STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW OF DERBY REHABILITATION & HEALTH CARE CEN	445 N WESTVIEW DR , DERBY, Kansas, 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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 1448814, 1448820, and 1448807 (KS00194345) .	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 62 residents; the sample included six residents reviewed for bowel movements and related monitoring. Based on observation, interview, and record review revealed the facility failed to monitor and respond to Resident (R)1 for lack of bowel movements. Findings included: - R1's Electronic Medical Records (EMR) documented diagnoses that included unspecified symptoms and signs involving cognitive functions and awareness (various disorders that affect an individual's intellectual capabilities and conscious perception of their surroundings), and constipation (difficulty passing stools). R1's 07/25/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS noted R1 was always incontinent of bladder, but bowels were unrated on the assessment; R1 did not have a toileting program, and/or constipation. R1's “Urinary Continence and Indwelling Catheter Care	F0684		

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 reverse for further 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.

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

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F0684 SS = D	Continued from page 1 Area Assessment" (CAA), dated 07/25/25, documented R1 was incontinent of bladder and bowel. Staff assisted him with peri-care check and changes with the assistance of two staff members. R1's "Care Plan" dated 9/06/25, documented R1 was incontinent of bowels and directed staff to take R1 to the toilet at the same time each day and provide peri-care for each incontinent episode. R1's "Care Plan" dated 02/18/25, documented R1 took pain medication and instructed staff to monitor for constipation. R1's "Physician Orders" in the EMR documented an order for Milk of Magnesia (laxative) 400 milligrams (mg)/5 milliliters (ml); give 15ml by mouth as needed for constipation, give at bedtime if no bowel movement in three days; ordered on 07/11/25. R1's "Physician Orders" in the EMR documented an order for sennosides (laxative) 8.6 mg by mouth every night for constipation; ordered on 07/12/25. Review of R1's bowel movement frequency in the EMR dated 08/24/25 through 9/16/25 revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 08/24/25 at 03:52 PM through 09/02/25 at 09:13 PM (nine consecutive days) with no medication given for constipation and no assessment documented. The EMR for the same timeframe listed above also revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 09/06/25 at 09:59 PM through 09/14/25 at 08:17 PM (eight consecutive days). On 09/12/25 (after six consecutive days with no bowel movement), R1 received Milk of Magnesia. The follow-up from the Milk of Magnesia was documented as unknown, with no additional explanation documented in the nurses' notes. No additional documentation concerning constipation was provided, and no assessment was documented. R1's "Tasks" documented a bowel movement on 09/14/25 at 08:17 PM. On 09/16/25 at 12:58 PM, R1 lay in bed. The bed was in the lowest position with a fall mat on the floor beside his bed. R1 reported he has had falls with broken bones. On 09/16/25 at 1:58 PM, Certified Medication Aide (CMA) R stated R1 was dependent on two staff members to take	F0684		

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F0684 SS = D	Continued from page 2 him to the toilet; R1 sometimes told staff when he had to go. CMA R said staff documented when residents had bowel movements. CMA R said she was not aware of R1 receiving medications for constipation, as she had not given him any. On 09/16/25 at 04:22 PM, Licensed Nurse (LN) G stated that staff monitor bowel movements and if there was no bowel movement in three days, the nurse would notify the provider. LN g said the nurse would listen to bowel sounds and would follow the standing orders. LN G said staff would definitely investigate and assess the resident and document it in the EMR if the resident went three to four days with no bowel movement. On 09/16/25 at 04:43 PM, Administrative Nurse D stated that the staff monitors the bowel movements, and the Certified Nurse Aides (CNA) were supposed to document bowel movements in the EMR, but it has not always been done. Administrative Nurse D said the nurse was supposed to monitor the EMR dashboard for alerts, as the EMR would alert staff if a bowel movement was not documented in three days. Administrative Nurse D said it was not always being followed up on, and she was working on getting staff to follow up on alerts. The facility did not provide a policy to address the monitoring of residents to prevent constipation.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 62 residents; the sample included six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement an intervention to prevent further falls after a fall with serious injury for Resident (R) 1.	F0689		

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F0689 SS = D	Continued from page 3 Findings included: - R1's Electronic Medical Records (EMR), documented diagnoses which included unspecified symptoms and signs involving cognitive functions and awareness (various disorders that affect an individual's intellectual capabilities and conscious perception of their surroundings), displaced intertrochanteric fracture of right femur with nonunion (a break in the right thigh bone, specifically in the area between the greater and lesser trochanters, where the bone fragments have shifted out of alignment and have failed to heal after a prolonged period, even after treatment), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, and a history of falling. R1's 07/25/25 "Significant Change Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS documented R1 had two or more noninjury falls, two or more falls with an injury that was not severe, and one fall with a major injury. R1's 07/25/25 "Falls Care Area Assessment" (CAA) documented R1 required the assistance of two staff and a mechanical lift for transfers and required a wheelchair for mobility. R1's "Care Plan", dated 12/20/24, documented R1 was at high risk for falls, had numerous falls since admission, and was expected to have ongoing falls due to impulsivity and poor safety awareness. An intervention, dated 12/20/24, stated the facility was to provide non-skid footwear to R1. An intervention dated 02/13/25 stated the facility was to lower R1's bed to the lowest position and use a floor mat. An intervention dated 03/26/25 directed staff to ensure R1 had a call light and not to leave in the bathroom unattended; R1 required a bolstered mattress. An intervention, dated 06/18/25, stated that staff will get R1 up and bring him out to the living room area if he is awake in bed. An intervention dated 07/10/25 stated R1 sometimes puts himself on the fall mat beside his bed. R1's "Fall Investigation Report," written on 07/14/25, documented on 07/08/25 at 04:00 PM, staff left R1 unattended in the dining room. R1 stood up and fell. The intervention stated that the facility was to send R1 to the hospital for a femur fracture. The report lacked any intervention to prevent further falls.	F0689		

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F0689 SS = D	Continued from page 4 On 09/16/25 at 12:58 PM, R1 lay in bed at the lowest position with a fall mat on the floor beside his bed. R1 reported he had had many falls, rubbed his arm and leg, and stated he had gotten hurt. On 09/16/25 at 1:58 PM, Certified Medication Aide (CMA) R stated R1 had a lot of falls. Staff put his bed low, with a fall mat, and would sometimes sit with R1. CMA R said R1 was dependent on two staff members for assistance with care. CMA R reported if someone fell, the nurse would be called to assess them, get vital signs, and assist the resident up if safe to do so. CMA R stated staff were not involved in choosing the interventions for the falls and said the chosen interventions were not good. On 09/16/25 at 04:22 PM, Licensed Nurse (LN) G stated that when a resident fell, the staff would call the nurse and assess for range of motion, vital signs, any signs of injury, and initiate neurological checks. The nurse created an intervention, and the Director of Nursing (DON), MDS Coordinator, and Assistant DON would review the intervention and change it if needed. On 09/16/25 at 04:43 PM, Administrative Nurse D stated the previous DON had recently quit and oversaw the investigations for falls. Administrative Nurse D stated she was unable to find most of the investigations for the previous falls. Administrative Nurse D stated it was her expectation that the nurse on duty would put an intervention in the computer at the time of a fall; then a team of nurses would review the falls on the next working day to create an appropriate intervention and put the intervention into the computer. Administrative Nurse D stated staff just started doing fall huddles to discuss the fall at the time and started putting the intervention on the communication board. The facility's policy "Skilled Fall Policy" dated 05/2025, documented the community shall ensure that the Fall Program is maintained to reduce the occurrence of falls, reduce the risk of injury, and promote independence and safety. After each fall, an occurrence report will be completed, the root cause will be determined, and interventions will be implemented.	F0689		