a spray bottle of disinfectant. The products contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.

On 03/03/25 at 07:14 AM, an inspection of an unsecured closet next to the maintenance office revealed a one-gallon carton of floor cleaner on the floor. The product contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed."

On 03/03/25 at 07:15 AM, an unlocked utility closet next to R4's room revealed an unlocked electrical panel. The panel contained the warning,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37	F 689		

"high voltage - the danger of electric shock."

On 03/03/25 at 07:17 AM, an unlocked utility closet next to R60's room revealed an unlocked electrical panel. The panel contained the warning, "high voltage - the danger of electric shock."

On 03/05/25 at 01:16 PM, Administrative Nurse D stated all areas within the facility that contained potential hazards for the residents should remain locked and staff were expected to check the doors to ensure they were secured.

The facility was unable to provide a policy related to environmental safety as requested on 03/05/25.

The facility failed to secure areas containing hazardous materials out of reach of seven cognitively impaired /independently mobile residents in the secured unit. This deficient practice placed the affected residents at risk for preventable injuries and accidents.
- R28's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of muscle weakness, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hypertension (HTN - elevated blood pressure).

The "Significant Change Minimum Data Set" (MDS) dated 03/14/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R28 required substantial to maximum staff assistance for transfers. The MDS documented R28 had one non-injury during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38	F 689		

observation period.

The "Quarterly MDS" dated 12/15/24 documented a BIMS score of three which indicated severely impaired cognition. The MDS documented that R28 required substantial to maximum staff assistance for transfers. The MDS documented R28 had one non-injury during the observation period.

R28's "Fall Care Area Assessment" (CAA) dated 03/18/24 documented he had a history of falls.

R28's "Care Plan" dated 10/15/22 documented he was found on the floor. The plan of care documented nursing staff would ensure R28 was wearing gripper socks when up for the day and not the pressure-reducing boots only when in bed. The plan of care dated 10/25/22 documented nursing staff would ensure R28's call light was within reach. The plan of care dated 03/06/23 documented nursing staff would ensure R28's items were within his reach when in bed. The plan of care dated 09/17/23 documented nursing staff would remind R28 to ask for assistance with toileting or wanting to walk and staff would assist R28 to the bathroom every two hours. The plan of care dated 11/20/23 documented staff would cue R28 during transfers to assist with pivoting. The plan of care dated 01/11/24 documented R28 had a witnessed fall when staff lowered him to the floor. The plan of care documented staff would ensure R28 had the appropriate footwear (non-skid socks or shoes) and gripper strips on the floor next to his bed. The plan of care dated 02/16/24 documented staff would educate R28 to ask for assistance with care. The plan of care dated 04/08/24 documented staff instructed R28 to call for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39	F 689		

assistance when he wanted to serve popcorn. The plan of care dated 07/19/24 documented staff increased R28's monitoring when in the dining room and would encourage him to sit in the common area following meals. The plan of care dated 02/18/25 documented when R28 became restless after meals, staff was to assist him to a chair in the common area as tolerated or offered to be laid down in the bed. The plan of care lacked staff direction for fall prevention for the following dates 11/20/24 and 11/21/24.

R28's EMR under the "Progress Notes" tab documented an "Incident Note" dated 01/11/24 at 07:55 AM during a staff-assisted transfer R28's legs buckled, and he fell to the ground with staff assistance. R28 received a skin tear on his left forearm. R28 was wearing only his socks and no shoes.

On 02/16/24 at 07:40 PM, a "Situation, Background, Assessment, and Recommendation" (SBAR- communication tool) documented R28 was found on the floor in the dining room.

On 04/08/24 at 04:15 PM a "Health Status Note" documented dietary staff found R28 on the floor in the dining room. R28 was instructed not to get up without assistance.

On 04/08/24 at 06:29 PM a "Health Status Note" documented dietary staff found R28 on the floor in the dining room. R28 was instructed not to get up without assistance.

On 07/19/24 at 07:30 PM a "Health Status Note" that documented R28 attempted to transfer himself from his wheelchair and fell to the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40	F 689		

On 11/20/24 at 06:06 PM a "Health Status Note" documented R28 attempted to stand up from his wheelchair, fell to the floor, and received a skin tear on his right elbow.

On 11/21/24 at 07:30 PM a "Health Status Note" documented R28 was found on the floor in the hallway. R28 had an incontinent episode. A fall intervention was put into place to assist R28 to bed after supper mealtime as R28 preferred to lie down after dinner.

On 02/13/25 at 08:35 PM a "Health Status Note" documented R28 was found on the floor in the common area. R28 had bruising, redness, and swelling on the right side of his forehead and a skin tear on his right elbow.

On 03/05/25 09:51 AM, R28 sat in his wheelchair in the dining room. R28 had eggs and other food on his lap and there was not a plate or any fluids on the table in front of him. No nursing staff was noted in the dining room.

On 03/05/25 09:55 AM, no gripper strips were on the floor in front of R28's bed.

On 03/05/25 at 12:25 PM, Certified Nurse Aide (CNA) M stated R28 was a high fall risk. CNA M stated that R28 had a fall mat next to his bed when he was in bed.

On 03/05/25 at 12:50 PM, Licensed Nurse (LN) G stated that everyone had access to the resident's care plan. LN G stated that R28's fall interventions should be on his care plan and the staff could review the interventions from the Kardex (a nursing tool that gives a brief overview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41 of the care needs of each resident). LN G stated the charge nurse would try to come up with a new fall intervention. On 03/05/25 at 01:17 PM, Administrative Nurse D stated that R28 was now a high fall risk. Administrative Nurse D stated the management team would review the fall and the fall intervention. Administrative Nurse D stated she was not sure who would ensure past interventions were in place for the resident. The facility's undated "Fall Assessment" policy documented the purpose of the Fall Management Program, which was to develop, implement, monitor, and evaluate an interdisciplinary team fall prevention approach and manage strategies and interventions that foster resident independence and quality of life. The Fall Management Program promoted the safety, prevention, and education of both staff and residents. The facility failed to ensure the gripper strips were in place in front of R28's bed. This deficient practice placed R28 at risk of falls and possible injuries.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 42	F 698		

The facility identified a census of 69 residents. The sample included 18 residents, with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to consistently monitor and document Resident (R) 54's dialysis (a procedure where impurities or wastes were removed from the blood), shunt for bruit (blowing or swishing sound heard when blood flows through a shunt), thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt), and dressing. This deficient practice placed R54 at risk of potential adverse outcomes and physical complications related to dialysis.

Findings included:

- R54's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dialysis hypertension (HTN - elevated blood pressure), unsteadiness on his feet, muscle weakness, need for personal assistance, hearing loss, and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Significant Change Minimum Data Set" (MDS) for R54 dated 01/16/24 recorded a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R54 required dialysis during the observation period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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F 698	Continued From page 43	F 698		

R54's "Functional Abilities Care Area Assessment" (CAA) dated 01/16/24 documented R54 Functional abilities will be addressed in the care plan. R54 required the assistance of one with activities of daily living (ADL) and two persons with transfers due to a fractured shoulder.

R54's "Care Plan" dated 12/10/24 documented R54 required hemodialysis related to end-stage renal disease (a severe and irreversible condition where the kidneys lose their ability to function properly). R54 would have no signs and symptoms of complications from dialysis. Nurses would monitor thrill and bruit to the right upper extremity and obtain vital signs before and after dialysis. R54 would go to dialysis on Mondays, Wednesdays, and Fridays from 10:30 AM to 03:00 PM each dialysis day. Nursing staff were to encourage R54 to go to the scheduled dialysis appointments.

R54's EMR under the "Orders" tab dated 08/04/23 revealed the following physician's order: Dialysis Monday, Wednesday, and Friday at 08:45, check thrill and bruit to right lower extremity, and obtain vital signs (VS) before and after dialysis in the afternoon, every Monday, Wednesday, and Friday for dialysis, dated 12/27/24.

R54's EMR lacked documentation or direction for nursing staff to check R54's dressing, bruit, and thrill daily.

On 03/03/25 at 07:28 AM, R54 sat in her wheelchair waiting to go to breakfast. R54 was able to communicate with visitors, by using a maker board.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 44 On 03/04/25 at 08:00 AM, R54 sat in the dining room waiting for her breakfast with peers. On 03/05/25 at 12:52 PM, Licensed Nurse (LN) G stated nurses do not have a place to document daily monitoring of R54's dressing, bruit, and thrill. He stated he monitored the bruit and thrill daily. LN G stated the bruit and thrill should be monitored daily, and nursing should document the bruit and thrill were monitored daily. On 03/05/25 at 01:16 PM, Administrative Nurse D stated she thought the dressing, bruit, and thrill were monitored before and after dialysis days, and that information was documented on the dialysis communication sheet. Administrative Nurse D was unsure if the bruit and thrill were monitored or documented on the days R54 did not go to dialysis. She stated that information would be documented on the "Treatment Administration Record" (TAR). The facility's dialysis communication policy failed to cover the access site monitoring. The facility failed to consistently monitor and document R54's dialysis shunt for bruit, thrill, and dressing. This deficient practice placed R54 at risk of potential adverse outcomes and physical complications related to dialysis.	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 45	F 755		

§483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The sample included 18 residents, with one medication room and three medication carts. Based on observation, record review, and interviews, the facility failed to ensure controlled substances were accounted for and reconciled between shifts. This placed the residents at risk for misappropriation and/or diversion of controlled substances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 755	Continued From page 46	F 755		

Findings included:

- On 03/04/25 at 07:12 AM a review of the January, February, and March of 2025 "Shift Change Controlled Substance Inventory Count Sheet" on the 100 and 200, halls revealed a missing signature for the "On Nurse" were 02/14, 02/15, 02/16, 02/17, 02/18, 02/ 20, 02/22, 02/23, 03/01, and 03/02.

On 03/04/25 at 07:12 AM a review of January, February, and March of 2025 "Shift Change Controlled Substance Inventory Count Sheet" on the 100 and 200 halls revealed a missing signature for the "Off Nurse." The missing signatures for 02/02, 02/05, 02/18, 02/20, 02/22, and 02/28.

On 03/04/25 at 07:12 AM, Certified Medication Aide (CMA) S stated all CMAs or Nurses were to count the medication cards, and pills, and sign the count sheet. She stated she did not know what the process was if the count sheet was not signed.

On 03/05/25 at 12:52 AM, Licensed Nurse (LN) G stated the CMAs were to count all cards and then count all narcotics per pill. The CMA with a nurse or another CMA was to count at the end of every shift with the incoming and outgoing nurse or CMA.

On 03/05/25 at 01:16 PM, Administrative Nurse D said it was the policy to count cards, and pills, and sign each shift. She stated if the narcotic count was not signed, the CMA should take the sheet to the charge nurse or to the director of nursing to reconcile medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 47 The facility's "Controlled Substance" policy dated 12/24 documented that controlled substances were subject to special handling storage, disposal, and record-keeping requirements. The facility would maintain compliance with these special provisions. All controlled substances are to be counted every shift The count was to be performed by the oncoming LN or CMA where applicable and the off-going LN or CMT where applicable. The oncoming nurse or CMA would be responsible for viewing the controlled substance proof of use record to verify the amount on the record at the time of the count both nurse or CMA would sign the Narcotic sign in and out sheet. The facility failed to ensure an accurate reconciliation of controlled medications was completed. This placed residents at risk of medication misappropriation and diversion.	F 755		
F 756 SS=E	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 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	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 48	F 756		

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 identified a census of 69 residents. The sample included 18 residents with seven residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician reviewed and addressed the Consultant Pharmacist (CP) recommendations for Resident (R) 60's as needed antipsychotic medication (a class of medications used to treat major mental conditions that cause a break from reality). The facility also failed to ensure the CP identified and reported irregularities regarding the lack of dosing instructions for Voltaren (topical pain reliever medication) gel for R4. The facility also failed to ensure the physician reviewed and addressed the CP's recommendations for reeducation of R14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 49	F 756		

analgesics (pain relief) dosage. The facility also failed to ensure the physician had reviewed and addressed the CP's recommendation for R26's antidepressant (a class of medications used to treat mood disorders) medication. These deficient practices placed these residents at risk for adverse medication effects and unnecessary medications.

Findings included:

- R60's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Admission Minimum Data Set" (MDS) dated 10/14/24 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R60 had received antipsychotic medication, antianxiety (a class of medications that calm and relax people) medication, antidepressant (a class of medications used to treat mood disorders), and insulin (medication to regulate blood sugar) during the observation period. The MDS documented R60 had not completed a gradual dose reeducation (GDR) and the physician had not documented a GDR was clinically contraindicated. R11's MDS lacked documentation a medication regimen review was completed during the observation period.

The "Quarterly MDS" dated 01/14/25 documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 50	F 756		

a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R60 had received insulin, antipsychotic medication, and antidepressant medication during the observation period. The MDS documented R60 had not completed a gradual dose reeducation (GDR) and the physician had not documented a GDR was clinically contraindicated. R11's MDS lacked documentation a medication regimen review was completed during the observation period.

R60's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/21/24 documented a pharmacist would review and attempt a GDR as needed.

R60's "Care Plan" dated 10/29/24 documented staff would administer her medication as ordered. The plan of care documented the CP would review her medication monthly per protocol. The plan of care documented the nursing staff would monitor for side effects from her psychotropic medication.

R60's EMR under the "Progress Notes" tab revealed a "Consulting Pharmacy Note" dated 10/27/24 at 07:19 PM "Medication Regimen Review" (MRR) documented please see pharmacy recommendations in the report.

Review of the "Monthly Medication Review" (MMRs) from October 2024 to February 2025 provided by the facility revealed an MMR dated 10/28/24 that was reviewed and signed by the physician on 03/05/25. The MMR had indicated a 14-day stop date was required for any as-needed antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 51	F 756		

On 03/04/25 at 10:05 AM, R60 laid asleep on her bed. R11 was covered with a blanket and her call light was pinned next to her on the bed.

On 03/04/25 at 11:16 AM, Administrative Nurse E stated the facility was unable to provide June and July of 2024. Administrative Nurse E stated the pharmacy was unable to locate the MMRs.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated he did not take care of MMRs.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated she had only been in the facility since November 2024 and the pharmacy reviews may have been from the previous nursing administration. Administrative Nurse D stated the CP would email the MMRs to her and Administrative Nurse E. Administrative Nurse D Stated Administrative Nurse E would print the MMRs, and then have the attending physicians address the CP recommendations. Administrative Nurse D stated the facility had realized part of the process for addressing the MMR was missing and had not been completed as required.

The facility's "Medication Regimen Review (MMR)" (undated) indicated the CP would complete monthly medication reviews for each resident and report irregularities identified within the review. The policy indicated the CP will communicate their recommendations with the medical provider and Director of Nursing (DON).

The facility failed to ensure the physician reviewed and addressed the CP recommendations for R60's antipsychotic medication. This deficient practice placed R60 at risk for unnecessary medication use, side effects,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 52	F 756		

and physical complications.
- The "Medical Diagnosis" section within R4's Electronic Medical Records (EMR) included diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, aphasia (difficulty speaking), chronic kidney disease, and heart failure.

R4's "Admission Minimum Data Set (MDS)" dated 12/16/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance with transfers, bed mobility, dressing, toileting, bathing, and personal hygiene. The MDS noted no pain reported during the assessment. The MDS noted she took opioid (a class of controlled drugs used to treat pain) medication.

R4's "Psychotropic Drug Use Area Assessment (CAA)" completed 09/03/24 indicated she took antidepressants (a class of medications used to treat mood disorders). The plan instructed staff to observe for side effects. The CAA noted a care plan was implemented to address the risks of her medications.

R4's "Care Plan" initiated on 04/27/24 indicated she was at risk for pain related to her medical diagnoses. The plan instructed staff to monitor for signs/symptoms of pain and provide treatment. The plan noted she took medications with Black Box Warnings (BBW - the highest safety-related warning that medications can be assigned by the Food and Drug Administration).

R4's EMR under "Physician's Orders" revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 53	F 756		

order dated 10/01/24. The order instructed staff to administer Diclofenac Sodium External Gel topically (topical ointment used to treat pain) three times daily to affected areas for pain. The order lacked a dosage for administration.

A review of R4's "Monthly Medication Review" for 11/2024 revealed the Consultant Pharmacist (CP) identified R4's Diclofenac order lacked a dosage and site of application. The CP recommended clarifying the dosage amount and location of administration. The facility provided no documented response to the CP's recommendation.

On 03/04/25 at 07:30 AM, R4 sat in her wheelchair in her room. R4 was administered her medication but did not want her Diclofenac medication applied.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated all valid medication orders were to include the amount to be administered and the location of the application. He stated the facility was to take the pharmacy's recommendations and update the orders.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated all medication orders should have an accurate dosage amount to be given. She stated Diclofenac should be measured before administration to ensure the correct amount was given. She stated she had only been in the facility since November 2024 and the pharmacy reviews may have been from the previous nursing administration.

The facility's "Medication Regimen Review (MMR)" (undated) indicated the CP would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54	F 756		

complete monthly medication reviews for each resident and report irregularities identified within the review. The policy indicated the CP would communicate their recommendations with the medical provider and Director of Nursing (DON).

The facility failed to follow the CP's recommendations related to R4's Diclofenac medication. This placed R4 at risk for unnecessary medications and potential side effects.
- The "Diagnosis" tab of R14's Electronic Medical Record (EMR) documented diagnoses of obesity (excessive body fat), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hemiplegia (paralysis of one side of the body), affecting left nondominant side, muscle weakness, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), lack of coordination, need for assistance with personal care, cellulitis (bacterial infection of the skin and underlying tissues), and abnormalities of gait and mobility.

The " Quarterly Minimum Data Set (MDS)" dated 01/12/25, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R14 required substantial to maximum assistance for bathing and dressing, and was dependent on staff for toileting. The MDS documented R14 received antidepressants (a class of medications used to treat mood disorders) during the observation period.

The" Annual MDS" dated 07/12/24 documented a BIMS of 15 which indicated intact cognition. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55	F 756		

MDS documented R14 had impairment of one side of her body. The MDS documented R14 needed substantial to maximum assistance for bathing and dressing. R14 was dependent on staff for toileting. The MDS documented R14 received antidepressants during the look-back period.

R14's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 07/12/24 documented R14 takes medication for depression daily, and Licensed staff would monitor for symptoms of adverse reaction daily and document them. The pharmacist would review her medication quarterly and attempt to reduce it as needed.

R14's "Care Plan" dated 05/1023 documented R14 had depression and took an antidepressant. R14 would remain free of signs and symptoms of distress, symptoms of depression, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), or sad mood. Nursing staff were to monitor, document, and report to the physician any ongoing signs and symptoms of depression. Nursing staff were to administer medications as ordered and monitor and document any side effects and effectiveness.

R14's EMR under "Progress Notes" dated 06/26/24 documented see note regarding psychotropic gradual dose reduction (GDR) per pharmacy.
The facility was unable to provide upon request evidence of the Monthly Regiment Review (MRR) and that the physician had addressed the consulting pharmacist (CP) recommendation.

R14's EMR under "Orders" documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56	F 756		

following physician's order:
Trazadone (antidepressant medication) oral tablet, give 50 milligrams (mg), give 1.5 tablets by mouth at bedtime for difficulty sleeping.

Acetaminophen (APAP - analgesics) Tylenol Tablet Give 650 mg by mouth one time a day for pain Do Not Exceed 3 gm APAP/24 hours (hrs) Start Date of 02/20/24 - discontinue (D/C) date of 11/26/24.

Acetaminophen Tablet 325 MG Give two tablets by mouth every four hours as needed for pain Not To Exceed 3 gm/24 hrs -Start Date of 06/30/22 - D/C Date of 11/26/24.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated he did not review the MRR's from the CP.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated she realized a process had been broken when she was hired at the facility. She stated the facility was unable to produce the CP's recommendations for June and July of 2024. Administrative Nurse D stated the physician was unable to address and make recommendations for June and July of 2024.

The facility's "Psychotropic Medication Use" revised 12/24 documented the residents would only receive antipsychotic medication when necessary to treat specific conditions, for which were indicated.

The facility failed to ensure the CP identified and made recommendations related to R14's antidepressant medication, and analgesics. This placed R14 at risk for unnecessary psychotropic medications and possible toxicity-related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 57	F 756		

complications.

- The "Diagnosis" tab of R26's Electronic Medical Record (EMR) documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) non-dominant side, attention and concentration deficit, dysphagia (swallowing difficulty), memory deficit, muscle weakness, need for assistance with person care, difficulty in walking, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set (MDS)" dated 10/31/24, documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R26 required set up or touching for eating. and was dependent of staff for oral hygiene bathing, and dressing. The MDS documented R26 received antidepressant (a class of medications used to treat mood disorders), and antianxiety (a class of medications that calm and relax people), during the observation period.

The" Annual MDS" dated 01/29/25 documented a BIMS score of four which indicated severely impaired cognition. The MSD documented R26 set up or touching for eating, and was dependent of staff for oral hygiene bathing, and dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 58	F 756		

The MDS documented R26 received antidepressant and antianxiety medication during the observation period.

R26's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/09/24 documented R26 takes medication for depression and anxiety and staff would observe daily for adverse effects and document as needed. The CAA documented R26 would have a licensed pharmacist review and make recommendations for gradual dose reduction (GDR) as needed would be addressed in her care plan.

R26's "Care Plan" Date 02/05/2024 documented R26 had depression and took medication to assist with the management of signs and symptoms. R26 takes an antidepressant (a class of medications used to treat mood disorders) daily and tends to isolate herself in her room. Staff were to administer her medication as ordered by the physician and documented any side effects.

R26's EMR under "Orders" documented the following physician's order:
Sertraline HCL (antidepressant medication) 50 milligram (mg) give one tablet by mouth in the morning for depression dated 05/22/24.

A review of R26's EMR under progress revealed the following note under "Progress Notes" dated 06/26/20 documented see consulting pharmacy note regarding psychotropic gradual dose reduction (GDR).

The facility was unable to provide upon request evidence of the Monthly Regiment Review (MRR), and that the physician had addressed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 59 consulting pharmacist (CP) recommendation. On 03/03/25 at 07:19 AM, R26 laid on her bed asleep. On 03/04/25 at 08:24 AM, R26 was sitting in her Broda chair (specialized wheelchair with the ability to tilt and recline), in the dining room. 0n 03/04/25 at 10:05 AM Administrative Nurse E stated the facility was unable to find all of the CP's recommendation for residents done in June and July of 2024. She stated the facility was unable to obtain the records due to transferring pharmacist. On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated he did not review the MRR's from the CP. On 03/05/25 at 01:16 PM, Administrative Nurse D stated she realized a process had been broken when she was hired at the facility. She stated the facility was unable to produce the CP's recommendations for the months of June and July of 2024. She stated the physician was unable to address and make recommendations for the months of June and July of 2024. The facility's "Psychotropic Medication Use" revised 12/24 documented residents would only receive antipsychotic medication when necessary to treat specific conditions, for which they were indicated. The facility failed to ensure the CP identified and made recommendations related to R26's Sertraline. This placed R26 at risk for unnecessary psychotropic medications and related complications.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 60 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. The sample included 18 residents, with seven reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to ensure R4's Diclofenac (topical medicated ointment used to treat pain) medication had a dosage administration amount. This deficient practice placed both residents at risk for unnecessary medications and potential side effects. Findings Included:	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 61	F 757		

- The "Medical Diagnosis" section within R4's Electronic Medical Records (EMR) included diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, aphasia (difficulty speaking), chronic kidney disease, and heart failure.

R4's "Admission Minimum Data Set (MDS)" dated 12/16/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance with transfers, bed mobility, dressing, toileting, bathing, and personal hygiene. The MDS noted no pain reported during the assessment. The MDS noted she took opioid (a class of controlled drugs used to treat pain) medication.

R4's "Psychotropic Drug Use Area Assessment (CAA)" completed 09/03/24 indicated she took antidepressants (a class of medications used to treat mood disorders). The plan instructed staff to observe for side effects. The CAA noted a care plan was implemented to address the risks of her medications.

R4's "Care Plan" initiated on 04/27/24 indicated she was at risk for pain related to her medical diagnoses. The plan instructed staff to monitor for signs/symptoms of pain and provide treatment. The plan noted she took medications with Black Box Warnings (BBW - the highest safety-related warning that medications can be assigned by the Food and Drug Administration).

R4's EMR under "Physician's Orders" revealed an order dated 10/01/24. The order instructed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 62	F 757		

to administer Diclofenac Sodium External Gel topically three times daily to affected areas for pain. The order lacked a dosage for administration.

A review of R4's "Monthly Medication Review" for 11/2024 revealed the Consultant Pharmacist (CP) identified R4's Diclofenac order lacked a dosage and site of application. The CP recommended the facility clarify the dosage amount and location of administration. The facility provided no documented response to the CP's recommendation.

On 03/04/25 at 07:30 AM, R4 sat in her wheelchair in her room. R4 was administered her medication but did not want her Diclofenac medication applied.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated all valid medication orders were to include the amount to be administered and the location of the application.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated all medication orders should have an accurate dosage amount to be given. She stated Diclofenac should be measured before administration to ensure the correct amount was given.

The facility failed to provide a policy related to physician's orders as requested on 03/0625.

The facility failed to ensure R4's Diclofenac's order contained a dosage amount to be administered. This placed R4 at risk for unnecessary medications and potential side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758 SS=E	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 §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	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64	F 758		

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 "Medical Diagnosis" section within R57's Electronic Medical Records (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R57's "Admission Minimum Data Set (MDS)" dated 12/19/24 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS noted he required substantial to maximal assistance with transfers, toileting, bed mobility, bathing, and personal hygiene. The MDS noted he took anxiolytic medication.

R57's "Psychotropic Drug Use Area Assessment (CAA)" completed 12/28/24 indicated he was on hospice services and took antianxiety medication. The CAA instructed staff to monitor him for side effects. The CAA noted the consultant pharmacist (CO) would recommend a gradual dose reduction (GDR) as needed and a care plan was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 65	F 758		

R57's "Care Plan" initiated on 12/28/24 indicated he had a terminal illness of Parkinson's disease. The plan noted he was at risk for depression, anxiety, loss of interest in activities, and a decline in functioning. The plan instructed staff to administer his medications as ordered and monitor for side effects. The plan instructed staff to report changes in behavior or a decline in his daily functioning.

R57's EMR under "Physician's Orders" revealed an order started on 01/31/25. The order instructed staff to administer 0.5 milliliters of Lorazepam Oral Concentrate (medication used to treat anxiety) by mouth every four hours as needed (PRN) for anxiety. The order lacked a stop date or intended duration.

R57's EMR lacked documented rationale for the medication's extended use.

On 03/04/25 at 11:21 PM, R57 rested in his bed. R57 reported no concerns related to the medication regimen.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated all PRN psychotropic medications should have a stop date. He stated nursing staff should review the orders each day to ensure the medications were administered appropriately.

On 03/05/25 at 01:16 PM, Administrative Nurse D was not aware that R57's PRN Lorazepam medication required a stop date.

The facility's "Psychotropic Medication Use" revised 12/24 indicated the facility will ensure all PRN psychotropic medications were limited to 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 66	F 758		

days unless a longer timeframe was deemed appropriate.

The facility failed to implement a 14-day stop date on R57's PRN Lorazepam order or provide documentation showing the clinical necessity to continue the medication. This deficient practice placed R57 at risk for unnecessary medications and side effects.
The facility identified a census of 69 residents. The sample included 18 residents with seven reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to provide a 14-day stop-date on as-needed (PRN) anxiolytic (a class of medications that calm and relax people) medication or documented rationale of continued use for Residents (R) 57 and R60. The facility additionally failed to complete gradual dose reductions (GDR) for R14 and R26's antidepressant (a class of medications used to treat mood disorders) medications. This deficient practice placed the residents at risk for unnecessary psychotropic (alters mood or thought) medications and side effects.

Findings Included:

- The "Medical Diagnosis" section within R57's Electronic Medical Records (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 758	Continued From page 67	F 758		

R57's "Admission Minimum Data Set (MDS)" dated 12/19/24 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS noted he required substantial to maximal assistance with transfers, toileting, bed mobility, bathing, and personal hygiene. The MDS noted he took anxiolytic medication.

R57's "Psychotropic Drug Use Area Assessment (CAA)" completed 12/28/24 indicated he was on hospice services and took antianxiety medication. The CAA instructed staff to monitor him for side effects. The CAA noted the consultant pharmacist (CO) would recommend a gradual dose reduction (GDR) as needed and a care plan was completed.

R57's "Care Plan" initiated on 12/28/24 indicated he had a terminal illness of Parkinson's disease. The plan noted he was at risk for depression, anxiety, loss of interest in activities, and a decline in functioning. The plan instructed staff to administer his medications as ordered and monitor for side effects. The plan instructed staff to report changes in behavior or a decline in his daily functioning.

R57's EMR under "Physician's Orders" revealed an order started on 01/31/25. The order instructed staff to administer 0.5 milliliters of Lorazepam Oral Concentrate (medication used to treat anxiety) by mouth every four hours as needed (PRN) for anxiety. The order lacked a stop date or intended duration.

R57's EMR lacked documented rationale for the medication's extended use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 68	F 758		

On 03/04/25 at 11:21 PM, R57 rested in his bed. R57 reported no concerns related to the medication regimen.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated all PRN psychotropic medications should have a stop date. He stated nursing staff should review the orders each day to ensure the medications were administered appropriately.

On 03/05/25 at 01:16 PM, Administrative Nurse D was not aware that R57's PRN Lorazepam medication required a stop date.

The facility's "Psychotropic Medication Use" revised 12/24 indicated the facility will ensure all PRN psychotropic medications were limited to 14 days unless a longer timeframe was deemed appropriate.

The facility failed to implement a 14-day stop date on R57's PRN Lorazepam order or provide documentation showing the clinical necessity to continue the medication. This deficient practice placed R57 at risk for unnecessary medications and side effects.
- The "Diagnosis" tab of R14's Electronic Medical Record (EMR) documented diagnoses of obesity (excessive body fat), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hemiplegia (paralysis of one side of the body), affecting left nondominant side, muscle weakness, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), lack of coordination, need for assistance with personal care, cellulitis (bacterial infection of the skin and underlying tissues), and abnormalities of gait and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 69	F 758		

mobility.

The " Quarterly Minimum Data Set (MDS)" dated 01/12/25, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R14 required substantial to maximum assistance for bathing, and dressing, and was dependent on staff for toileting. The MDS documented R14 received antidepressants (a class of medications used to treat mood disorders) during the observation period.

The" Annual MDS" dated 07/12/24 documented a BIMS of 15 which indicated intact cognition. The MDS documented R14 had impairment of one side of her body. The MDS documented R14 needed substantial to maximum assistance for bathing and dressing. R14 was dependent on staff for toileting. The MDS documented R14 received antidepressants during the look-back period.

R14's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/12/24 documented R14 takes medication for depression daily, and a Licensed staff would monitor for symptoms of adverse reaction daily and document. The pharmacist would review her medication quarterly and attempt to reduce it as needed.

R14's "Care Plan" dated 05/1023 documented R14 had depression and took an antidepressant. R14 would remain free of signs and symptoms of distress, symptoms of depression and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), or sad mood. Nursing staff were to monitor, document, and report to the physician any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 70	F 758		

ongoing signs and symptoms of depression Nursing staff were to administer medications as ordered and monitor and document any side effects and effectiveness.

R14's EMR under "Progress Notes" dated 06/26/24 documented see note regarding psychotropic gradual dose reduction (GDR) per pharmacy.

The facility failed to provide upon request evidence of the Monthly Regiment Review (MRR), and that the physician had addressed the consulting pharmacist (CP) recommendation.

R14's EMR under "Orders" documented the following physician's order:
Trazadone (antidepressant medication) oral tablet, give 50 milligrams (mg), give 1.5 tablets by mouth at bedtime for difficulty sleeping.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated he did not review the MRR's from the CP.

On 03/05/25 at 01:16 PM Administrative Nurse D stated she realized a process had been broken when she was hired at the facility. She stated the facility was unable to produce the CP's recommendations for June and July of 2024. She stated the physician was unable to address and make recommendations for June and July of 2024.

The facility's "Psychotropic Medication Use" revised 12/24 documented residents would only receive antipsychotic medication when necessary to treat specific conditions, for which they are indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 71	F 758		

The facility failed to ensure the physician reviewed and addressed the CP recommendations for R14. This deficient practice placed R14 at risk for unnecessary medication use, side effects, and physical complications.

- The "Diagnosis" tab of R26's Electronic Medical Record (EMR) documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) non-dominant side, attention and concentration deficit, dysphagia (swallowing difficulty), memory deficit, muscle weakness, need for assistance with person care, difficulty in walking, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set (MDS)" dated 10/31/24, documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R26 required set up or touching for eating, and was dependent on staff for oral hygiene bathing, and dressing. The MDS documented R26 received antidepressants (a class of medications used to treat mood disorders), and antianxiety (a class of medications that calm and relax people), during the observation period.

The" Annual MDS" dated 01/29/25 documented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 72	F 758		

BIMS score of four which indicated severely impaired cognition. The MSD documented R26 set up or touching for eating, and was dependent on staff for oral hygiene bathing, and dressing. The MDS documented R26 received antidepressant and antianxiety medication during the observation period.

R26's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 01/09/24 documented R26 takes medication for depression and anxiety and staff would observe daily for adverse effects and document as needed. The CAA documented R26 would have a licensed pharmacist review and make recommendations for gradual dose reduction (GDR) as needed would be addressed in her care plan.

R26's "Care Plan" Date 02/05/2024 documented R26 had depression and took medication to assist with the management of signs and symptoms. R26 takes an antidepressant daily and tends to isolate herself in her room. Staff were to administer her medication as ordered by the physician and documented any side effects.

R26's EMR under "Orders" documented the following physician's order:

Lorazepam (antianxiety medication) oral concentrate two milligrams/milliliter (mg/ml) give 0.25 ml by mouth every four hours as needed (PRN) for anxiety and restlessness for 12 months starting on 09/06/24, ending on 09/06/25.

Sertraline HCL (antidepressant medication)50 milligram (mg) give one tablet by mouth in the morning for depression dated 05/22/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 73	F 758		

A review of R26's EMR under progress revealed the following note under "Progress Notes" dated 06/26/20 documented see consulting pharmacy note see note regarding psychotropic gradual dose reduction (GDR).

The facility was unable to provide upon request evidence of the Monthly Regiment Review (MRR), and that the physician had addressed the consulting pharmacist (CP) recommendation.

On 03/03/25 at 07:19 AM, R26 laid on her bed asleep.

On 03/04/25 at 08:24 AM, R26 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room.

On 03/05/25 at 12:53 PM, Licensed Nurse (LN) G stated he did not review the MRR's from the CP.

On 03/05/25 at 01:16 PM, Administrative Nurse D stated she realized a process had been broken when she was hired at the facility. She stated the facility was unable to produce the CP's recommendations for June and July of 2024. She stated the physician was unable to address and make recommendations for June and July of 2024.

The facility's "Psychotropic Medication Use" revised 12/24 documented residents would only receive antipsychotic medication when necessary to treat specific conditions, for which they are indicated.

The facility failed to ensure the physician reviewed and addressed the CP recommendations for R26. This deficient practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 74 placed R26 at risk for unnecessary medication use, side effects, and physical complications.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. The sample included 18 residents, three medication carts, and one medication room. Based on observation, record review, and interviews, the facility failed to properly label medication in one of the three medication carts.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 75 This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - On 03/05/25 at 09:06 AM the licensed nurse medication cart on the 400 hallway contained one opened, undated insulin (a hormone that lowers the level of glucose in the blood) pen. On 03/05/25 at 09:06 AM, Licensed Nurse (LN) G stated all insulin pens should be labeled once they are removed from the refrigerator and placed into the medication cart. On 03/05/25 at 01:17 PM, Administrative Nurse D stated she expected all insulin pens to be dated and labeled once the pens were opened. The facility failed to provide a policy related to medication storage. The facility failed to properly label medications. This deficient practice could potentially cause adverse consequences or ineffective treatment to the affected residents.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 76	F 812		

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The facility had one main kitchen and one dining area. The facility failed to ensure that staff members properly tested and recorded the dish machine temperatures. This deficient practice placed residents at risk for contamination and food-borne illness.

Findings included:

- The initial tour of the facility on 03/03/25 at 07:29 AM review of the "Dish Machine Log" from 02/01/25 to 02/28/25 revealed 34 undocumented dish machine water temperature opportunities out 84 opportunities. The dish machine lacked a "Dish Machine Log" for 03/2025 was eight undocumented dish machine water temperatures.

On 03/03/25 at 07:30 AM, Dietary Aide CC stated the dish machine water temperature was checked all the time. Dietary Staff CC stated the "Dish Machine Log" for 03/2025 was in the Certified Dietary Manager's office.

On 03/04/25 at 12:06 PM, Dietary Staff BB stated the dish machine water temperature should be checked at least daily. Dietary Staff BB stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 77 had not posted the "Dish Machine Log" 03/2025. The facility's undated "Food Storage" policy did not cover the water temperatures for the dish machine. The facility failed to ensure that staff members properly tested and recorded the dish machine temperatures. This deficient practice placed residents at risk for contamination and food-borne illness.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive	F 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 78	F 838		

disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;
(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 79	F 838		

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	03/05/2025

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

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F 838	Continued From page 80	F 838		

resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The sample included 18 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergencies. This failure affected all 69 residents residing in the facility.

Findings Included:

- On 03/03/25 Administrative Nurse D provided a "Facility Assessment" updated 08/12/24. A review of the assessment revealed the following:

The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends.

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F 838	Continued From page 81 The assessment failed to identify the means of input gathered from the residents and their representatives when formulating the assessment data. The assessment lacked informed contingency plans for events that do not require activation of the facility's emergency plan but have the potential to impact resident care. On 03/05/25 at 01:34 PM Administrative Staff A stated he updated the assessment annually based on the changes that were put out by the Centers for Medicaid and Medicare Services (CMS). The facility's "Facility Assessment Quick Reference Guide" dated 08/2024 indicated the facility assessment was to be individualized to the community needs and developed utilizing evidence-based data-driven methods. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 69 residents residing in the facility.	F 838		
F 880 SS=E	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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	175218	A. BUILDING _____ B. WING _____	03/05/2025

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F 880	Continued From page 82	F 880		

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 §483.71 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

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F 880	Continued From page 83	F 880		

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 69 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to store oxygen saturation equipment and nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) tubing in a sanitary manner and further failed to ensure the required personal protective equipment (PPE) was worn while doing tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) care. This deficient practice placed the residents at risk for infectious diseases.

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F 880	Continued From page 84	F 880		

Findings included:

- On 03/03/25 at 07:08 AM, during the walk-through of the facility, Resident (R) 225's oxygen tubing and cannula were wrapped over her walker and her nebulizer tubing was on her side table, the tubing for R225 was not stored in a sanitary manner.

On 03/04/25 at 01:26 PM, Licensed Nurse (LN) G performed tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) care for R38 who was on enhanced barrier precautions. LN G donned sterile gloves to perform tracheostomy care but did not don a gown or mask to provide R38's care.

On 03/04/25 at 01:26 PM, LN G stated he was not aware he should have worn anything for PPE except gloves.

On 03/05/25 at 01:19 PM, Administrative Nurse D stated respiratory equipment not in use should be placed in a bag. She stated the assistant director of nursing has done training for staff; she was unsure if the staff had been trained on EHB. The Administrative Nurse D stated there are signs placed on doors for residents who are placed on EHB, for staff to follow.

The facility's "Infection Prevention and Control Program" policy documented the primary mission was to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 880	Continued From page 85 The facility failed to store oxygen saturation equipment and nebulizer tubing in a sanitary manner and further failed to ensure that required PPE was worn while doing tracheostomy care. This deficient practice placed the residents at risk for infectious diseases.	F 880		