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	04/22/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria. Finding included:- During the initial tour of the main kitchen on 04/20/26 at 08:00 AM, observation revealed the kitchen did not have foot activated trash cans by the hand-washing station, and four of the trash cans did not have lids. The kitchen refrigerator had two bags of diced onions without a date, and one bag was open to air. In the freezer, one bag of hash browns was left open, and in the dry storage one can of prunes had a dent.On 04/20/26 at 08:20 AM, observation of the rehabilitation on the second floor's refrigerator revealed one box of hamburger patties left open to air, food particles in the cabinet drawers and dust or dirt in the grooves of the cabinet's doors.On 04/20/26 at 08:30 AM, observation of the third rehabilitation kitchen revealed one bag of biscuits in the freezer, which had a brown substance in the bottom of the freezer, also observed dried food particles in the crevices of the cabinet and dust. On 04/20/26 at 08:35 AM, observation of the second-floor satellite kitchen on long term care unit revealed a white food substance behind the soda machine which also had soda syrup on the sides of the machine.04/20/26 at 08:35 AM Dietary Director BB stated his staff needed to step up their game.The facility's policy Maintaining a Sanitary and Safe Food Preparation Area revised 06/25/24. The purpose of this policy is to ensure that the facility will maintain a clean, sanitary and safe food preparation area. All machines and equipment that require cleaning shall be cleaned after use. The regular cleaning of all floors, walls, ceilings, and storerooms will be completed according to a specific and routine cleaning schedule.The facility's policy Food Storage revised 6/25/24. Food storage areas will be maintained in a clean, safe, and sanitary manner. Food services staff will always maintain clean food storage areas. Storage of prepared food stored in the refrigerator until services shall be dated and labeled. Such food will be tightly sealed with plastic wrap, foil or a lid.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure Resident (R) 143 and his representative were provided with a bed hold policy that included the facility's per diem rate to hold a bed. Findings included:- R143's Electronic Medical Record (EMR) documented R143 admitted the facility on 01/27/26. A Notice of Transfer form in the EMR dated 02/02/26 documented R143 was sent out to the hospital. The Notice of Transfer form, documented the form was provided to R143 and their representative.R143's EMR lacked evidence the bed hold policy was provided to R143 and his representative. Upon request, the facility was unable to provide evidence the bed hold policy was provided to the resident at the time of transfer. On 04/22/26 at 09:19 AM, Administrative Staff A confirmed the bed hold policy was not provided to R142 because the resident was on skilled services. Administrative Staff A stated that the facility did not provide bed holds for their short stay residents per facility policy. The facility's Bed Holds and Return to Facility policy dated 09/06/18 documented the facility will inform residents or a representative before resident is transferred to a hospital, or therapeutic leave of the bed hold policy. In addition, the social worker will mail a notice and contact the resident by phone the resident and the resident representative the next business day.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to update the plan of care for activity of daily living (ADL) assistance for Resident (R) 3. Findings included:- R3's Electronic Health Record (EHR) documented the following diagnosis: 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) with hemiparesis/hemiplegia (weakness and paralysis on one side of the body).R3's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R3 required assistance with all ADLs.R3's Care Plan dated 10/08/25 recorded she had an impaired ability to care for herself and directed staff she needed help performing ADLs. The care plan lacked intervention to provide nail care.On 04/20/26 at 09:10 AM, observation of R3's right hand revealed a black substance under two of the five fingernails.On 04/23/26 at 10:18 AM, interview with Administrative Staff A revealed the facility will update the Kardex because the staff will pick up a new one each day at the start of their shift, and then staff will update the main care plans from there.The facility's policy revised 11/23/17 Resident Directed Care Plans-Comprehensive the car planning process for each resident will include the resident, the neighborhood interdisciplinary team will develop a plan of services to be provided by the neighborhood. The following will not be included in a resident's care plan, daily care needs and standard practices of the neighborhood unless there are specific resident issue that need to be addressed. The care plan will include when residents need assistance with one of the following types of care hygiene/ADL care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide activity of daily living (ADL) assistance for Resident (R) 3 when staff failed to ensure she received fingernail hygiene care. Findings included:- R3's Electronic Health Record (EHR) documented the following diagnoses: 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) with hemiparesis/hemiplegia (weakness and paralysis on one side of the body).R3's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R3 required assistance with all ADLs.R3's Care Plan dated 10/08/25 recorded she had an impaired ability to care for herself and directed staff she needed help performing ADLsOn 04/20/26 at 09:10 AM, observation of R3's right hand revealed a black substance under two of the five fingernails.04/21/26 at 2:00 PM observation of R3's right hand revealed a black substance under two of her five fingernails.04/22/26 at 8:00 AM observation of Certified Nurse Aide (CNA) O prepares R3 for her shower. She receives a shower from hospice on Wednesdays and Fridays.04/22/26 at 10:50 AM observation R3's fingernails on her right hand, the dark substance had been removed, a brown stain remained under two of the five fingernails.On 04/22/26 at 08:20 AM, Interview with Certified Nurse Aide (CNA) N revealed the nail care the staff are to clean her nails every shift. R3 tends to ding in her brief, which causes her to have stuff under her fingernails.On 04/22/26 at 08:26 AM, Interview with Licensed Nurse (LN) F revealed R3's fingernails are to be cleaned every shift. She expects the staff to clean her nails anytime her nails have a dirty substance under them.The facility's policy dated 12/1/28 Nail and Foot Care Nail care can be provided by licensed nurses, caregivers, and volunteers. Nail care may be provided as part of life enhancement.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interviews, and record reviews, the facility failed to ensure staff implemented the interventions to promote wound healing for Resident (R) 11 when staff failed to use the foot cradle and Prevalon boots. Findings included:-R11's Electronic Health Record (EHR) documented diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to the body) and peripheral vascular disease (PVD-slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).R11's 03/18/26 Quarterly Minimum Data Set (MDS) documented R11 had one Stage 2 (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) and one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below). R11's Care Plan documented R11 was at risk for a pressure ulcer or other related skin issues due to her peripheral artery disease with occlusion. The plan directed staff R11 preferred to use a foot cradle (a supportive medical device used in a bed to keep the sheets and blankets from touching or putting pressure on a patient's limbs) and directed staff to apply Prevalon boot (special pressure-reducing heel protectors) to bilateral lower extremities when in bed.R11's CNA Kardex documented R11 was to have a blanket cradle attached to her bed to tent her blankets and was to wear Prevalon boots when in bed.R11's 04/08/26 arterial doppler (ultrasonography used to evaluate the direction and pattern of blood flow) to both lower extremities documented occlusion (the blockage, closure, or plugging of a hollow organ, vessel, or passage in the body) documented a doppler was performed on both lower extremities and the findings suggested severe PVD.A wound assessment report dated 04/21/26 documented the right lateral (pertaining to the side, away from the middle) wound was an arterial ulcer, Stage 3.A re-evaluation skin evaluation form dated 04/07/26 documented the right outer foot wound as a full thickness wound and listed the wound type as arterial.Observation on 04/21/26 at 07:43 AM, R11 laid in bed. The blanket cradle was not in place at the end of the bed and was observed lying on the floor next to the bed. R11's Prevalon boots were not applied to either foot. The boots lay on the floor next to R11's dresser. Observation on 04/21/26 at 11:31 AM revealed that R11 lay in bed. The blanket cradle was in place though the blankets were sunk down in the middle of the frame and rested directly on R11's right and left foot.Interviewed on 04/21/26 at 08:38 AM, Administrative Nurse F stated R11's Prevalon boots were to be in place on her feet and said the blanket cradle should always be at the end of R11's bed when she was in bed.Interviewed on 04/21/26 at 11:23 AM, Certified Nurse Aide (CNA) P stated R11's blanket cradle and Prevalon boots should be on her when she was in bed.Interviewed on 04/22/26 at 10:19 AM, Administrative Nurse F stated R11's wound was classified as pressure prior to receiving the results of the arterial doppler on 04/08/26. Administrative Nurse F said R11 had an order for the foot cradle and Prevalon boots to be utilized when she is in bed. Administrative Nurse F said she expected the blanket cradle and the Prevalon boots to be in place when R11 was in bed.Interviewed on 04/22/26 at 10:35 AM, Administrative Nurse D stated she expected staff to follow interventions and orders for wounds that were currently in place. Administrative Nurse D said staff should have implemented R11's Prevalon boots and blanket cradle per order.The facility did not provide a policy for non-pressure related skin conditions.

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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. Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards for Resident (R)37 who required supplemental oxygen continuously and had the oxygen concentrator (a medical device that filters surrounding air to deliver concentrated oxygen) set-up in his bathroom with approximately 30 feet of oxygen tubing strung throughout his room, and R146 who required staff assistance when ambulating and ambulated throughout his room without staff present. Findings included:- Review of the Electronic Medical Record (EHR) revealed the following: 1. The EMR for R37 documented diagnoses of acute on chronic Systolic (congestive) heart failure (when a patient with pre-existing systolic heart failure experiences a sudden, severe worsening of symptoms), chronic respiratory failure with hypoxia (a long-term condition where the respiratory system cannot adequately oxygenate the blood), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, lack of coordination, and abnormalities of gait and mobility. R37's admission Minimum Data Set (MDS), dated 04/10/26, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment documented that he had impairment in both lower extremities and used a wheelchair for mobility. He was independent when eating, required substantial or maximum assistance for toileting hygiene and putting on footwear, required partial to moderate assistance for bathing and lower body dressing, supervision or touching assistance for upper body dressing and personal hygiene, and set-up and clean-up assistance for oral hygiene. The MDS also documented R37 had shortness of breath or trouble breathing with exertion and received oxygen therapy. R37's Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 04/10/26, documented he needed help with ADL functions and mobility R37's Urinary Incontinence and Indwelling Catheter CAA, dated 04/10/26, documented that he required assistance with toileting transfers, hygiene, and had urinary incontinence. R37's Care Plan dated 04/06/26, documented that he used a wheelchair and staff were to assist with transfers. Other interventions included that personal items were to be kept within his reach and that R37 was to receive oxygen as ordered by the provider. Observed on 04/20/26 at 10:03 AM, R37 wore humidified oxygen. The oxygen concentrator was positioned in the bathroom, and the tubing was laid on the floor and strung to his chair that was approximately 30 feet in another part of his room. The oxygen tubing was strung across the floor, and there were several coils of tubing on the floor next to R37's recliner, where he was sitting. On 04/21/26 at 08:58 AM, Certified Nurse Aide (CNA) M stated that the oxygen concentrator should have been placed as close to the resident as possible and the oxygen tubing should not have been strung across the room. On 04/21/26 at 09:05 AM, R37 stated that his oxygen concentrator had remained in the bathroom, it was never moved. On 04/21/26 at 11:40 AM, Licensed Nurse (LN) G stated that the oxygen concentrator should have been as close to the resident as possible and as short of oxygen tubing as possible used to prevent tripping hazards. On 04/22/26 at 10:45 AM, Administrative Nurse D stated that it was appropriate for oxygen tubing to have been strung throughout the room and that the concentrator could be placed in another room. She said that this was used as a method to help wean the resident off the supplemental oxygen. Administrative Nurse D said that she expected staff to use the shortest length of oxygen tubing possible, no more than approximately nine feet. 2. The EMR for R146 documented diagnoses of need for assistance with personal care and abnormalities of gait and mobility. R146's Admit MDS, dated 04/17/26, documented a BIMS six, which indicated severe cognitive impairment. The MDS documented that he used a walker and wheelchair for mobility and that R146 required partial to moderate staff assistance for toileting hygiene, bathing, lower body dressing and putting on footwear, he required supervision or touching assistance for upper body dressing, set-up and clean-up assistance for oral hygiene and was independent for eating. R146's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Falls CAA, dated 04/17/26, documented that he had impaired balance and required assistance and support during transfers and gait, and he had potential for falls and injury. R146's Care Plan documented an intervention, dated 04/15/26, that he required one person for transfers. Another intervention, dated 04/17/26, documented that R146 was walk to dine. R146's EMR had active Physician Orders, dated 04/13/26, for Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat. R146's CNA Kardex for Wednesday 04/22/26 All Shifts documented that he was a one person assist with transfers, and one person assist with wheelchair mobility or 4-wheeled walker (4WW). R146's Initial Plan of Treatment for Physical Therapy Rehabilitation, dated 04/14/26, documented that R146 was a fall precaution, had decreased safety awareness, required contact-guard assistance with sitting to standing and required assistance when ambulatory. Observed on 04/20/26 at 11:09 AM, R146 was sitting alone in his room with gait belt around his mid-section, he then stood up and began ambulating with his 4WW that had a bath blanket draped loose over the front of it. Observed on 04/21/26 at 11:20 AM, R146 stood up from his recliner and ambulated with his 4WW from the recliner to the bathroom without staff present. Several staff walked by his room as he ambulated alone. Observed on 04/22/26 at 11:07 AM, R146 ambulated across his room with his 4WW. Staff were present in the hall outside the room. On 04/21/26 at 08:23 AM, CNA M said that she was unsure if R146 required ambulation assistance. On 04/21/26 at 11:40 AM, LN G stated that R146 had a walk to dine intervention on his care-plan and that indicated that he required stand-by assistance. LN G also said that if he walked to the bathroom or anywhere staff were to be present. On 04/21/26 at 12:15 PM, Consultant GG stated that R146 required contact guard assistance with all ambulation and the Kardex had him listed as assist x1 and that he was impulsive. On 04/22/26 at 10:45 AM, Administrative Nurse D stated that resident ambulation instructions should have been communicated between all staff on a unit and that the ambulation restrictions were listed on the CNA Kardex and were to have been communicated from shift to shift and staff to staff. The facility policy Fall Prevention and Management Protocol, dated 06/28/23, documented that staff would ensure the resident was oriented to their bedroom, which would include how to operate the resident call system at the bedside and in the bathroom. The policy also documented that furniture would be arranged to ensure a clear path and direct access to the bathroom. Also documented was that the nurse would add to the resident's Kardex the activities or habits that made the resident high risk for falls, along with known interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews, and record review, the facility failed to provide Resident (R)148's physician ordered medications due to lack of availability. Findings included:- R148's Electronic Medical Records (EMR) documented diagnoses, which included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and aftercare following joint replacement surgery. R148's 04/22/26 admission Minimum Data Set (MDS) was not completed. R148's ADL functional/Rehabilitation Potential Care Area Assessment (CAA), dated 04/12/26, documented R148 required assistance with care including toileting. R148's admission Care Plan dated 04/18/26, documented staff were to assess R148 for pain and give pain medications as ordered.R148's admission Care Plan dated 04/18/26, directed staff to give medications as ordered and monitor behavior concerns or anxiety.R148's Physician Orders documented an order for clonazepam (an antianxiety medication) one milligram (mg) at bedtime for anxiety, started on 04/18/26.R148's Physician Orders documented an order for Soma (a muscle relaxant that is used to treat pain) 350 mg at bedtime for muscle pain. The order was changed to as needed on 04/20/26. R148's electronic Medication Administration Record (MAR) documented R148 did not get her ordered clonazepam on 04/18/26, 04/19/26, and 04/20/26. R148's MAR documented R148 did not get her ordered Soma on 04/18/26 and 04/19/26. R148's Progress Notes for 04/18/26 through 04/20/26 documented the clonazepam and Soma were not available. The note lacked documentation that the provider was notified of the missed medication or that the pharmacy was called in an attempt to get the medications.R148's Weekly IDT Meeting dated 04/22/26, documented the nursing barriers were chronic pain and anxiety.R148's vital sign tab documented the following pain ratings using a 0-10 scale (rating system where zero equals no pain and 10 equals the worst pain imaginable):04/18/26 at 07:30 PM R148's pain was rated 10. 04/18/26 at 11:56 PM R148's pain was rated 7.04/19/26 at 4:05 PM R148's pain was rated 9. 04/19/26 at 10:20 PM R148's pain was rated 10.On 04/20/26 at 02:03 PM, R148 was anxious and fidgeting in her bed. She reported her pain was not controlled. R148 reported that staff was not correctly giving her pain medication as ordered. She stated, They say they are giving it, but they are not.On 04/21/26 at 03:05 PM, Certified Medication Aide (CMA) R stated if a medication was unavailable, she would check the Cubex (a box that medications are kept) and if it was not in there, she would notify the nurse.On 04/22/26 at 10:57 AM, Administrative Nurse II stated that medications should be in the available in the facility within 24 hours of admission or orders. Administrative Nurse II said the facility received the orders prior to admission and got them in the computer and ordered, so when the residents arrive, the medication would be there or arrive shortly. The facility also had a Cubex where the nurse could get medications if the medication did not arrive. Administrative Nurse II said if the medication did not arrive, the nurse should follow up with the pharmacy to inquire why the medication did not arrive.On 04/22/26 at 11:25 AM, Administrative Nurse D stated she expected the nurses to get the medications for the residents as ordered.The Provider Pharmacy Requirements documented the pharmacy agreed to provide routine and timely pharmacy services as contracted and emergency pharmacy services 24 hours a day. The emergency medications are available within four hours. All other medications ordered will be provided as soon as possible or the next routine delivery unless otherwise directed by the facility staff.The Cubex Station Policies and Procedures effective 12/21/16 documented the nursing staff will use the Cubex for first dose and other situations where medications are not readily available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to display accurate and identifiable posted nurse staffing information. Findings included:- On 04/21/2026 at 08:55 AM, observation revealed a daily staffing sheet hanging on the wall near the nursing station on the first floor of the facility.Review of the Daily Nursing Staffing Information sheets from 07/04/25, 12/02/26, 03/05/26, and 04/21/26 revealed the sheets lacked the scheduled hours. The resident census was missing from the daily nursing staffing information sheets on 12/02/26 & 03/05/26.On 04/22/26 at 01:30 PM, Administrative Nurse D reported that the floor nurse assigned to each unit would fill out the posted staffing sheet for that unit and would then post it prior to the upcoming shift. She then stated that the posted staffing sheet required the facility name, date, current census and the staffing sheet listed the actual hours worked for the nurses, Certified Nurse Aides (CNA), and Certified Medication Aides (CMA), but was unsure about the total hours being listed.The facility posting daily nurse staffing policy listed their procedure number 01.01.10 with date approved 07/07 and supersedes 05/27/09 for CFR 483.30(e). The policy documented the Director of Nursing Services or designee will ensure that the number of registered nurses, licensed practical nurses and certified nurse aides (caregivers and medication aides) scheduled for each day is posted at the entrance to each household.