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 _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER VILLAGE OF LENEXA	**8505 PFLUMM ROAD LENEXA, KS 66215**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00150180. The 2567 was sent to the facility electronically on 2.24.2020	F 000		
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 1 received the necessary dementia care and services that were person-centered, reflected the resident's goals for care, and maximized the resident's dignity and well-being while providing cares. As a result, staff caused skin tear injuries to both R1's hands while providing cares. Findings included: - R1's "Electronic Medical Record" (EMR) documented diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), major depressive disorder (major mood disorder), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).	F 744		

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

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

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F 744	Continued From page 1	F 744		

The "Admission Minimum Data Set" (MDS) dated 06/13/19 documented a Brief Interview for Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R1 required extensive assistance from one staff member with activities of daily living (ADL). R1 received antipsychotics (class of medications used to treat psychosis and other mental emotional conditions), antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression), and diuretics (medication to promote the formation and excretion of urine) seven out of seven days during the look back period. There was no gradual dose reduction (GDR) attempted and the primary care physician documented that a GDR was clinically contraindicated on 06/10/19.

The "Quarterly" MDS dated 12/10/19 documented a BIMS score of one which indicated severely impaired cognition. Behaviors that were noted one to three days of the assessment period included physical behavioral symptoms directed towards other such as hitting, kicking, pushing, scratching, grabbing, abusing other sexually. Other behaviors recorded four to six days of verbal behaviors directed towards others such as threatening, screaming, and cursing at others. R1 also had behaviors of rejection of care and wandering for one to three days. R1 required extensive assistance from two staff members for bed mobility, transfers, and personal hygiene; and extensive assistance from one staff member for toilet use and locomotion on and off the unit. R1 received the same medication as noted on the "Admission MDS," and the primary care physician documented GDR was clinically contraindicated on 12/10/19.

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F 744	Continued From page 2	F 744		

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 06/13/19 documented R1 had periods of disorganized thoughts and inattention.

The "Behavioral Symptoms CAA" dated 06/13/19 documented R1 was to be redirected by staff and was usually easily redirected.

The "Behavior Care Plan" dated 07/09/19 directed staff to provide an opportunity for positive interaction, attention, and to explain each care before it was given.

The "Impaired Cognitive Function, Dementia or Impaired Thought Processes Care Plan" related to dementia dated 06/10/19 directed staff when communicating with R1 to provide necessary cues, and stop and return if agitated.

The "Progress Note" dated 02/09/20 at 09:00 PM documented the Certified Nurse Aid (CNA) reported the resident was combative when being put to bed and sustained two skin tears on the top of both hands. Upon assessment, the resident's skin was generally very thin and fragile. Staff cleansed and steri-stripped the areas. This Nurse re-educated the CNA when the resident was non-compliant with care in any way to step away and come get the nurse. The CNA informed this nurse that the resident was not in a physically safe position for her to step away at the time. The director of nursing (DON) and on call clinician were notified and a message was left for resident's daughter.

The clinical record lacked measurements of the skin tears.

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F 744	Continued From page 3	F 744		

On 02/11/20 at 10:41 AM R1 sat in her wheelchair holding a doll. She had bruising to the back of both hands. R1's bruising to the hands was red around the outside and purple to the middle area. R1's right and left hand had four steri-strips on each hand holding the skin tears together, the skin tear on the right hand was approximately 2.5 inches long and the skin tear on the left hand was approximately 2 inches long.

On 02/11/20 at 10:55 AM R1 pointed to the top of her hand and stated to an unidentified staff member "it keeps bothering."

On 02/11/20 at 11:43 AM CNA M stated during cares R1 rolled onto her back and started swinging at CNA M. CNA M stated she grabbed R1's hands and asked R1 to let her change her. After that, CNA M stated she continued to change R1 and then lowered the bed to the floor. At that time CNA M noted R1 had a skin tear (ST) to one of her hands and further stated that she did not realize that both hands had STs. CNA M notified Licensed Nurse (LN) G about the STs on R1s' hands and went to finish her work. CNA M revealed that she should not have grabbed R1s' hands. She said she should have just backed away. CNA M further revealed that when R1 had behaviors, staff would normally back away.

On 02/11/20 at 02:18 PM CNA O stated that R1 can "turn" on staff in a second and become upset and refuse cares. When that happens, staff will get someone else to help R1. CNA O revealed that staff were aware that R1 had these behaviors and would get on the walkie (communication device) and ask for help. She further revealed all nursing staff should wear a walkie when at work.

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On 02/11/20 at 02:29 PM Administrative Nurse D stated he expected staff to back away from a resident that had behaviors of swinging and kicking at staff, refusing cares, and to get someone else to provide cares for that resident.

On 02/11/20 at 02:40 PM Administrative Staff A stated that staff can use the walkie to communicate and ask for help. She revealed that CNA M did have her walkie on at the time. Administrative Staff A stated that she expected CNA M to back away from R1 when she was having behaviors or being resistive to cares, keep her in line of sight, and use her walkie to call for help.

CNA M was documented to have dementia training on behavior management, abuse prevention, and philosophy of care, family and staff issues on 01/24/19.

The facility's policy "Behavioral Assessment, Intervention and Monitoring" dated December 2016 directed staff to be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities.

The facility failed to implement appropriate dementia interventions for R1 when staff attempted to hold R1's hands during a period of R1's behaviors. This deficient practice caused multiple skin tear injuries to R1's hands.