STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47834 The facility identified a census of 116 residents. The sample includes 24 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial well-being and had the potential to affect all residents. Findings Included: - An inspection of the facility revealed a suggestion box, located inside a walkway area that required a door code to access. The facility inspection revealed the facility had no labeled grievance boxes in place. On 06/04/24 at 10:19 AM, the Resident Council (RC) members reported they were not aware of how to file a grievance, or if the facility provided a way to file an anonymous grievance. The RC members reported they turned their complaints into Social Services or would have a member of their family contact Social Services to file a complaint on their behalf. The RC members stated they were not aware of any grievance form drop box. On 06/04/24 at 11:17 AM Administrative Staff A stated the facility did not have a grievance box, and that the box in question was a suggestion box. Administrative Staff A stated their policy was that grievances are filed via email, phone calls, or through social services. Administrative Staff A further stated he believed the residents knew how to file grievances as the facility did receive grievances from the residents. On 06/05/24 at 12:42 PM Activity Staff Z stated she had not been in the facility long but was trained to have residents go to social services if the resident had a complaint. She reported that she did not know where the grievance box was or if the facility had one. Activity Staff Z further stated she was unaware if there was a way to file an anonymous grievance and did not know about the suggestion box in an area that required a code to access. Activity Staff Z stated she spoke with a member of the nursing staff, and she reported nursing staff told her they believed the grievance box was on the assisted living side of the facility and residents would have gone there to file a grievance. (continued on next page)

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.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided the Supporting the Right of Residents to Voices Grievances policy revised on 08/21/18, which documented a resident or their representative has the right to file grievances anonymously. A concern or complaint may be received in verbal or written form from any resident, responsible party, or family member. Residents and their families may also report a complaint or grievance in writing to any team member in the household or community using the Resident/Family Concern form located accessible to each neighborhood. The facility failed to implement a system to allow residents and their representatives to file grievances anonymously. This deficient practice placed all residents at risk for decreased psychosocial well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49634 The facility identified a census of 116 residents. The sample included 24 residents with two residents sampled for pressure ulcers (a localized injury to the skin and/or underlying tissue usually over a bony prominence, due to pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to ensure staff followed the intervention in place for pressure-reducing boots for Resident (R) 14 to prevent the possible development of a pressure ulcer. This deficient practice placed R14 at risk for complications associated with skin breakdown. Findings included: - R14's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), atrial fibrillation (rapid, irregular heartbeat), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN-elevated blood pressure), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) for R14 dated 03/06/24 recorded a Brief Interview for Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS recorded R14 as at risk for the development of pressure ulcers or injuries. The MDS documented that R14 needed a pressure-reducing device for the chair, a pressure pressure-reducing device for the bed, a turning or repositioning program, and ointments or medication. R14's Pressure Ulcer/Injury Care Assessment (CAA) dated 07/14/23 documented R14 required staff help with bed mobility. The MDS documented R14 had poor strength and endurance, muscle weakness, impaired mobility, and impaired balance and received medication with a Black Box Warning (BBW- the highest safety-related warning that medications can be assigned by the Food and Drug Administration. The CAA documented nursing staff were to provide incontinent care as needed, skin inspections, application of moisture barrier products, and the use of a specialty mattress with an air pump, heels up (a cushion to elevate the heels), turning and repositioning program, and a wheelchair cushion. R14's Care Plan dated 06/19/21 documented R14 as at risk for pressure ulcer development and other related skin issues due to mobility impairment. R14's skin would be checked each day. Nursing was to follow R14's toileting plan for repositioning. Nursing would provide a pressure-reducing cushion for R14's wheelchair. R14 would wear heel protector boots when in her bed and a heel-up cushion. On 06/05/24 at 07:23 AM R14 laid flat in her bed with her heels directly on the mattress. R14's boot was placed on the open bed. The resident did not have her heel-up cushion or boots in place and R14's heels laid directly on the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/24 at 07:36 AM Certified Nursing Aide (CNA) N stated all CNAs were to know what services R14 needed. CNA N stated when staff picked up hall assignments, each staff should also pick up a copy of the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). She stated the Kardex was a brief description of the care required for each resident. Nurses would let any staff member know where the Kardex's were kept. On 06/05/24 at 01:32 PM Licensed Nurse (LN) I stated all nursing staff were responsible for ensuring residents needing special equipment or devices were put in place. LN H stated all nursing staff had access to the plan of care and Kardex. On 06/05/24 at 03:00 PM Administrative Nurse D, stated all nursing staff was responsible for resident care. Administrative Nurse D stated if a resident needed heels elevated or boots, they should have been in place. The facility policy Pressure Injury Prevention and Management Policy, last revised in January 2018, documented that all residents were considered to have some risk for the development of pressure ulcers. Select the appropriate interventions based on the needs and preferences of the resident in the resident's care plan. Some of the possible interventions to assist with reducing the risk included placing a pillow or HeelZup (a cushion device that elevates the heel off the bed surface) under the lower legs to raise the heels off the bed when the resident was lying on their back as indicated on the plan of care. The facility failed to implement pressure-reducing interventions for r14's heels. This deficient practice placed R14 at risk for complications associated with skin breakdown.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 116 residents. The sample included 24 residents with five residents reviewed for falls. Based on observation, record review, and interviews, the facility failed to identify and implement appropriate, resident-centered interventions to prevent falls for cognitively impaired Resident (R) 96. This placed R96 at risk for additional falls and or injuries. Findings included: - R96's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses sequelae of cerebrovascular accident (CVA-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), vascular dementia (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic kidney disease (kidneys are damaged and can't filter blood the way they should), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot responded to the insulin), and aphasia (condition with disordered or absent language function). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R96 had two or more falls in the review period. The MDS documented R96 was independent with eating. The MDS documented R96 dependent on staff for hygiene and toileting. The Cognitive Loss/Dementia Care Assessment (CAA) dated 07/25/23 documented R96 had a BIMS of three and instances of refusing care during the observation period. R96 had a diagnosis of CBA, cognitive communication deficit, and a recent dramatic change in independence. R96 had moderate to severe impairment in decision which may result in unsafe behavior and potential for injury, or difficulty with performance of activities of daily living (ADLs). The Falls CAA dated 07/25/23 documented R96's balance was impaired. R96 had a CVA, cognitive communication deficit, recent dramatic change in independence, difficulty walking, and the need for assistance with personal care. R96 was at risk of falls due to balance problems and needed assistance for support during transfers and gait. R96 received staff support. Nursing staff were to provide safety cues, monitoring, a hi-low bed, perimeter mattress, gait belt, pendent call light, use of pancake call light at the bedside, and a pull string style call light in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R96's Care Plan dated 08/07/23 documented R96 was at risk for falls, due to her diagnosis. The plan of care documented on 08/05/23 staff were to encourage R96 to always wear nonskid footwear. The plan of care dated 08/07/23 documented nursing was to involve R96 in a restorative nursing program as needed, place her bed against the wall, place a perimeter mattress to orient R96 to the edge of the bed, place personal items within R96's reach, and orientate R96 to her surroundings every time staff left the room. The plan of care noted R96 might attempt to self-transfer and staff were to help. R96 used a bed cane for positioning. R96's plan of care dated 12/05/23 documented anti-rollback and anti-tip mechanisms on the wheelchair for safety. The plan of care dated 12/19/23 documented that in R96's culture, it was custom to kneel to pray on the floor next to the bed with hands clutched. R96 does not always explain to nursing staff. The plan of care dated 02/25/24 documented that staff were to provide a double stacked call light with one call light on the wheelchair and one on R96's bed. R96's cupholder should be placed on the wheelchair for the fluid of choice. The Nursing Note dated 01/12/24 documented a witnessed fall without injury. R96 was holding onto the counter and went to the floor slowly. A new intervention for R96's fall documented staff was to ensure the foot pedals were removed when R96 sat in her wheelchair. Staff to use foot pedals if staff are pushing R96. A Nursing Note dated 01/13/24 documented an unwitnessed fall without injury. R96 was found seated on the floor by her bed. New interventions for R96's fall documented staff to continue with the care plan. Staff were to allow R96 space when she was resistant to care and return shortly. The Nursing Note dated 01/22/24 documented an unwitnessed, non-injury fall. R96 was found on the floor seated next to her bed with her knees bent and her arms folded around them. The new fall intervention documented that staff were to continue to follow the care plan. Staff were to allow space when the resident was resistant and encourage her to allow staff to assist and check on her frequently. The Nursing Note dated 02/02/24 documented R96 was observed on her hands and knees in the Den, her wheelchair was behind her, and no injury was noted. A new intervention for the fall documented that if R96 was observed closing a door behind her, staff were to encourage her to participate in an activity. The Nursing Note dated 02/04/24 documented R96 had a witness fall without injury, she was trying to put snacks away and fell on her right side. New interventions documented staff to encourage and assist R96 to a quiet area or to her room to relax when not ready for bed. The Nursing Note dated 02/09/24 documented R96 was found in the sunroom on her hands and knees with her wheelchair behind her, the fall was unwitnessed without injury. New intervention for fall included staff to adjust the toileting schedule. The Nursing Note dated 02/25/24 documented R96 had an unwitnessed fall. R96 lay on her right side, in her room by the TV. R96's wheelchair was on her left side, and no injuries were noted. New interventions for fall included a double pancake light was ordered, and staff were to place one on the wheelchair and one on R96's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Note dated 03/25/24 documented that R96 was found on the floor near her bed. R96 was seated on her bottom with knees to her chest and her wheelchair was behind her in a locked position. There was no injury noted. The new intervention included staff checking on R96 often and offering to assist her with her night clothing around 07:00 PM. The Nursing Note dated 03/31/24 documented R96 had an unwitnessed fall in the hallway. R96 was kneeling holding onto the wheelchair with her hands. R96 had no injury. A new intervention was to place a cup holder on the wheelchair for fluid choices. The Nursing Note dated 04/04/23 documented R96 had a witnessed fall in her room, with no injury. The new intervention included assisting R96 to the bathroom prior to changing her clothing. The Nursing Note dated 04/21/24 documented R96 had an unwitnessed fall with no injury. The nursing note documented R96 was seated on her bottom in front of the nurse's station with her wheelchair directly behind her. The new intervention included a medication review, and if R96 was in a crowded space and getting agitated with other residents, staff were to assist R96 to a more open space and allow others to pass by. The Nursing Note dated 05/15/24 documented R96 had an unwitnessed without injury. The nursing note documented R96 lying on her right side on the floor next to her bed with the wheelchair within her reach. The new intervention for R96 fall was to give printed paper which included basic math addition worksheets and place worksheets in R96's room. A Nursing Note dated 05/20/24 documented R96 had a witnessed fall without injury. New intervention for R96's fall included staff continuing to provide observation and safety when the resident was observed standing without assistance. On 06/02/24 at 10:14 AM R96 was in the commons area. She sat behind the couch in her wheelchair looking at her peers. On 06/04/24 at 07:18 AM R96 laid in bed on her right side. R96 wore a purple stocking hat, with blankets pulled up around her. During an interview on 06/05/24 at 01:05 PM Certified Nurse Aide (CNA)R stated he knew the interventions for falls by looking at the Kardex. During an interview on 06/05/24 at 01:34 PM Licensed Nurse (LN) I stated R96 had several falls in the last six months. LN I stated all nursing staff have tried to come up with interventions. LN I said when residents fall a new intervention was placed in the resident's care plan. During an interview on 06/05/24 at 03:00 PM, Administrative Nurse D stated she had started a performance improvement plan (PIP) for all falls. Administrative Nurse D stated she did not feel the fall interventions were person-centered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Fall Prevention and Management Protocol, last revised 06/28/23, documented: The interdisciplinary team (IDT) would develop a plan for care with interventions that would reduce the resident's risk for falls. The plan would include specific information about the resident's routine and personal habits that may place the resident at risk for falls. After a fall the plan of care would be reviewed, and a new intervention would be added if appropriate to help prevent future falls if appropriate. The IDT would review the fall in the risk meeting or skilled meeting making appropriate recommendations to the plan of care to help prevent falls. The neighborhood nurse and team would work on possible interventions that were individualized to each resident who was at high risk for falls and would communicate the new fall intervention in the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) (care plan) and the master care plan. The facility failed to identify and implement appropriate, resident-centered interventions to prevent falls for R96, who was cognitively impaired. This placed R96 at risk for additional falls and or injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 116 residents. The sample included 24 residents with three residents reviewed for bowel and bladder. Based on observations, record review, and interviews, the facility failed to provide the necessary care and services related to incontinence (lack of voluntary control over urination or defecation) care for Resident (R) 33, who had a history of urinary tract infections (UTI- infection of the urinary tract system) and failed to provide the necessary care and services related to indwelling catheters for R415. This deficient practice placed R33 and R415 at risk for UTIs and related complications. Findings included: - R33's Electronic Medical Record (EMR) documented diagnoses of overactive bladder (a bladder control problem that leads to the sudden urge to urinate), need for assistance with personal care, dementia (a progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Annual Minimum Data Set (MDS) dated [DATE], documented R33 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R33 required substantial/maximal assistance with toileting hygiene, sit-to-standing transfers, chair/bed-to-chair transfers, and toilet transfers. R33 was frequently incontinent of urine and always continent of bowel movements. The Quarterly MDS dated [DATE], documented R33 had a BIMS score of eight which indicated moderate cognitive impairment. R33 required substantial/maximal assistance with toileting hygiene, sit-to-standing transfers, chair/bed-to-chair transfers, and toilet transfers. R33 was frequently incontinent of urine and bowel movements. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/02/24, documented R33 scored a 10 on her BIMS assessment and the cause of the problem was cognitive impairment related to Parkinson's disease. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 02/12/24, documented R33 needed help with ADLs and mobility. Nursing provided ADL, mobility, and transfer assistance as needed. The Urinary Incontinence and Indwelling Catheter CAA dated 02/12/24, documented R33 required assistance with toileting transfers and toileting hygiene. R33 was frequently incontinent and nursing provided toileting assistance, toilet transfers, skin cleansing and inspection, incontinence care as needed, and application of moisture-barrier product after each incontinent episode. R33's Care Plan dated 12/21/22, documented she had an impaired ability to take care of herself and needed help performing ADLs. The Care Plan directed R33 needed assistance with one staff member for bathing, ADLs, and dressing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Care Plan dated 12/21/22, documented she was incontinent or had the potential to be incontinent of urine and directed that R33 required assistance with one staff for peri-care (cleaning the genital and anal areas of a patient). R33's Care Plan dated 03/06/23, documented she had the potential for bowel incontinence and directed staff to provide peri-care with each incontinent episode, applied protective barrier cream after each incontinent episode, and monitored R33 for signs and symptoms of infection. R33's EMR revealed an Elimination Assessment on 05/06/24 that documented she needed extensive assistance with toileting and was occasionally incontinent of urine and bowel movements. Upon request, the facility provided urinalysis (UA-lab analysis of urine) with Culture and Sensitivity (CS- a test used to identify the type of organism causing an infection and the compounds the organism was sensitive or resistant to) results for the last six months for R33. The results revealed the following: R33 had a UA completed on 12/20/23 with CS results on 12/22/23 that documented R33 had a UTI caused by Escherichia coli (E. coli- bacteria that can cause infection). R33 had a UA completed on 01/12/24 with CS results on 01/17/24 that documented R33 had a UTI caused by Enterococcus faecium (E. faecium- bacteria that can cause infection). R33 had a UA completed on 02/11/24 with CS results on 2/13/24 that documented R33 had a UTI caused by E. coli. R33 had a UA completed on 03/10/24 with CS results on 03/14/24 that documented R33 had a UTI caused by E. coli. On 06/05/24 at 02:12 PM, Certified Nurse Aide (CNA) O was in R33's room with her while she was on the toilet. CNA O donned (put on) gloves and removed R33's soiled pull-up then placed a clean pull-up on R33. CNA O doffed (removed) gloves but did not perform hand hygiene before donning new gloves. CNA O gave the resident toilet paper to wipe her mouth then adjusted her left hearing aid. CNA P pushed the sit-to-stand lift (mechanical lift used for transfers) into the bathroom and donned gloves. CNA O placed R33's feet onto the sit-to-stand lift's footrest and then doffed gloves. She did not perform hand hygiene before donning new gloves. CNA O pulled several wipes out of the wipe package located on the back of the toilet and held them in her right hand. She adjusted R33's pants to get her ready to stand up and the wipes touched the pants. CNA P lifted R33 up with the sit-to-stand and CNA O used one wipe to wipe R33's peri-area from behind one time. CNA O placed the other wipes on top of the wipe package and then doffed her gloves. She did not perform hand hygiene before donning new gloves. CNA O used one wipe to wipe R33's peri-area from behind, she used the same wipe for four swipes, then grabbed another wipe and used that same wipe for three swipes. CNA O grabbed a tube of barrier cream out of the drawer beside the sink and applied it with the same gloved hand she used to wipe R33 with. CNA O doffed gloves and then donned new gloves without performing hand hygiene. CNA P doffed gloves then pulled R33 out of the bathroom with the sit-to-stand lift and positioned her into her wheelchair with CNA O's assistance. After R33 was disconnected from the lift, CNA O doffed gloves and performed hand hygiene. CNA O gathered up the trash while CNA P put R33's foot pedals on and placed her at her table. CNA P then performed hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 02:28 PM, CNA O stated staff completed hand hygiene before and after providing care. She stated if gloves were removed during peri-care then hand hygiene should be completed before putting new gloves on. CNA O stated to prevent contamination during peri-care, staff used a different wipe with every swipe, and the wipes were pulled out one at a time. She stated she did not put wipes on top of the package. During an interview on 06/05/24 at 02:35 PM, Licensed Nurse (LN) J stated staff completed hand hygiene before starting peri-care and donned gloves. She stated after the dirty portion of peri-care was completed, staff removed gloves and washed hands before putting new gloves on to complete the clean portion of peri-care. LN J stated staff prevented contamination during peri-care by using one wipe per swipe, not using the same wipe, or folding the wipe over to continue to use. She stated wipes were pulled out one at a time. During an interview on 06/05/24 at 02:41 PM, Administrative Nurse D stated staff completed hand hygiene when entering resident rooms and got the resident ready before peri-care was started. She stated staff sanitized their hands again and then donned gloves. Administrative Nurse D stated staff wiped front-to-back for females then removed their gloves and sanitized their hands before putting new gloves on. She stated staff used one wipe per swipe and held the wipes in their clean hand or put them on a clean surface to prevent contamination of the wipes. The facility's Female Perineal Care policy, last revised 08/22/08, directed staff to perform the following for perineal procedure: collected equipment, washed their hands, explained the procedure to the resident, put on gloves, cleaned the anal area first by wiping with wet washcloth or perineal wipes from the vagina towards the anus with one stroke, discarded soiled washcloth or soiled wipe and repeated with clean washcloth or wipe until skin was clear of fecal material, discarded gloves into trash and washed hands, put on clean gloves, used a clean washcloth or perineal wipe to cleanse perineal area and used a clean washcloth or perineal wipe for each wipe until no fecal material was present on skin, then removed gloves and washed hands. The facility failed to provide the necessary care and services to R33, who had a history of UTIs. This deficient practice had the risk for UTIs and unwarranted physical complications for R33. 41037 - R415's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of overactive bladder, urinary retention (lack of ability to urinate and empty the bladder), dementia (a progressive mental disorder characterized by failing memory, confusion), and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE] was in progress and not completed. R415's Care Area Assessment (CAA) had not been completed. R415's Baseline Care Plan dated 05/26/24 documented she had a Foley catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and staff would monitor for signs or symptoms of urinary tract infections. The plan of care documented she used a dependent drainage bag at night and a urinary leg bag during the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R415's EMR under the Orders tab revealed the following physician orders: Change Foley catheter monthly with French 15 due to urine retention dated 05/26/24. Replace Foley catheter monthly with French 15 as needed due to urine retention dated 05/26/24. Replace urinary leg bag and dependent drainage bag weekly dated 05/26/24. May change urinary dependent drainage bag to urinary leg bag during the day. Rinse bags after disconnection daily dated 05/26/24. Change urinary leg bag to dependent drainage bag at bedtime. Rinse bags after disconnection dated 05/26/24. Catheter care every shift twice daily dated 05/26/24. Empty the catheter drainage bag at the end of each shift and record results in the vital sign section in the EMR twice daily dated 05/26/24. Hiprex (medication used to suppress UTI) one gram give one tablet by mouth twice daily with meals for urinary tract infection (UTI) dated 05/28/24. During an observation on 06/05/24 at 06:48 AM R415 laid on her bed. Licensed Nurse (LN) H washed her hands and donned gloves. She opened the room door to exit the room to obtain an isolation gown from the bin outside the room. LN H returned to R415's room, closed the door, and donned the isolation gown. LN H failed to doff her gloves and perform hand hygiene and apply clean gloves. LN H assisted R415 with raising the left-leg pajama pants. LN H obtained the urinary leg bag from the bathroom and laid the bag on the foot of R415's bed. LN H failed to perform hand hygiene and change gloves prior to cleaning the tip of the urinary leg bag. LN H disconnected the dependent drainage bag from R415's catheter and attached the leg bag to R415's catheter. LN H rinsed R415's dependent drainage bag and placed it in a plastic bag in the bathroom. LN H doffed her gloves and donned a new glove. LN H failed to perform hand hygiene between the glove change. During an interview on 06/05/24 at 06:48 AM, Licensed Nurse (LN) H stated she should have performed hand hygiene between glove changes during R415's urinary leg bag change. During an interview on 06/05/24 at 11:37 AM, Administrative Nurse E, the facility infection preventionist, stated staff should perform hand hygiene between glove changes, going from dirty to clean or if visibly soiled. Administrative Nurse E stated the facility had frequent hand hygiene education when there was an increase in urinary tract infections noted. Administrative Nurse E stated the facility had yearly skills fair for nursing staff to review the infection control procedures. During an interview on 06/05/24 at 02:41 PM, Administrative Nurse D stated staff completed hand hygiene when entering resident rooms and got the resident ready before catheter care was started. She stated staff sanitized their hands again and then donned gloves. Administrative Nurse D stated staff should perform hand hygiene between glove changes. (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Caring for a Resident with a Urinary Catheter policy last revised 04/2011 documented that catheter care would be provided daily and when there was the possibility of fecal incontinence. The facility failed to ensure the standard of care was provided during catheter care for R415 for a resident who was being treated for UTI. This deficient practice placed R1415 at risk of catheter-related complications and further UTIs.

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	175242	A. Building B. Wing	06/05/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 116 residents. The sample included 24 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure the oxygen tubing was stored in a sanitary manner to decrease exposure and contamination for Resident (R)413. This deficient practice placed R413 at increased risk for respiratory infection and complications. Findings included: - R413's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of pulmonary fibrosis (lungs become scared and damaged), need for assistance with personal care, and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Admission Minimum Data Set (MDS) dated [DATE] was in progress. R413's Care Area Assessment (CAA) was in progress. R413's Care Plan dated 05/29/24 documented staff would monitor for shortness of breath, assess his lung sounds, and give medications as ordered. R413's EMR under the Orders tab revealed the following physician orders: Oxygen at two liters per minute via nasal cannula. Oxygen sats every shift twice daily dated 05/30/24. During an observation on 06/03/24 at 10:17 AM, R413's nasal cannula lay directly on the floor next to R413's bed. During an interview on 06/05/24 at 06:48 AM, Licensed Nurse (LN) H stated R413's nasal cannula should never be placed on the floor. During an interview on 06/05/24 at 11:37 AM, Administrative Nurse E stated oxygen equipment should never be placed on the floor. During an interview on 06/05/24 at 03:00 PM, Administrative Nurse D stated oxygen nasal cannulas or oxygen masks should never be placed on the floor. Administrative Nurse D stated the nasal cannula or oxygen mask should be replaced to prevent respiratory infections. The facility's Nebulizer & Oxygen Storage and Cleaning policy dated 11/2021 documented the facility would ensure that a resident received nebulizer & oxygen services and care that was consistent with professional standards of practice and meeting the resident's goals and preferences. Oxygen tubing would be stored in a bag when not in use by the resident. (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R413's oxygen tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R413 at increased risk for respiratory infection and complications.

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	175242	A. Building B. Wing	06/05/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 116 residents. The sample included 24 residents with five residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 60 had a documented risk assessment, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R60 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. Findings included: - R60's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), abnormalities of gait, delirium (sudden severe confusion, disorientation, and restlessness), lack of coordination, cognitive-communication deficit, and hypertension (HTN-elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R60 had one non-injury fall since admission. The Quarterly MDS dated [DATE] documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented R60 was dependent on staff assistance for transfers and for the ability to move from a sitting to a standing position. R60's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/18/23 documented she had cognitive impairment, which placed her at risk for impaired decision-making. R60's Falls Care Area Assessment (CAA) dated 07/18/23 documented her balance was impaired related to her diagnosis of Alzheimer's disease. Contributing factors included a history of falls, poor safety awareness, poor decision-making skills, poor strength and endurance, muscle weakness, impaired balance, and impaired gait. R60's Care Plan dated 05/10/23 documented she had bilateral bed canes on her bed to assist with transfers and repositioning when in bed. A review of R60's EMR lacked evidence of a safety assessment for side rails, prior to the installation of side rails. The facility was unable to provide a risk assessment for side rails for R60. On 06/04/24 at 08:32 AM observation revealed R60 sat in her wheelchair next to her bed. The head of the bed was slightly elevated and there were bed canes in place on each side of her bed. During an observation on 06/05/24 at 06:15 AM R60 sat upright in her wheelchair with foot pedals on her wheelchair as nursing staff pushed her to her room. (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 02:47 PM, Administrative Staff A stated he was unable to locate a safety assessment for R60. Administrative Staff A stated the facility was going to initiate a performance-improving plan (PIP) to address the at-risk assessment for a resident's use of side rails. The facility's Bed [NAME] Assessment policy last revised 03/2010 documented the facility would ensure that residents receive appropriate assessment for the use of bed canes for positioning purposes only. The facility did not use side rails. Upon admission, if a bed cane were added then the therapy department or a nurse would assess the purpose of the bed cane, including why they need it and what alternatives were or not an option. The bed cane use would be reviewed for appropriateness, during the annual assessment and with quarterly assessments. No physician orders are needed for bed canes since the facility used them for positioning only. Bed Canes would only be utilized for assisting in residents maintaining their bed mobility. The facility failed to ensure that R60 had a documented risk assessment, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the resident at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

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	175242	A. Building B. Wing	06/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 116 residents. The sample included 24 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for Resident (R) 71 and R92, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). This placed these residents at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - R71's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R71 had received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), antidepressants (a class of medications used to treat mood disorders) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 99, and a staff interview indicated moderately impaired cognition. The MDS documented R71 had received antipsychotic medication, antianxiety medication, and antidepressant medication during the observation period. R71's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/06/23 documented she had received antidepressant, antianxiety, and antipsychotic medications and R71 was at risk for adverse side effects from the medications. R71's Care Plan dated 12/22/22 documented that staff would administer her medication as ordered and monitor for any side effects. R71's EMR under the Orders tab revealed the following Physician Orders: Trazodone (antidepressant) 50 milligram (mg) give half tablet (25 mg) by mouth twice a day for depression, dementia, and Alzheimer's disease, dated 05/30/24. Mirtazapine (antidepressant) 15mg tablet give half tablet (7.5 mg) by mouth at bedtime for insomnia (inability to sleep), dated 05/30/24. (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sertraline (antidepressant) 100 mg tablet give one tablet by mouth daily in the morning for anxiety, dated 05/30/24. Lorazepam (antianxiety) 0.5 mg tablet give one tablet by mouth every eight hours as needed for increased anxiety, dated 05/30/24, and had a stop date of 06/13/24. Risperidone (antipsychotic) 1 mg tablet give one tablet by mouth three times daily for Alzheimer's disease, dementia, dated 05/30/24. R71's clinical record lacked a physician-documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication for a resident with dementia. Upon request, the facility was unable to provide the physician's documentation. During observation on 06/05/24 at 06:33 AM, R71 slept on the couch in the common area. During an interview on 06/05/24 at 11:06 AM Administrative Nurse D stated the facility discussed residents taking antipsychotic medication during the daily meetings. Administrative Nurse D stated it was the goal of the facility for each resident taking antipsychotic medication to be on the lowest dose or be discontinued. Administrative Nurse D stated dementia was not an appropriate indication for the use of antipsychotic medication. The facility's Monitoring Residents on Psychotropic Drugs policy revised on 10/10/17, documented that each resident's psychotropic regimen would be managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Psychotropic medications would only be administered when necessary to treat a specific, diagnosed , and documented condition and when the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The use of non-pharmacological approaches for behavioral intervention would be implemented, unless contraindicated, to minimize the need for medications. The facility failed to provide a physician-documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication for R71. This deficient practice placed her at risk for unnecessary psychotropic medication and related complications. 49634 - R96's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses sequelae of cerebrovascular accident (CVA-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), vascular dementia (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic kidney disease (kidneys are damaged and can't filter blood the way they should), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and aphasia (a condition with disordered or absent language function). (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R96 had a diagnosis of dementia during the review. The Cognitive Loss/Dementia Care Assessment (CAA) dated 07/25/23 documented R96 had a BIMS score of three and had instances of refusing care during the observation period. R96 had a diagnosis of CVA, cognitive communication deficit, and a recent dramatic change in independence. R96 had a moderate to severe impairment in decision-making, which may result in unsafe behavior and potential for injury and/or difficulty with the performance of activities of daily living (ADLs). The Care Plan dated 01/09/24 documented R96 used psychotropic drugs, had depression, and vascular dementia with psychotic disturbances. Staff were to give R96's medication as ordered, monitor for signs and symptoms of depression and delusions, attempt non-pharmaceutical approaches prior to administering medications, and report any gait disturbances poor balance, dizziness, vertigo, or unsteady gait. The plan of care documented that staff should report any adverse symptoms, educate R96's family of adverse effects, approach R96 gently in a non-confrontational manner, and administer medication to assist with my depression and psychosis. The EMR under the Orders tab dated 04/29/24 documented staff to give Risperdal (a mood stabilizer or antipsychotic) give 0.5mg tab twice daily, for vascular dementia with psychotic disturbances. R96's clinical record lacked a physician-documented rationale which included nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication. Observation on 06/02/24 at 10:14 AM R96 sat in the commons area behind the couch in her wheelchair looking at her peers. On 06/05/24 at 11:06 AM Administrative Nurse D stated the facility discussed residents taking antipsychotic medication during the daily meetings. Administrative Nurse D stated it was the goal of the facility for each resident taking antipsychotic medication to be on the lowest dose possible or for the medication to be discontinued. Administrative Nurse D stated that dementia was not an appropriate indication for the use of antipsychotic medication. On 06/05/24 at 01:32 PM Licensed Nurse (LN) I stated she was unsure if dementia was an appropriate diagnosis for an antipsychotic drug. The facility's Monitoring Residents on Psychotropic Drugs policy revised on 10/10/17, documented that each resident's psychotropic regimen would be managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Psychotropic medications would only be administered when necessary to treat a specific, diagnosed , and documented condition and when the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The use of non-pharmacological approaches for behavioral intervention would be implemented, unless contraindicated, to minimize the need for medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure nonpharmacological interventions and risk versus benefits were attempted prior to the administration of antipsychotic medication for R96, who had a diagnosis of dementia. This placed the resident at risk for unnecessary psychotropic medications and related complications.

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	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50660 The facility identified a census of 116 residents. The facility had one main kitchen and two kitchenettes with dining areas. Based on observation, record review, and interview, the facility failed to ensure that staff stored and prepared food items in accordance with the professional standards for food service safety. This deficient practice placed the residents at risk for foodborne illnesses. Findings included: - On [DATE] at 07:17 AM, the initial tour of the kitchen revealed the following: Freezer number 12 had opened bags of frozen carrots, hash browns, sweet potato fries, French toast sticks, chicken wings, breaded okra, and curly fries that were not closed, labeled, or dated. Walk-in freezer number two had unlabeled and undated blueberries. Walk-in refrigerator number one had a rolling cart with a tray of macaroni and cheese and a tray of dried rice with butter that was not covered, labeled, or dated. Cooler number seven for leftover food had three containers of mashed potatoes, two containers of gravy, a tub of chicken base, and a container of chili that were not labeled or dated. Cooler number six had numerous plates of uncovered desserts that were dated [DATE]. Cooler number five had containers of cauliflower, blueberries, and tomatoes that were not dated. Observation on [DATE] at 07:34 AM revealed cooler number eight had six containers of unknown food not labeled or dated, a tray of small cups with lids that were not labeled or dated, and an opened half-gallon of milk that was not dated. Observation on [DATE] at 07:34 AM revealed the clean dish storage area had numerous bowls and ramekins in plastic containers that were not covered or all inverted. Observation on [DATE] at 07:38 AM revealed the walk-in refrigerator number three had a box of mandarin oranges that were leaking and a package of raspberries with mold visible. Observation on [DATE] at 07:41 AM revealed the dry storage had an opened back of pecans not dated or sealed. In the interview on [DATE] at 10:16 AM, Dietary CC stated all opened food items were to be wrapped closed, labeled, and dated before storing. She stated if she saw food that was not dated, then she threw it away unless somebody just started working on an item. Dietary CC stated dishes were stored underneath covers or upside down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	06/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the interview on [DATE] at 10:20 AM, Dietary BB stated dishes were kept covered and pots and pans were kept inverted. He stated if staff took food out of the original packaging, the items were kept wrapped or in a closable plastic bag and then discarded after three days. Dietary BB stated he expected frozen food items to be stored in closable plastic bags. He stated he expected the kitchen supervisor to inspect all food areas daily for outdated items, items not dated or labeled, and expired food. The facility's Food Storage policy, last revised in [DATE], directed food stored in the refrigerator were dated and labeled and tightly sealed with plastic wrap, foil, or a lid. The policy directed all food not in its original container was labeled and was good for seven days past the open date. The facility's Maintaining a Sanitary and Safe Food Preparation Area policy, last revised [DATE], directed areas for cleaning dishes and utensils were located in a separate area from the food service line to ensure a sanitary environment was maintained. The policy did not address the proper storage of dishes to prevent contamination. The facility failed to ensure that staff stored food items in accordance with the professional standards for food service safety and failed to store dishes inverted or covered. This deficient practice placed the residents at risk for foodborne illnesses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175242	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Village	13840 W 91st Terrace Lenexa, KS 66215

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 116 residents. The sample included 24 residents with six residents sampled for hospice services. Based on observation, record review, and interview, the facility failed to ensure a consistent method of communication process, including how the communication would be documented between the facility and the hospice provider, to ensure the needs of the resident were addressed and met 24 hours per day for Resident (R) 5. This placed R5 at risk of decline and/or from maintaining the highest practicable physical, mental, and psychosocial well-being. Findings included: - R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral atherosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque (fatty deposits) inside the artery walls, kidney disease(your kidneys are damaged and cannot filter blood the way they should), dementia (a progressive mental disorder characterized by failing memory, confusion), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R5's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R5 needed partial to moderated assistance with bathing and dressing. The MDS R5 had received hospice services while in the facility. R5's Functional/Rehabilitation Potential CAA dated 05/15/24 documented R5 needed help with activities of daily living (ADL). R5 had a balance deficit during transfers and gait. The MDS documented that R5 had the potential for further decline in ADLs and mobility. The MDS revealed R5 had graduated from hospice service. Nursing was to provide ADLs, mobility, and transfer assistance. R5's Care Plan dated 11/28/23 documented that R5 had impaired mobility and needed help with performing ADLs. R5 needed the assistance of one staff for ADLs, dressing, grooming, and bathing. R5's Care Plan lacked direction to staff for the collaboration of care and services with the hospice provider which included the services, frequency of visits, medications, and equipment provided by hospice. A review of the communication EMR under the Assessments and Hospice tab lacked documentation of collaboration of care for R5 from January 2024 through May 2024. Observation on 06/03/24 at 10:12 AM revealed R5 was sitting in her room in her wheelchair watching TV. Observation on 06/04/24 at 10:02 AM revealed R5 was up in her wheelchair. R5 was out in the hall visiting with nursing staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/23/24 at 10:59 AM Licensed nurse (LN) I stated the hospice providers had access to the facility's EMR. LN I stated hospice providers scanned documentation into EMR after each visit. LN I stated all services and equipment provided by the hospice could be found in the facility's plan of care for R5. On 06/05/24 at 03:00 PM Administrative Nurse D stated R5's plan of care should include all the services and equipment provided by the hospice provider. Administrative Nurse D stated the files were scanned into the EMR under the hospice tag for each visit. Administrative Nurse D stated the facility had to call the hospice provided to obtain the visits from 01/24-05/24. She stated the information was not scanned consistently and should have been scanned into the EMR with each visit. Administrator Nurse D stated we do have the information for each visit now, and the facility was scanning the files into R5's EMR. The facility's Hospice Services policy, last revised 04/24/24, documented the written hospice agreement would include a communication process including how the communication would be documented between the facility and the hospice provider to ensure the needs of the resident was addressed and met 24 hours a day. A plan of care would be established in coordination with the interdisciplinary team members(s), the physician, the resident, and/or designee. The plan of care would include the diagnosis, a common focus (problem) list and interventions, and what services the facility and/or hospice was responsible to provide. The facility failed to ensure collaboration between the facility and the hospice provider and failed to develop a care plan by the facility that included a description of the services, medication, and equipment provided to R5 by the facility. This deficient practice placed R5 at risk for delayed services which could affect her mental, and psychosocial well-being.

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	175242	A. Building B. Wing	06/05/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41037 The facility identified a census of 116 residents. The sample included 24 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to the implementation of procedures to monitor and prevent Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens, hand hygiene, placement of urinary dependent drainage bag, and the sanitary storage of respiratory equipment. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings included: - During an observation on 06/03/24 at 10:17 AM, Resident (R)413's nasal cannula was laid directly on the floor next to R413's bed, and a pile of soiled linen was laid directly on the right side of his bed. During an observation on 06/03/24 at 11:17 AM, R89 sat in his recliner in his room. R89's catheter tubing and catheter drainage bag were touching the floor. During an observation on 06/04/24 at 11:42 AM, R89 sat in his recliner in his room. R89's catheter drainage bag was hung from the pocket of his recliner and the bottom of the catheter bag touched the floor. During an observation on 06/05/24 at 06:48 AM R415 laid on her bed. Licensed Nurse H washed her hands and donned her gloves, she opened the room door to exit the room, to obtain an isolation gown from the bin outside the room. LN H returned to R415's room, closed the door, and donned an isolation gown. LN H failed to doff her gloves and perform hand hygiene. LN H assisted R415 with raising the left-leg pajama pants. LN H obtained the urinary leg bag from the bathroom and laid the bag on the foot of R415's bed. LN H failed to perform hand hygiene and change gloves prior to cleaning the tip of the urinary leg bag. LN H disconnected the dependent drainage bag from R415's catheter and attached the leg bag to R415's catheter. LN H rinsed R415's dependent drainage bag and placed it in a plastic bag in the bathroom. LN H doffed her gloves and donned a new glove. LN H failed to perform hand hygiene between glove changes. (continued on next page)

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	175242	A. Building B. Wing	06/05/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 06/05/24 at 02:12 PM, Certified Nurse Aide (CNA) O was in R33's room with her while she was on the toilet. CNA O donned (put on) gloves and removed R33's soiled pull-up then placed a clean pull-up on R33. CNA O doffed (removed) gloves but did not perform hand hygiene before donning new gloves. CNA O gave the resident toilet paper to wipe her mouth then adjusted her left hearing aid. CNA P pushed the sit-to-stand lift (mechanical lift used for transfers) into the bathroom and donned gloves. CNA O placed R33's feet onto the sit-to-stand lift's footrest and then doffed gloves. She did not perform hand hygiene before donning new gloves. CNA O pulled several wipes out of the wipe package located on the back of the toilet and held them in her right hand. She adjusted R33's pants to get her ready to stand up and the wipes touched the pants. CNA P lifted R33 up with the sit-to-stand and CNA O used one wipe to wipe R33's peri-area from behind one time. CNA O placed the other wipes on top of the wipe package and then doffed her gloves. She did not perform hand hygiene before donning new gloves. CNA O used one wipe to wipe R33's peri-area from behind, she used the same wipe for four swipes, then grabbed another wipe and used that same wipe for three swipes. CNA O grabbed a tube of barrier cream out of the drawer beside the sink and applied it with the same gloved hand she used to wipe R33 with. CNA O doffed gloves and then donned new gloves without performing hand hygiene. CNA P doffed gloves then pulled R33 out of the bathroom with the sit-to-stand lift and positioned her into her wheelchair with CNA O's assistance. After R33 was disconnected from the lift, CNA O doffed gloves and performed hand hygiene. CNA O gathered up the trash while CNA P put R33's foot pedals on and placed her at her table. CNA P then performed hand hygiene. The facility provided a policy related to Legionella testing but was unable to provide a plan, facility based risk assessment, or procedures and monitoring related to Legionella prevention. During an interview on 06/05/24 at 06:48 AM, Licensed Nurse (LN) H stated that R413's nasal cannula should never be placed on the floor and soiled linen should never be placed on the floor. LN H stated she should have performed hand hygiene between glove changes during R415's urinary leg bag change. During an interview on 06/05/24 at 11:37 AM, Administrative Nurse E, the facility infection preventionist, stated staff should perform hand hygiene between glove changes, going from dirty to clean or if visibly soiled. Administrative Nurse E stated the facility had frequent hand hygiene education when there was an increase in urinary tract infections noted. Administrative Nurse E stated the facility had a yearly skills fair for nursing staff to review the infection control procedures. During an interview on 06/05/24 at 01:47 PM Administrative Staff A stated there was not a facility specific risk assessment for identification for Legionella disease completed. Administrative Staff A stated he had downloaded the requirements from the Centers for Disease Control (CDC) website. During an interview on 06/05/24 at 02:28 PM, CNA O stated staff completed hand hygiene before and after care. She stated if gloves were removed during peri-care then hand hygiene should be completed before putting new gloves on. CNA O stated to prevent contamination during peri-care, staff used a different wipe with every swipe, and the wipes were pulled out one at a time. She stated she did not put wipes on top of the package. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/05/24 at 02:35 PM, Licensed Nurse (LN) J stated staff completed hand hygiene before starting peri-care and donned gloves. She stated after the dirty portion of peri-care was completed, staff removed gloves and washed hands before putting new gloves on to complete the clean portion of peri-care. LN J stated staff prevented contamination during peri-care by using one wipe per swipe, not using the same wipe, or folding the wipe over to continue to use. She stated wipes were pulled out one at a time. During an interview on 06/05/24 at 02:41 PM, Administrative Nurse D stated staff completed hand hygiene when entering resident rooms and got the resident ready before peri-care was started. She stated staff sanitized their hands again and then donned gloves. Administrative Nurse D stated staff wiped front-to-back for females then removed their gloves and sanitized their hands before putting new gloves on. She stated staff used one wipe per swipe and held the wipes in their clean hand or put them on a clean surface to prevent contamination of the wipes. During an interview on 06/05/24 at 03:00 PM, Administrative Nurse D stated staff completed hand hygiene when entering resident rooms and got the resident ready before catheter care was started. She stated staff sanitized their hands again and then donned gloves. Administrative Nurse D stated staff should perform hand hygiene between glove changes. During an interview on 06/05/24 at 02:41 PM, Administrative Nurse D stated staff completed hand hygiene when entering resident rooms and got the resident ready before peri-care was started. She stated staff sanitized their hands again and then donned gloves. Administrative Nurse D stated staff wiped front-to-back for females then removed their gloves and sanitized their hands before putting new gloves on. She stated staff used one wipe per swipe and held the wipes in their clean hand or put them on a clean surface to prevent contamination of the wipes. The facility's Caring for a Resident with a Urinary Catheter policy last revised 04/2011 documented that catheter care would be provided daily and when there was the possibility of fecal incontinence. The facility's Nebulizer & Oxygen Storage and Cleaning policy dated 11/2021 documented the facility would ensure that a resident received nebulizer & oxygen services and care that was consistent with professional standards of practice and meeting the resident's goals and preferences. Oxygen tubing would be stored in a bag when not in use by the resident. The facility's Infection Control Program policy dated 05/2024 documented hand hygiene had frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and was an essential element of standard precautions. The term Hand Hygiene includes both hand washing with either plain or antimicrobial soap and water and the use of alcohol-based products (gels, rinses, foams) containing an emollient that does not require water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Female Perineal Care policy, last revised 08/22/08, directed staff to perform the following for perineal procedure: collected equipment, washed their hands, explained the procedure to the resident, put on gloves, cleaned the anal area first by wiping with wet washcloth or perineal wipes from the vagina towards the anus with one stroke, discarded soiled washcloth or soiled wipe and repeated with clean washcloth or wipe until skin was clear of fecal material, discarded gloves into trash and washed hands, put on clean gloves, used a clean washcloth or perineal wipe to cleanse perineal area and used a clean washcloth or perineal wipe for each wipe until no fecal material was present on skin, then removed gloves and washed hands. The facility failed to ensure proper infection control standards were followed related to the implantation of a procedure or plan to monitor and prevent Legionella disease or other opportunistic waterborne pathogens, hand hygiene during catheter care, and peri care, storage of oxygen equipment, proper placement of soiled linen, and catheter bags resting on the floor. This deficient practice placed the residents at risk for complications related to infectious diseases.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41037 The facility identified a census of 116 residents. The sample included 24 residents with five residents reviewed for immunizations. Based on record review, and interviews, the facility failed to obtain consent or declinations for Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination or administration information for Residents (R) 53 and R71. This placed the residents at increased risk for complications related to pneumonia. Findings included: - Review of R53's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R71's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. Upon request for R53's and R71's declination or administration of PCV20, the facility was unable to provide consent or declination. During an interview on 06/05/24 at 11:37 AM, Administrative Nurse E, the facility infection preventionist, stated that R53 and R71 had a history of refusing all pneumococcal vaccinations offered in the past. Administrative Nurse E stated she was unable to locate a declination or consent for R53 or R71. The facility's Administration of Pneumococcal Vaccine to Residents policy revised 12/2022 documented to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal disease, the facility would ensure that all residents would be offered the pneumococcal vaccine injection as desired by the resident and approved by the primary care physician. The facility failed to obtain PCV20 consents, declinations, or administration information for R53 and R71 who were eligible to receive the vaccination. This placed R53 and R71 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.