STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175536	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester Village of Lenexa	8505 Pflumm Road 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 26 residents. The sample included 12 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 19 was appropriately clothed when his bare thigh and leg were showing, and his door was left open. This deficient practice placed R19 at risk for impaired dignity and decreased psychosocial well-being. Findings included: - R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficient (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), difficulty in walking, hypertension (high blood pressure), transient ischemic attack (TIA - temporary episode of inadequate blood supply to the brain), malnutrition (not enough calories), 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), insomnia (inability to sleep), and hypokalemia (low level of potassium in the blood). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R19 impaired on one side of his body and used a wheelchair or walker. The MDS documented R19 required set up or clean up for eating, oral hygiene, and toileting. The MDS documented he required supervision or touching for dressing and required setup or clean up for lying to sitting on the side of the bed. The Modified Significant Change MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R19 was independent with oral hygiene and toileting and used a walker or wheelchair. The MDS documented R19 required substantial to maximum assistance of staff for upper body dressing and need staff to setup or cleanup for eating. The MDS documented R19 was independent for the lying to sitting on the side of the bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's The Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 08/09/24 documented R19 was alert and oriented with some forgetfulness and confusion. R19 had difficulty hearing, and usually understands others. R19 had clear speech and could make himself understood. R19 required staff assistance with his activities of daily living (ADL), he self-propels in his wheelchair and will walk short distances in his room with his walker and assistance. R19 was at risk for fall related a history of falling, not calling for assistance when he was wanting to transfer, and he takes psychotropic (alters mood or thought) medications. R19's Care Plan dated 06/19/23 documented R19 walked with a gait belt in his room with staff assistance and used his wheelchair for the rest of the time. R19 was able to self-propel his wheelchair and at times might ask staff to push him. R19's plan of care dated 09/09/23 documented he needed assistance of one staff for toileting, transfers, and dressing. On 03/17/25 at 07:24 AM, R19 laid in his bed on his back, staff members where assisting R19 with sitting on the side of his bed. R19's right thigh and leg were visible from the hall, through his room door. On 03/19/25 at 11:16 AM, Certified Nursing Aide (CNA) M stated all staff should close the curtains, talk to the resident, and ensure the door was closed when a resident was not completely dressed. On 03/19/25 at 11:22 AM, Licensed Nurse (LN) G stated all staff were to train to ensure residents have privacy, doors were closed, and curtains are pulled when residents were dressing. On 03/19/25 at 11:33 AM, Administrative Nurse D stated the facility addressed privacy and dignity daily in their huddles. Staff should talk to residents while doing cares, pull curtains if the residents was in a double occupancy room, and ensure the door was closed if the resident is not clothed. The facility's Quality of Life revised on 01/25 policy documented resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be always treated with dignity and respect. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed. Residents shall be encouraged and assisted to dress in their own clothes. Residents would be assisted in attending the activities of their choice, including activities outside the facility. Residents' private space and property shall be always respected. Staff would knock and request permission before entering residents' rooms. Staff would not handle or move a resident's personal belongings (including radios and televisions) without the resident's permission. dignity and assist residents as needed. The facility failed to ensure R19 was appropriately clothed while his door was open. R19's bare leg and thigh were showing when his door was left open. This deficient practice placed R19 at risk for impaired dignity and decreased psychosocial well-being.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 26 residents. The sample included 12 residents. Based on record review, interview, and observation, the facility failed to ensure the physician was notified of Resident (R) 2's daily weights that were missed or notified related to weight gain which could lead to fluid overload. The facility further failed to notify R15's physician related to his blood sugar monitoring. This deficient practice placed the residents at risk for further decline and a delay in treatment. - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R2 had received an anticoagulant, antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), hyperglycemic (medication that raises blood sugar levels), and opioid (a class of controlled drugs used to treat pain) medications. R2's Nutritional Status Care Area Assessment (CAA) dated 01/03/25 documented her weight would fluctuate related to her diagnosis of CHF and diuretic medication. R2's Care Plan dated 02/01/24 documented the nursing staff would obtain and monitor her lab work and diagnostic work as ordered. The plan of care also documented the nursing staff would report results to the physician and follow up as indicated with the physician. R2's EMR under the Orders tab revealed the following physician orders: Spironolactone (diuretic) oral tablet 25 milligram (mg) give a half of tablet by mouth in the morning for edema (swelling resulting from an excessive accumulation of fluid in the body tissues) dated 12/22/23. Daily weight related to CHF in the morning for edema. Notify physician of weight gain of two pounds in 24 hours. Document accordingly dated 01/29/24. Lasix (diuretic) oral tablet 40 mg (Furosemide) give one tablet by mouth in the morning for CHF dated 04/18/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R2's EMR under the Weights/Vital Sign tab, review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) from 01/01/25 through 03/16/25 (75 days) revealed five times R2 refused on the following dates 01/04/25, 01/05/25, 01/07/25, 01/08/25, and 02/08/25. Documented Other, See Progress Notes four times on the following dates 01/09/25, 01/11/25, 01/15/25, and 01/16/25. R2's MAR and TAR lacked documentation four times on the following dates 01/19/25, 01/23/25, 01/28/25, and 02/07/25. Weight gain was noted greater than two pounds eight times on the following dates 01/20/25, 01/25/25, 01/29/25, 03/03/25, 03/06/25, 03/09/25, 03/10/25, and 03/14/25. The clinical record lacked documentation of physician notification of daily weight was not obtained or outside the ordered parameter. On 03/18/25 at 11:02 AM, R2 sat in her wheelchair in her room as she looked through her dresser drawers. On 03/19/25 at 11:19 AM, Licensed Nurse (LN) G stated the physician should be notified of any daily weight that are not obtained or outside the physician ordered parameter for R2 related to her CHF. LN G stated the notification should be documented in R2's clinical record and the physician response should also be documented. On 03/19/25 at 11:35 AM, Administrative Nurse D stated she would expect the physician order to be followed. Administrative Nurse D stated she would expect the physician to be notified of any daily weights not obtained for any reason and if the weight was outside the physician ordered parameter. Administrative Nurse D stated she would expect the nurse to document a note under the progress notes with physician's response. The facility's Guidelines for Notifying Physician of Clinical Problems policy last revised 09/2017 documented these guidelines are intended to help ensure that medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and that all significant changes in resident / patient status are assessed and documented in the medical record. The facility failed to ensure R2's physician was notified of his missed weights or weights that recorded more then a two pound weight gain within 24 hours. This deficient practice placed R2 at risk for complications related to his CHF for further decline and a delay in treatment. - R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and hypertension (HTN - elevated blood pressure). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R15 had received insulin (medication to regulate blood sugar) and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R15 had received insulin and antidepressant medication. R15's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/16/24 documented required assistance with activities of daily living. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Care Plan last revised 03/17/25 documented nursing staff would administer diabetic medication as ordered. The plan of care documented the nursing staff would monitor for side effects and document the effectiveness. R15's EMR under the Orders tab revealed the following physician orders: -Check blood glucose (BG) before meals and at bedtime for DM. Notify physician if BG less than (<) 70 and greater than (>) 350. Document in a progress note dated 09/03/24. -Insulin lispro injection solution (Insulin) Inject six unit subcutaneously (SQ) with meals for DM. Give with food, not before meal arrives. Hold if BG is < 80 or he has not eating (contact provider) dated 09/19/24. -Insulin lispro injection solution inject as per sliding scale for DM: If BG 151 - 200 = give 4 units SQ; If BG 201 - 250 = give six units SQ; If BG 251 - 300 = give eight units; If BG 301 - 350 = give 10 units SQ; If BG 351- 399 = If BG give 12 units SQ, If BG 400 - 9999 = give 14 units SQ. If > 400, give 14 units SQ and contact provider. Rotate injection sites dated 10/29/24. -Lantus (insulin) solo star subcutaneous solution pen-injector 100 unit/milliliter (ml) (insulin glargine) inject 16-unit SQ at bedtime for DM. Contact provider if BG<80 prior to administration. Rotate injection sites dated 01/10/25. Review of R15's Medication Administration Record (MAR) from 01/01/25 to 03/16/25 (75 days) revealed R15's BG was > 350 26 times on the following dates: 01/01/25, 01/02/25, 01/04/25, 01/05/25, 01/07/25, 01/08/25, 01/09/25, 01/10/25, 01/13/25, 01/14/25, 01/21/25, 01/22/25, 01/25/25, 01/28/25, 02/01/25, 02/07/25,02/08/25,02/13/25, 02/18/25, 02/23/25, 02/27/25, 03/05/25, 03/07/25, 03/09/25, 03/11/25, and 03/14/25. The clinical record lacked documentation of physician notification of out of parameter BG. On 03/18/25 at 07:43 AM, R15 sat at the dining room table in his wheelchair. R15 visited with the other residents at the dining room table as he ate his breakfast. On 03/19/25 at 11:19 AM, Licensed Nurse (LN) G stated the physician should be notified of any BG that was outside the physician ordered parameter for R15 related to DM. LN G stated the notification should be documented in R15's clinical record and the physician response should also be documented. On 03/19/25 at 11:35 AM, Administrative Nurse D stated she would expect the physician order to be followed. Administrative Nurse D stated she would expect the physician to be notified of any BG outside the physician ordered parameter. Administrative Nurse D stated she would expect the nurse to document a note under the progress notes with physician's response. The facility's Guidelines for Notifying Physician of Clinical Problems policy last revised 09/2017 documented these guidelines are intended to help ensure that medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and that all significant changes in resident / patient status are assessed and documented in the medical record. The facility failed to notify R15's physician of BG that was out of parameters 26 times over 75 days. This deficient practice placed R15 at risk for further decline and a delay in treatment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 26 residents. The sample included 12 residents, with two residents reviewed for treatment and services to prevent and heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 9's heels were offloading while in bed to prevent pressure ulcers. This placed R9 at increased risk for pressure ulcer development. Findings Included: - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), 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), chronic pain, overactive bladder, major depressive disorder (major mood disorder that causes persistent feelings of sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), 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 body tissues), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Quarterly Minimum Data Set (MDS) for R9 dated 02/06/25 recorded a Brief Interview for Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R9 was dependent on staff for bathing, R9 required substantial to maximum assistance for toileting, and dressing. The MDS documented R9 was at risk for pressure ulcers and had a pressure reducing device in wheelchair and her bed. The MDS documented R9 had moisture associated skin damage during the observation period. The Significant Change MDS for R9 dated 08/16/24 recorded a BIMS score of four, which indicated severely impaired cognition. The MDS documented R9 required set up or clean up for eating and oral hygiene and was dependent on staff for toileting. The MDS documented R9 required substantial to maximum assistance for dressing. The MDS documented R9 was at risk for pressure ulcers and had a pressure reducing device in her wheelchair and bed. R9's Pressure Ulcer/ Injury Care Area assessment dated [DATE] documented R9 was removed from hospice due to her overall health/condition improving. R9 had started therapy and was working on developing a restorative program. R9 was alert and oriented with some confusion. R9 required assistance with her activities of daily living (ADL) and was a one-to-two-person lift. R9 uses a wheelchair for mobility and propels herself. R9 incontinence and needing assistance with bed mobility and repositioning puts her at risk for pressure ulcers and other skin break down. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's Care Plan dated 11/15/23 documented R9 was at risk for wounds, pressure ulcers, and other skin break down related to incontinence and needing assistance with ADLs, nursing was to administer treatment to skin as ordered. R9's plan of care documented R9 used a low air loss mattress pressure reduction mattress on her bed. Nursing was to complete weekly skin assessment sand report any skin issues to the physician. R9's Braden Scale for Prediction Pressure Sore Risk dated 02/01/25 documented a score of 16 indicating a risk for pressure ulcers. R9's physician's orders under the Orders tab revealed the following orders: Low air loss mattress:390 alternating every shift for mattress functioning dated 01/26/25. Offload bilateral (both sides) heels while in bed every shift for wound prevention dated 02/01/24. Apply Skin-prep (liquid skin protectant) to bilateral heels twice daily for wound prevention, please report any signs or symptoms of deterioration to physician immediately dated 02/01/24. On 03/18/25 at 07:05 AM, R9 laid on her bed covered up, R9's heels laid directly on the mattress. On 03/19/25 at 07: 19 AM, R9 laid on her bed, Licensed Nurse (LN) applied skin prep to R9's heels. R9's heels laid directly on the mattress. On 03/19/25 at 11:16 AM, Certified Nurse's Aide (CNA) M stated it was the charge nurse's responsibility to ensure a resident's heels were floating. CNA M stated the nurse could as the CNAs to help with those duties. On 03/19/25 at 11:22 AM, LN G stated all nursing staff could ensure a resident's heels were floated. LN G stated she believed the charge nurse was the one who would sign off on the Treatment Administration Record (TAR) to ensure the heels were being floated. On 03/19/25 at 11:33 AM, Administrative Nurse D stated the task was on the TAR for the charge nurse to be the final check, to ensure the task was performed. The facility's Prevention of Pressure Injuries dated 08/24 documented review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Use a standardized pressure injury screening tool to determine and document risk factors. Supplement the use of a risk assessment tool with assessment of additional risk factors. The facility failed to ensure pressure R9's heels were offloading while in bed to prevent pressure ulcers. This placed R9 at increased risk for pressure ulcer development.

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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** 49634 The facility identified a census of 26 residents. The sample included 12 residents, with one resident observed for bowel and bladder. Based on observation, record reviews, and interviews, the facility failed to ensure Resident (R) 14's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) tubing did not drag on the floor. This deficient practice placed R14 at risk of complications and possible urinary tract infections due to potential urine backflow. Finding included: - R14's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hydroureter (a condition where the ureter, the tube that carries urine from the kidney to the bladder, becomes dilated (enlarged) due to a blockage in the urinary tract), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), retention of urine, need for assistance with persona care, weakness, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R14 had an impairment on both sides of his body. The MDS documented R14 was dependent on staff for eating, oral hygiene, bathing, toileting, and dressing. The MDS documented R14 had a neurogenic bladder. The Significant Change MDS dated [DATE] documented a BIMS of 14 which indicated intact cognition. The MDS documented R14 had no impairment of his body and used a wheelchair for mobility. The MDS documented R14 required substantial to maximum assistance with eating, and was dependent on staff for bathing, toileting, and dressing. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/13/24 documented R14 had a Significant Change done because he had recently lost weight. R14 was requiring more assistance with activities of daily living (ADL) and had a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) on his sacrum (large triangular bone/area between the two hip bones). R14 was alert and oriented with forgetfulness at times. He had clear speech, could make himself understood, and understood others. He had adequate hearing and vision with his glasses. He uses a wheelchair that staff pushed for mobility, a sit to stand lift for transfers, and he needed assistance from staff with his ADLs. He was at risk for falls related to generalized weakness and requiring staff assistance for transfers. He had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and had bowel incontinence. His incontinence and needed assistance with bed mobility and repositioning which puts him at risk for pressure ulcers and other skin break down. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's Care Plan revised on 01/31/24 documented R14 had a neurogenic bladder and had a supra pubic catheter. Staff were to monitor for signs and symptoms of urinary tract infection (UTI - an infection in any part of the urinary system) such as pain, blood-tinged urine, and cloudiness. The plan of care dated 06/14/24 documented staff would complete catheter care each shift and as needed (PRN), catheter bag was emptied each shift, and place catheter bag inside a dignity bag. R14's EMR under Orders tab documented change supra pubic catheter dressing every shift, cleanse site with normal saline pat dry, cover with a 4x4 dressing and secure with tape, may change PRN and every shift dated 07/07/2023. R14's EMR under Orders tab documented may use leg bag during the day, and use large bag at night, rinse out bag when not in use and place in a plastic bag in the bathroom for bladder health dated 07/07/23. On 03/17/25 at 07:23 AM, R14 sat at the breakfast table in his wheelchair awaiting breakfast. R14's catheter bag tubing was dragging on the floor. On 03/17/25 at 11:24 AM, R14 sat at the dining room table awaiting lunch, visiting with peers. R14's catheter bag tubing was on the floor. On 03/19/25 at 11:16 AM, Certified Nurse Aide (CNA) M stated all catheter bags should have a dignity bag, and staff should wear gloves when taking care of a resident with a catheter. CNA M stated all tubing should be off the floor. On 03/19/25 at 11:22 AM, Licensed Nurse (LN) G stated the catheter bag tubing had a clamp to curl the tubing off the floor. She stated all catheter bag tubing should be on the floor. On 03/19/25 at 11:33 AM, Administrative Nurse D stated all catheter tubing should be off the floor, she stated the facility was doing staff competences for catheter care. The facility failed to provide a policy for catheter care. The facility failed to ensure R14's catheter tubing was placed below the level of the bladder. This deficient practice placed R14 at risk of complications and further urinary tract infections due to potential urine backflow.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 26 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure dosing instructions for as needed Voltaren (topical pain reliever medication) gel and failed to follow a physician order for daily weights to monitor for fluid overload for Resident (R) 2. The facility also failed to follow a physician order for blood sugar monitoring for R15. The facility further failed to ensure R6's anticoagulant (a class of medications sued to prevent the blood from clotting) medication was administered as ordered. These deficient practices placed the residents at risk of unnecessary medication use, side effects, physical complications, and fluid overload. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R2 had received an anticoagulant, antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), hyperglycemic (medication that raises blood sugar levels), medication to regulate blood sugar), and opioid (a class of controlled drugs used to treat pain) medications. R2's Nutritional Status Care Area Assessment (CAA) dated 01/03/25 documented her weight would fluctuate related to her diagnosis of CHF and diuretic medication. R2's Care Plan dated 02/01/24 documented the nursing staff would obtain and monitor her lab work and diagnostic work as ordered. The plan of care also documented the nursing staff would report results to the physician and follow up as indicated with the physician. R2's EMR under the Orders tab revealed the following physician orders: Spironolactone (diuretic medication) oral tablet 25 milligrams (mg) give a half of tablet by mouth in the morning for edema (swelling resulting from an excessive accumulation of fluid in the body tissues) dated 12/22/23. Daily weight related to CHF in the morning for edema. Notify physician of weight gain of two pounds in 24 hours. Document accordingly dated 01/29/24. Lasix (diuretic medication) oral tablet 40 mg (Furosemide) give one tablet by mouth in the morning for CHF dated 04/18/24. (continued on next page)

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	175536	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester Village of Lenexa	8505 Pflumm Road Lenexa, KS 66215

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Voltaren arthritis pain external gel one percent (diclofenac sodium (topical)) applies to right distal scapula (shoulder blade) topically every six hours as needed for pain management. Apply round dressing and use dosing card to measure dose dated 02/03/25. The order lacked a dosing instruction. Review of R2's EMR under the Weights/Vital Sign tab, review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) from 01/01/25 through 03/16/25 (75 days) revealed five times R2 refused on the following dates: 01/04/25, 01/05/25, 01/07/25, 01/08/25, and 02/08/25. Documented Other, See Progress Notes four times on the following dates: 01/09/25, 01/11/25, 01/15/25, and 01/16/25. R2's MAR and TAR lacked documentation four times on the following dates: 01/19/25, 01/23/25, 01/28/25, and 02/07/25. Weight gain was noted greater than two pounds eight times on the following dates: 01/20/25, 01/25/25, 01/29/25, 03/03/25, 03/06/25, 03/09/25, 03/10/25, and 03/14/25. The clinical record lacked documentation of physician notification of daily weight was not obtained or outside the ordered parameter. On 03/18/25 at 11:02 AM, R2 sat in her wheelchair in her room as she looked through her dresser drawers. On 03/19/25 at 11:19 AM, Licensed Nurse (LN) G stated the physician should be notified of any daily weight that are not obtained or outside the physician ordered parameter for R2 related to her CHF. LN G stated the notification should be documented in R2's clinical record and the physician response should also be documented. On 03/19/25 at 11:35 AM, Administrative Nurse D stated she would expect the physician order to be followed. Administrative Nurse D stated she would expect the physician to be notified of any daily weights not obtained for any reason and if the weight was outside the physician ordered parameter. Administrative Nurse D stated she would expect the nurse to document a note under the progress notes with physician's response. The facility's Guidelines for Notifying Physician of Clinical Problems policy last revised 09/2017 documented these guidelines are intended to help ensure that medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and that all significant changes in resident/patient status are assessed and documented in the medical record. The facility failed to ensure dosing instructions for Voltaren gel and to follow a physician order for daily weights to monitor weight gain for fluid overload for R2. This deficient practice placed R2 at risk for unnecessary medication use, side effects, physical complications, and fluid overload. - R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and hypertension (HTN - elevated blood pressure). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R15 had received insulin (medication to regulate blood sugar) and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R15 had received insulin and antidepressant medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/16/24 documented required assistance with activities of daily living. R15's Care Plan last revised 03/17/25 documented nursing staff would administer diabetic medication as ordered. The plan of care documented the nursing staff would monitor for side effects and document the effectiveness. R15's EMR under the Orders tab revealed the following physician orders: -Check blood glucose (BG) before meals and at bedtime for DM. Notify physician if BG less than (<) 70 and greater than (>) 350. Document in a progress note dated 09/03/24. -Insulin lispro injection solution (Insulin) Inject six unit subcutaneously (SQ) with meals for DM. Give with food, not before meal arrives. Hold if BG is < 80 or he has not eaten (contact provider) dated 09/19/24. -Insulin lispro injection solution inject as per sliding scale for DM: If BG 151 - 200 = give 4 units SQ; If BG 201 - 250 = give six units SQ; If BG 251 - 300 = give eight units; If BG 301 - 350 = give 10 units SQ; If BG 351- 399 = If BG give 12 units SQ, If BG 400 - 9999 = give 14 units SQ. If > 400, give 14 units SQ and contact provider. Rotate injection sites dated 10/29/24. -Lantus (insulin) solo star subcutaneous solution pen-injector 100 unit/milliliters (ml) (insulin glargine) inject 16-unit SQ at bedtime for DM. Contact provider if BG < 80 prior to administration. Rotate injection sites dated 01/10/25. Review of R15's Medication Administration Record (MAR) from 01/01/25 to 03/16/25 (75 days) revealed R15's BG was > 350 26 times on the following dates: 01/01/25, 01/02/25, 01/04/25, 01/05/25, 01/07/25, 01/08/25, 01/09/25, 01/10/25, 01/13/25, 01/14/25, 01/21/25, 01/22/25, 01/25/25, 01/28/25, 02/01/25, 02/07/25, 02/08/25, 02/13/25, 02/18/25, 02/23/25, 02/27/25, 03/05/25, 03/07/25, 03/09/25, 03/11/25, and 03/14/25. The clinical record lacked documentation of physician notification of out of parameter BG. On 03/18/25 at 07:43 AM, R15 sat at the dining room table in his wheelchair. R15 visited with the other residents at the dining room table as he ate his breakfast. On 03/19/25 at 11:19 AM, Licensed Nurse (LN) G stated the physician should be notified of any BG that was outside the physician ordered parameter for R15 related to DM. LN G stated the notification should be documented in R15's clinical record and the physician response should also be documented. On 03/19/25 at 11:35 AM, Administrative Nurse D stated she would expect the physician order to be followed. Administrative Nurse D stated she would expect the physician to be notified of any BG outside the physician ordered parameter. Administrative Nurse D stated she would expect the nurse to document a note under the progress notes with physician's response. The facility's Guidelines for Notifying Physician of Clinical Problems policy last revised 09/2017 documented these guidelines are intended to help ensure that medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and that all significant changes in resident / patient status are assessed and documented in the medical record. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure to follow a physician order for blood glucose to monitor diabetic mellitus for R15. This deficient practice placed R15 at risk for unnecessary medication use, side effects and physical complications. 49634 - R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), hemiplegia (paralysis of one side of the body) affecting the right dominant side, open wound, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and venous insufficiency (a condition where the veins in the legs fail to return blood effectively to the heart). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R6 needed partial to moderate assistance with bathing and dressing. The MDS documented R6 took anticoagulant during the observation period. R6s Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/26/25 documented R6 needs assistance with activities of daily living (LTC) and uses a wheelchair for locomotion. The CAA documented R6 Was at risk for falls due to generalized weakness and unsteady gait. The CAA documented R6 had incontinence of bowel and bladder and required staff assistance with toileting. R6's Care Plan dated 09/01/24 documented R6 was able to perform her personal hygiene at times she might need staff to hand her a towel. R6's plan of cart documented R6 needed assistance of two staff for dressing and transfers. R6 plan of care documented R6 required set up assistance for eating. R6's plan of care documented R6 was able to help with upper body dressing and required staff to put on her socks. The EMR under Physician Encounter dated 01/16/24 documented therapeutic drug level monitoring. Prothrombin Time (PT) with International Normalized Ratio (INR), (a blood test that measures how long it takes for blood to clot, and interpret results) PT 13.8 and INR 1.2, INR subtherapeutic. New order given: increase total dose to 24 milligrams (mg) previously 21 mg: give warfarin (medication used to thin blood) three mg Tuesday, Thursday, Saturday, and Sunday. Give warfarin four mg Monday, Wednesday, and Friday, follow up with lab the following week. The EMR under Progress Note Orders Entered dated 01/16/25 documented the order you have entered Warfarin Sodium Oral Tablet three mg (Warfarin Sodium). Give one tablet by mouth at bedtime for atrial fibrillation (a-fib), (irregular heartbeat) anticoagulation. R6 Warfarin order of three mg was transcribed incorrectly. R6's EMR under Medication Administration Record MAR documented from 01/17/25 to 01/31/25 Warfarin Sodium Oral Tablet three mg (Warfarin Sodium) Give one tablet by mouth at bedtime every Tuesday, Thursday, Saturday and, Sunday for a-fib anticoagulation Start Date of 01/16/25 and discontinued (D/C) date of 02/03/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR under Physicians Encounter dated 01/24/25 documented labs on 01/23/25 subtherapeutic PT with INR 1.1. Orders not implemented as entered last week so R6 had only received warfarin three mg Tuesday, Thursday, Saturday, and Sunday. Reviewed with the facility administrator and nursing, reordered warfarin four mg Monday, Wednesday, and Friday, and three mg Tuesday, Thursday, Saturday, and Sunday. The orders were confirmed to be present in facility MAR and in medication list. Staff to repeat lab in one week. The Monthly Medication Review (MMR) dated 01/27/25 documented Per provider progress noted dated 01/16/25 R6 was to receive warfarin three mg on Tuesday, Thursday, Saturday, and Sunday, and four mg on Monday, Wednesday, and Friday. This order was transcribed on the chart correctly and R6 received three mg. Subsequent INR was subtherapeutic and dose was corrected at that time. Please ensure transcription of orders was verified accuracy. On 03/18/25 at 08:21 AM, R6 laid in her bed looking at her phone. On 03/18/25 at 10:24 AM, Consultant GG stated the physician now puts the orders in, and the nurse was the double check. Consultant GG stated she would expect the nursing facility to call her if an order was put in wrong. On 03/19/25 at 11:22 AM, Licensed Nurse (LN) G stated the physician now puts the or the facility has a nurse on staff for both sides of the building, the other nurse could be the second check. On 03/19/25 at 11:33 AM, Administrative Nurse D the physician inters orders in the facilities system, she stated a nurse had to verify the order after the physician puts the order in Administrative Nurse D stated if a nurse takes a verbal order, there was not a second check to ensure the medication order was accurate. The facility's Notifying the Physician of Clinical Problems dated 09/17 documented guidelines were intended to help ensure that medical care problems were communicated to the medical staff in a timely, efficient, and effective manner. All significant changes in resident or patient status were assessed and documented in the medical record. The immediate and non-immediate problems were not meant to be all-inclusive. The charge nurse or supervisor should contact the attending physician if a clinical situation appears to require immediate discussion and management. The facility failed to ensure the transcription of R6's blood thinner was transcribed correctly according to physician orders. This deficient practice placed R6 at risk for blood clots from forming or growing larger.

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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. 49634 The facility identified a census of 26 residents. The sample included 12 residents, with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to administer Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial pneumonia infections) vaccination after obtaining a signed consent for Resident (R) 4. This placed the residents at increased risk for complications related to pneumonia. Findings included: - Review of R4's clinical record lacked documentation the PCV20 was given, after obtaining a signed consent or a physician documented contraindication. On 03/18/25 at 08:33 AM, Administrative Nurse E stated the facility had begun putting the consent for vaccinations in the admission packet. He stated the charge nurse would get the consent and order the medication. On 3/19/25 at 11:33 AM, Administrative Nurse D stated the facility was ensuring all immunizations were offered and given, by putting the consent and declination in the admission packet. Administrative Nurse D stated it was ultimately the charge nurse's responsibility to ensure the consent was signed or declined and then order the vaccine from the pharmacy. The facility's Pneumococcal Vaccine policy undated documented all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents were assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, were offered the vaccine series within thirty days of admission to the facility unless medically contraindicated, or the resident has completed the current recommended vaccine series. Assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission, if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative received information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. Residents/representatives have the right to refuse vaccination. If refused, appropriate information was documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. The facility failed to offer the PCV20 after a consent was obtain for R4. This placed the resident at increased risk for complications related to pneumonia.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 41037 The facility identified a census of 26 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 03/19/25 at 08:40 AM a review of the training provided by the facility for agency Certified Nurse Aide (CNA) N, CNA O, CNA P, and Certified Medication Aide (CMA) R revealed the following: The facility was unable to provide documentation of CNA N had completed on resident rights training. The facility was unable to provide documentation of CNA O had completed on resident rights training. The facility was unable to provide documentation of CNA P had completed on resident rights training. The facility was unable to provide documentation of CMA R had completed on resident rights training. On 03/19/25 at 10:11 AM, Administrative Staff A stated the facility would start having the charge nurse ensure the agency staff had the required education before working at the facility. The facility failed to provide a policy related to required staff education. The facility failed to ensure the completion of the required resident rights training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.