STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 a Health Resurvey. This 2567 was electronically sent to the facility on 11/09/21.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents with 12 selected for review, including two residents reviewed for Activities of Daily Living. Based on observation, interview, and record review, the facility failed to ensure one of the residents who was dependent on staff for personal hygiene, Resident (R)26, received appropriate assistance needed for trimming of his fingernails. Findings included: - The "Order Summary Report," dated 10/04/21, included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and need for assistance with personal care. The "Annual Minimum Data Set" (MDS), dated 07/12/21, assessed Resident (R)26 with a "Brief Interview of Mental Status" (BIMS) score of six, indicating severe cognitive impairment. He did not reject care and required extensive assistance of	F 677		

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
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 677	Continued From page 1	F 677		

one staff for his personal hygiene cares.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 07/19/21, revealed R26 required extensive assistance of staff with ADL's.

The "Quarterly MDS," dated 10/08/21, did not reveal any changes from the prior assessment findings from the MDS on 07/12/21.

The "Care Plan," dated 10/27/21, indicated R26 had ADL self-care performance deficit related to dementia and weakness, and required moderate assistance of one staff member with showering twice weekly, and as needed or requested. The "Care Plan" also indicated under his potential /actual impairment to skin integrity and to keep his fingernails short.

On 10/27/21 at 02:14 PM, during an interview, an unidentified resident representative stated that the facility did not always trim R26's fingernails and she would have to ask when she came in to visit.

On 10/28/21 at 12:19 PM, R26 was in the dining room feeding himself lunch, observed fingernails to extend past his fingertips.

The bathing task, located in the electronic medical record (EMR), under the task tab, revealed R26 received a shower on 10/21/21 (Thursday) and 10/28/21 (Thursday), and lacked that the staff completed the bathing task on 11/01/21 (Monday) or that he refused.

On 11/01/21 at 12:35 PM, R26 observed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 677	Continued From page 2	F 677		

dining room feeding himself lunch, fingernails continued to extend past his fingertips.

On 11/01/21 at 01:38 PM, Certified Nurse Aide (CNA) O, stated that his fingernails are taken care of when he showers and looked at to see if they need trimmed. His showers are during the evenings on Monday and Thursday. He may resist his nails being trimmed by moving his hand away, but then will put it back for the nails to be trimmed.

On 11/02/21 at 09:08 AM, R26 was on his bed, observed fingernails continued to need to be trimmed and a brown substance was under some of the nails.

On 11/02/21 at 09:09 AM, R26 stated that his fingernails needed trimmed.

On 11/02/21 at 10:37 AM, CNA M stated staff try to provide nail care as often as possible as there are times he will "Dig in his pants". CNA M stated that for trimming his nails, there are times that they have a "Nail day" and would be assigned rooms, and the restorative aide would help trim residents nails as well. CNA M stated she did not know the last time his nails were trimmed.

On 11/02/21 at 11:24 AM, Administrative Nurse D stated that it was her expectations that fingernail care should be done during bathing and as needed, if a resident refused nail care it should be documented, but did not think there was a specific place for staff to document nail care, , and that sometimes he does refuse nail care.

Review of the "Progress Notes," dated 10/13/21 through 10/28/21, lacked notes regarding R26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 677	Continued From page 3 refusing fingernail care. On 11/02/21 at 12:12 PM, Administrative Staff A stated that the competency for nail care is their policy. The facility competency "Nail Care," undated, lacked instruction on when nail care should be performed, but indicated it was easier to do nails following a bath or to soak nails in warm water for a few minutes before cleaning. The facility failed to ensure this resident, who was dependent on staff for nail care, received appropriate personal hygiene assistance needed for trimming of his fingernails.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents with 12 residents selected for review, including seven residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to thoroughly investigate to determine contributing factors and causes of the falls, and implement appropriate interventions following falls to prevent further falls for Residents (R)4, R7, R10, R12, and R22.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 4	F 689		

Findings included:

- The "Order Summary Report," dated 10/04/21, for Resident (R)4, included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), repeated falls, atrial fibrillation (rapid, irregular heart beat), heart failure, polyneuropathy (the malfunction of many peripheral nerves throughout the body), and unsteadiness on feet.

The significant "Minimum Data Set," (MDS) dated 05/02/21, for R4 assessed her as having a Brief Interview of Mental Status (BIMS) score of eight, indicating moderately impaired cognition. R4 required extensive assistance of one for bed mobility, transfers, and personal hygiene. She was not steady, only able to stabilize with staff assistance when moving on and off the toilet. She used a wheelchair for mobility and was always incontinent of bladder and frequently incontinent of bowel. R4 had two or more non-injury falls since the last assessment.

The quarterly MDS, dated 07/31/21, assessed R4 with a BIMS score of five, indicating severe cognitive impairment. She required extensive assistance of one for bed mobility, dressing, toilet use, and personal hygiene. She needed limited assistance of one for locomotion, walking in the corridor, and transfers. Her balance was not steady, and she needed staff assistance to stabilize her when walking, turning around, and moving on and off the toilet. She was frequently incontinent of bladder, and occasionally incontinent of bowel. R4 had two or more non injury falls since the last assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 5	F 689		

The Falls "Care Area Assessment" (CAA), dated 05/16/21, indicated R4 was at risk for falls and had a history of falls with previous bilateral (both sides) hip fractures. She is reminded and encouraged to use her call light for any needs or care.

The "Care Plan" (CP) dated 10/27/21, identified her ability to transfer as she required limited assist of one to move between surfaces and to the toilet. She used a walker for ambulation in her room. She self-propelled in her wheelchair at times.

The Morse Fall Assessment dated 10/11/21, scored the resident as 65, which indicates a high risk for falling .

The "Progress Notes, " dated 10/10/21 at 07:20 PM, nurse was alerted R4 was on the floor in the open area of the room near the bed and door. R4 was lying flat on her back. R4 was not injured. She was transferred from the floor to the wheelchair with assistance of two staff. The facility lacked an appropriate intervention.

On 11/01/21 at 01:42 PM, CNA N revealed that R4 was a fall risk and that she should use the call light when she needed to go to the bathroom, but she didn't always use the call light.

On 11/01/21 at 03:00PM, Licensed Nurse (LN) H confirmed that the fall interventions for R4's fall on 10/10/21, to frequently remind R4 to use the call light. Her daughter reported that R4 knew she should use the call light, but she forgets. LN H confirmed the intervention was not appropriate due to R4's BIMS score of five and she doesn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 6	F 689		

always use the call light for assistance.

On 11/02/21 at 03:20 PM, Administrative Nurse D, confirmed the resident had a BIMS score of five, and the intervention for R4 to use the call light was not an appropriate intervention. Interventions should be put into place immediately and placed on the care plan.

The "Accidents and Occurrences Policy," undated, instructed the licensed nurse to communicate immediately interventions to prevent further occurrences and the Director of Nursing or designee will ensure relevant, individualized interventions have been added to the care plan.

The facility failed to implement interventions for R4 to prevent further falls from occurring when the staff implemented to remind the resident to use the call light for assistance and the resident's cognition would not allow the resident to remember to do that prior to getting up unassisted.

- The "Physician Orders," dated 10/04/21 for Resident (R) 22 revealed the resident admitted on 09/08/21. The resident had diagnoses of chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heart rate), depressive disorder (abnormal emotional state characterized b exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 7	F 689		

irrational fear), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The admission "Minimum Data Set," (MDS) dated 09/18/21, assessed R22 with a "Brief Interview of Mental Status" (BIMS) score of 12, which indicated moderately impaired cognition. R22 required extensive assistance with one -person physical assist for bed mobility, transfers, personal hygiene, dressing, and locomotion. R22's balance was not steady during transitions and was only to stabilize with staff assistance.

The Falls "Care Area Assessment" (CAA), dated 09/28/21, indicated R22 had a potential for falls related to chronic obstructive pulmonary disease which makes her tired when walking. The nursing staff are to assist her with toileting, bed mobility, and transfers to prevent falls.

The "Care Plan," dated 10/03/21, included R22 as a high risk for falls related to weakness, unaware of safety needs, and a history of falls. This care plan included interventions to anticipate and meet R22's needs. She is a moderate assist related to transfers. Staff should make sure her call light was within reach and encourage her to use it for any assistance for cares or as needed. .

The Morse Fall Risk Assessment, dated 10/02/21 revealed a score of 75, indicating the R22 as a high risk for falling.

The "Progress Note," dated 10/19/21 at 08:00 AM, revealed R22 fell on the bathroom floor. The Morse Fall Assessment completed on 10/19/21, revealed a score of 75 indicating high risk for falling. The facility failed to investigate what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 8	F 689		

caused her to fall in the bathroom and failed to add an appropriate intervention to prevent further falls.

The "Progress Note," dated 10/23/21 at 07:00 AM, revealed R22 had an unwitnessed fall on the bathroom floor. She was on her left side. Assessment revealed the resident did not hit her head on the floor, but she fell on the trash can and bruised her left side. R22 was alert and could communicate to the staff what had happened. The immediate intervention was to encourage R22 not to ambulate by herself. (The resident had moderate cognitive impairment and was unaware of safety needs.) The facility lacked investigation to what caused her fall and lacked an appropriate intervention for the resident.

The "Progress Note," dated 10/23/21 at 11:00 AM, revealed R22 had another unwitnessed fall, three hours after the previous fall. She sustained a skin tear to her nose and to her right arm. The intervention remained the same. Staff was to encourage the resident not to ambulate by herself. (The resident had moderate cognitive deficit and was unaware of safety needs.) The facility lacked an investigation to determine the cause of the fall.

On 10/28/21 at 02:14 PM, R22 was in her wheelchair in her room and was attempting to change her clothes. Certified Nurse Aide (CNA) M entered the room but did not offer to assist R22 with changing her clothes.

On 10/28/21 at 02:23 PM, CNA M stated R22 usually asks the staff to be pushed (propelled) back to her room. She is one person assist. She does not like to ask staff for assistance once she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 9	F 689		

is in her room.

On 10/28/21 at 02:45PM, Licensed Nurse (LN) H stated that when a resident has a fall, the resident should be assessed, family notified, and a report of the incident filled out. There should be an immediate intervention put into place.

On 11/02/21 at 03:21 PM, Administrative Nurse D stated interventions should be put in to place immediately. She documents the interventions in the care plan as quick as possible.

The "Accidents and Occurrences Policy," undated, instructed the licensed nurse to communicate immediately interventions to prevent further occurrences or injury to the staff and update the care plan. The Director of Nursing or designee would ensure relevant, individualized interventions have been added to the care plan to prevent re-occurrence and complete a thorough investigation of the occurrence to determine casual factors.

The facility failed to determine a root cause for three falls, failed to implement timely interventions, and failed to implement appropriate interventions, to prevent R22 from having further falls.

- The "Order Summary Report," dated 10/04/21, for Resident (R)12, revealed diagnoses of essential tremor (unintentional shaking movements in one or more parts of the body), repeated falls, dementia (progressive mental disorder characterized by failing memory, confusion), need for assistance with personal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 10	F 689		

care, muscle weakness, and abnormalities of gait and mobility.

The "Annual Minimum Data Set" (MDS), dated 02/26/21, revealed the facility did not assess R12's cognitive function via the "Brief Interview of Mental Status" (BIMS) assessment, or by staff assessment, and she did not reject care. R12 required supervision and one assist for bed mobility, locomotion off the unit, and toilet use. She was independent with transfers, walking in and out of room, and locomotion on the unit. She required extensive assistance of one staff for dressing and limited assistance of one staff for personal hygiene. Her balance during transitions and walking was not steady, but she was able to balance herself without staff support. She had no range of motion impairments to her upper and lower extremities, used a walker for mobility, and had one non-injury fall since the prior assessment.

The "Falls Care Area Assessment," dated 03/11/21, indicated R12 was up and mobile throughout the facility with her walker without difficulty but had a couple of periods of increased weakness and falls, for the most part she ambulated independently with her walker without difficulty. She had worked with therapy on and off related to her weakness and falls. She was encouraged and reminded to use her call light for any needs and cares. She had one non-injury fall since her last assessment.

The "Quarterly MDS," dated 05/29/21, assessed R12 with a BIMS score of eight, indicating moderate cognitive impairment and she did not reject care. She required limited assist of one for bed mobility and personal hygiene, and extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 11	F 689		

assistance of one for dressing and toilet use. She continued to be independent with transfers, walking, and locomotion on unit, and continued with supervision and one staff assist for locomotion off unit. There was no change in her balance during transitions and walking except for moving off and on the toilet where she required staff assistance to stabilize her. She had range of motion impairment to both lower extremities, used a walker for mobility, and had two or more non-injury falls since the last assessment.

The "Quarterly MDS," dated 08/26/21, assessed R12 with a BIMS score of six, indicating severe cognitive impairment and she did not reject care. She required extensive assistance of one staff for bed mobility and dressing, and limited assist of one staff for toilet use and personal hygiene. She was independent when walking in room and required supervision and setup for transfers and locomotion on and off the unit. Her balance was not steady and required staff support to stabilize when moving from a seated to a standing position, moving on and off the toilet, and surface-to-surface transfers. She was always steady when walking and turning around and facing the opposite direction. R12 had no range of motion impairment to her lower extremities and used a walker and a wheelchair for mobility. She had one non-injury fall and one major injury fall since the prior assessment.

The "Care Plan," dated 08/29/21, for falls, included R12 was at risk for falls and included, but was not limited to, these interventions:

1. The staff were to ensure that she was wearing well fitting clothes and notify the social worker is she was in need of more clothes, dated 07/17/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 12	F 689		

2. Closely monitor her for increased unsteady gait and encourage her to use her wheelchair. On 07/18/21, the facility updated the intervention to include "As gait is unsteady" after "Encourage her to use (the) wheelchair".

3. Re-educate R12 to make sure her door was fully open prior to exiting the room. Staff to encourage her to leave the door open for closer observation, but she does like to have her room door closed most of the time, dated 08/21/21.

4. Referral to Physical Therapy/Occupational Therapy for possible therapy, dated 08/29/21.

The "Morse Fall Scale," located under the assessment tab in the electronic medical record, dated 05/31/21, revealed R12 was at high risk for falling.

The "Progress Notes" indicated that R12 fell on these dates: 07/12/21, 07/15/21, 08/02/21, 08/04/21, 08/09/21, 08/29/21, and 09/29/21.

The "Progress Note," dated 07/12/21 at 11:00 AM, indicated that R12 was walking and her pants slid down her legs causing her to fall. The intervention on the care plan, for staff to ensure that R12 was wearing well-fitting clothes and to notify the social worker is she was in need of more clothes, had an initiation date of 07/17/21, five days after the fall. The facility failed to implement an immediate intervention to prevent further falls.

The "Progress Note," dated 07/15/21 at 02:01 PM, indicated that a Certified Nursed Aide (CNA) entered room and R12 was sitting on the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 13	F 689		

with her walker in front of her. The resident voiced she "Was coming from the bathroom and just went down". The "Occurrence Follow Up" report, dated 07/18/21, indicated the intervention implemented was to closely monitor R12 for increased unsteady gait and use the wheelchair as needed. This intervention was in place on the care plan on 09/05/20, and on 07/18/21 it was changed to use her wheelchair as needed as gait was unsteady. The facility failed to implement a new immediate intervention to prevent further falls.

The "Progress Note," dated 08/03/21 at 01:59 AM, indicated at 08:00 PM, R12 was on the floor, she had come from the bathroom and tried to turn the corner to her right towards her recliner, lost her balance, and fell. Staff reminded her to use the call light for help. (The resident had impaired cognition). The "Occurrence Follow Up" report, dated 08/21/21, indicated that the recommendation implemented on 08/04/21 was to discuss the frequency of falls with the Nurse Practitioner for any further recommendations. The facility failed to implement an immediate intervention to prevent further falls.

The "Progress Note," dated 08/04/21 at 12:45 PM, indicated that a CNA found R12 lying on the floor by the door, inside her room. Staff assisted her back to her walker, then to her bed. The post fall intervention on the care plan was to re-educate resident to make sure her door was fully open prior to exiting the room, and to encourage her to leave the door open for closer observation, but R12 liked to have her room door closed most of the time. The intervention had a date of 08/21/21, 17 days after the fall. The facility failed to implement an immediate intervention to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 14	F 689		

prevent further falls. The intervention was inappropriate, to re-educate R12, as her BIMS score was an eight, indicating moderate cognitive impairment.

The "Progress Note," dated 08/29/21 at 11:28 AM, revealed the resident fell in her room. R12 sat upright next to bed, holding on to her walker handles, which had been tipped over, and her call light had not been activated. R12 was unable to recall what she was doing when she fell. The intervention on the care plan, dated 08/29/21, was for a referral to Physical Therapy and Occupational Therapy for possible therapy. The facility failed to implement an immediate intervention to prevent further falls.

The "Progress Note," dated 09/29/21 at 10:29 AM, revealed that a therapist came to the nurses' station to alert the nurse that R12 was on the floor. R12 was laying face down in front of her sofa and her walker was resting over her head in an upright position. The "Occurrence Follow Up" report, dated 10/04/21, indicated that the intervention implemented on 09/29/21 was staff to closely monitor R12 for increased unsteady gait and encourage her to use the wheelchair as her gait was unsteady. This was a duplicate intervention from 07/18/21. The facility failed to implement a new immediate intervention to prevent further falls.

On 10/27/21 at 01:59 PM, R12 had a sign in place on the sliding bathroom door to use her call light. She sat in her easy chair in her room, with the wheelchair locked beside her.

On 11/01/21 at 02:45 PM, R12 was sitting in her room in her easy chair, her walker was on one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 15	F 689		

side of her and her wheelchair was on the other side of her.

On 10/27/21 at 01:57 PM, R12 stated she could get in and out of her wheelchair by herself if "They (staff) were involved with others".

On 11/02/21 at 10:14 AM, Licensed Nurse (LN) G stated after a resident would fall, staff attempt to determine the cause of the fall and then update the care plan with a new intervention. We pass it on in report if a resident had a fall and what the new intervention should be. LN G stated that R12 was a fall risk but was not currently aware of what interventions were in place to prevent her falls.

On 11/02/21 at 10:25 AM, CNA M stated she was made aware of fall interventions by communication with the nurses, a binder that included the interventions, and could check the Kardex (contains resident information) to see if a resident had a fall. CNA M indicated R12 was a fall risk and staff try to make sure her wheelchair is in the resident's reach and locked, as she would try to stand on her own. Staff should make sure the resident's call light is close to her, try to keep her room door open, and toilet her every two hours. R12 will use her walker but staff try to encourage her to stay in the wheelchair. Sometimes R12 would try to grab the walker. Staff should make sure that the wheelchair is closer to her so she will use it.

On 11/02/21 at 03:13 PM, Administrative Nurse D stated the interventions should be placed immediately after a fall by the nurses, however, they do not put the intervention on the care plan. Administrative Nurse D reported she was responsible to place fall interventions on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 16	F 689		

care plan "As quick as possible". The nurses should pass on to the CNA's what the interventions were, and staff talk about it in "Huddles" (team meetings) as well. Administrative Nurse D stated R12 understands her use of her call light but chooses not to comply with the education given and did not believe that her BIMS score was a factor for her not using her call light.

The "Accidents and Occurrences Policy," undated, instructed the licensed nurse to communicate immediately interventions to prevent further occurrences or injury to the staff and update the care plan. The Director of Nursing or designee would ensure relevant, individualized interventions have been added to the care plan to prevent re-occurrence and complete a thorough investigation of the occurrence to determine casual factors.

The facility failed to implement immediate interventions following six falls from 07/12/21 through 09/29/21for R12 to prevent further falls.

- The "Order Summary Report," dated 10/04/21, for Resident (R)7, included diagnoses of unsteadiness on feet, need for assistance with personal cares, repeated falls, and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Admission Minimum Data Set" (MDS), dated 11/22/20, assessed R7 with a "Brief Interview of Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment. He required extensive assistance of one staff for bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 17	F 689		

mobility, transfers, locomotion, and extensive assistance of two or more staff for toilet use. Ambulation did not occur during the assessment period, and he had range of motion limitations to both upper and lower extremities. R7 used a walker and a wheelchair for mobility and his balance was not steady and required staff assistance for moving from a seated to a standing position, moving on and off the toilet, and moving from surface-to-surface. He had falls in the six months prior to admission but none since admission.

The "Falls Care Area Assessment," dated 12/07/20, indicated R7 had muscle weakness and Parkinson's and required extensive assistance for most activities of daily living (ADL's). He used a high back wheelchair for locomotion and worked with therapy to gain strength and to continue to use his "U-walker" (a walker with a patented u-shaped base for bracing in every direction). Staff reminded him frequently to use his call light frequently to call for any assistance and needs.

The "Quarterly MDS," dated 05/12/21, assessed R7 with a BIMS score of nine, indicating moderate cognitive impairment. He required extensive assistance of one staff for bed mobility, transfers, walking, locomotion, and toilet use. His balance was unsteady for transition and walking and required staff support to maintain. There was no change in impairment to his range of motion or the mobility devices used. He had two or more non-injury falls since the prior MDS assessment.

The "Quarterly MDS," dated 08/10/21, revealed no changes to R7's BIMS score, ADL function, balance, or mobility devices used. He had one non-injury fall since the prior MDS assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 18	F 689		

The "Care Plan," dated 08/12/21, included, but was not limited to, the following interventions:

1. Staff were to frequently remind him to wait for assistance and turn on his call light to transfer from one surface to another, dated 04/28/21.

2. Staff were to encourage him not to stand without assistance, and to evaluate him for anti-rollbacks for the wheelchair so if he did try to stand when in his wheelchair, the chair would not roll away from him, dated 05/22/21.

3. Staff were to not leave him up in his chair alone related to his poor safety awareness and attempts to ambulate without assistance, dated 08/08/21.

4. Staff were to review some evening activity opportunities with activity director/resident, dated 09/20/21.

5. Staff were to make sure his call light clipped so it did not fall out of place, dated 09/26/21.

6. Be sure R7's bedside table was within reach before leaving the room and refer to the diagram on the wall in his room. R7 would often attempt to get things not in reach, dated 10/04/21. An additional intervention, dated 10/04/21 indicated when staff sat R7 at the table before meals, makes sure he is faced the television or had some activity do so he did not become restless.

The "Morse Fall Scale," dated 04/15/21, located under the assessment tab in the electronic medical record, assessed R7 as a high risk for falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 19	F 689		

The "Progress Notes" revealed R7 fell on the following dates: 04/27/21, 05/20/21, 06/11/21, 06/13/21, 08/03/21, 09/08/21, 09/25/21, 10/03/21, 10/04/21, 10/08/21, and 10/25/21.

The "Progress Note," dated 04/27/21 at 06:51 PM, indicated R7 tried to get out of his bed at 02:00 PM and fell, that resulted in an abrasion two by two (lacked unit of measurement) to his forehead. The "Occurrence Fall Follow Up" report, dated 04/28/21, revealed he was on the floor face down with his upper torso on the floor and his legs on the bed. His call light had been activated for six minutes, and he had poor safety awareness and trunk control. The intervention, dated 04/28/21, was to frequently remind him to wait for assistance after turning on the call light to transfer from one surface to another. This intervention was not appropriate to prevent further falls due to his poor cognition, was not immediate as it was implemented after the fall and was a duplicate intervention as it was on the care plan with an initiated date of 01/24/21.

The "Progress Note," dated 05/20/21 at 04:17 PM, indicated R7 was laying on his right side on the floor. The "Occurrence Fall Follow Up" report, dated 05/22/21 revealed that R7 was in the dining room area and fell from his wheelchair. Review of the camera indicated a Certified Nurse Aide (CNA) pushed him to the table and locked the brakes to his wheelchair and a few minutes later he had attempted to stand multiple times with the wheelchair backing up each time. After several attempts, he missed the wheelchair, which had moved, and fell to the floor. The intervention, dated 05/20/21, was to encourage him to not stand without assist, which was inappropriate due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 20	F 689		

to his poor cognition. Another intervention, dated 05/22/21, was to evaluate for anti-rollback bars (prevents the wheelchair from moving backwards when there is not any weight to the seat of the wheelchair) so if he tries to stand when in the wheelchair it will not roll away from him. The "Care Plan" nor the "Progress Notes" from 05/20/21 through 06/14/21, indicated if anti-roll back bars had been placed to the resident's wheelchair. The facility failed to implement an appropriate immediate intervention following the fall.

The "Progress Note," dated 06/11/21 at 12:41 PM indicated R7 was laying on the floor on his right side next to his bed with the wheelchair at the foot of the bed, the bed was in low position, and the call light was not activated. R7 told the staff he needed to get up, staff assisted him to the bed and he immediately said he wanted to get up, so staff assisted him into his wheelchair and brought him to the nurse's station. R7 continuously voiced there was nothing for him to do. The "Occurrence Fall Follow Up," dated 06/13/21, indicated R7 often asked to go back to his room after meals and an intervention, implement on 06/18/21 was for a re-assessment of his activity plan. The care plan included this intervention, with an initiated date of 06/13/21, and a resolved date of 09/20/21, was two days following the fall. The intervention was not an immediate intervention to prevent further falls.

The "Progress Note," dated 06/13/21 at 07:01 PM, indicated R7 was on the floor laying in front of his bed with his legs at the head of the bed and the rest of his body was on the floor. R7 reported he wanted to get up to go find someone to help him get up. The "Occurrence Fall Follow Up,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 21	F 689		

report, dated 07/18/21 (greater than one month following the fall), indicated that R7 often would state he wanted to lay down but then would attempt to get back up without assistance, had confusion, but could make his needs known. Activity staff reviewed his care plan and added a plan for one to one activity to help when he was increasingly restless. The intervention implemented, on 06/18/21 was a re-assessment of the activity plan, which was a duplicate intervention from the prior fall. The care plan included this intervention, with an initiated date of 06/13/21, and resolved on 09/20/21. The facility failed to implement an appropriate immediate intervention following the fall to prevent further falls.

The "Progress Note," dated 08/03/21 at 05:58 PM, indicated R7 was on the floor outside of his room around 11:00 AM, and staff reinforced to him that he should use his call light. (R7 had poor cognition). The "Occurrence Fall Follow Up," report, dated 08/21/21 (18 days after the fall), that the camera review showed that he was walking out of his room without a walker into the hallway outside of his room where he lost his balance and fell. The intervention implemented on 08/03/21, instructed to not leave him up in the chair in his room alone due to poor safety awareness and he would attempt to ambulate without staff assistance. However, the care plan had the intervention with a date initiated of 08/08/21, which was five days after the fall. The facility failed to implement an immediate intervention following the fall.

The "Progress Note," dated 09/08/21 at 06:57 PM, indicated the nurse walked past R7's room and observed him laying on the floor at the foot of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 22	F 689		

the bed, the bed was in a low position and his wheelchair was next to his dresser. R7 voiced he had to "make a flight". A small abrasion was on his fourth finger on his knuckle (note lacked size or which hand). A CNA assisted the resident with cares and then placed the resident back to bed. Staff clipped the call light to the blanket on his chest. The "Occurrence Fall Follow Up" report, dated 09/20/21 (12 days after the fall), indicated that he self-transferred from the bed to the wheelchair without activating his call light. The intervention, implemented on 09/08/21, was to frequently remind him to wait for assistance and to turn on the call light to transfer from one surface to another. This intervention was not appropriate as resident had poor cognition. Furthermore, this was a duplicate intervention, as the care plan had the same intervention, dated 04/28/21, in place following the fall that he had on 04/27/21. The facility failed to implement and appropriate immediate intervention following the fall to prevent further falls.

The "Progress Note," dated 09/13/21 at 01:25 PM, indicated an unidentified family member communicated with the facility that R7's bedside table was not put back in his reach after nursing cares completed. The facility failed to follow the care plan to prevent further falls from occurring.

The "Progress Note," dated 09/25/21 at 09:39 AM, indicated R7 was on the floor at the foot of his bed, his bed was not in the lowest position, and the call light was on the floor. R7 reported to staff he was going to grab some candies and pointed at the dresser. Staff assisted him back to bed and gave him candy from the bedside table, placed the call light in reach and lowered the bed to the lowest position. The "Occurrence Fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 23	F 689		

Follow Up" report, dated 10/04/21 (eight days following the fall), revealed R7 had poor safety awareness and did not wait for someone to assist, the call light fell to the floor but he may have activated it had it been reachable. The intervention implemented on 09/26/21 was to make sure call light was clipped to him so it did not fall out of place (prior falls occurred without the use of the call light). An additional intervention, dated 09/26/21, staff was to keep frequently used items within reach for him. The care plan portion that indicated he was a high risk for falls, included an intervention, dated 01/13/21, to keep frequently used personal items within reaching distance. The facility failed to implement an appropriate immediate intervention following the fall to prevent further falls and failed to follow the care plan by not keeping items in his reach.

The "Progress Note," dated 10/03/21 at 03:44 PM, indicated R7 laid prone (face down) on the side of the bed, and the bed was in the low position. The bedside table was in place against the wall above his head, his wheelchair was in front of the closet, and the call light was not initiated. R7 voiced he tried to get a drink of water. R7 had a reddened area to his right cheek, ear, and knee. The "Occurrence Fall Follow Up" report, dated 10/04/21, indicated R7 had poor safety awareness and was impulsive at times. The intervention, implemented on 10/04/21, a day after the fall, revealed staff to keep the bedside table within the resident's reach before leaving the room, refer to the sign with the diagram on the wall in the room, and he often attempted to get things that were not within his reach. The facility failed to keep items in the resident's reach, per the care plan intervention, dated 01/13/21 and 09/26/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 24	F 689		

The "Progress Note," dated 10/08/21 at 06:57 AM, indicated R7 was on the floor on the right side of his bed, next to his tray-table. Staff assisted the resident back to his bed. When staff notified his family of the fall, family reinforced that the staff must keep this tray-table at arms-length to reach his necessities. The "Progress Note," dated 10/09/21, indicated R7 reported to staff he was reaching for cards on the floor. Staff documented there were no cards on the floor, but there was shiny tape that he may have been reaching to get, which could have resulted in him rolling out of his bed. The "Occurrence Fall Follow Up" report, dated 10/09/21, revealed that his tray-table was in place where the tape guide located. The intervention, dated 10/13/21, five days after the fall, was to have a care plan with his family to assess additional family support for fall prevention such as compassionate care visits in the evenings. The intervention on the care plan, had a date of initiation of 10/09/21. The "Progress Note," dated 11/01/21 at 01:12 PM, a late entry for 10/13/21 at 02:02 PM, indicated that a care plan meeting occurred with R7, his family, and facility staff. R7's family wished for stimulation during the day as he gets "ancy" with going back to his room after meals, but a CNA mentioned he would request to lay down after meals and he would unlock his wheelchair brakes. The facility would order a new wheelchair with brakes in the back to assist with fall prevention. The facility failed to implement an immediate intervention to prevent further falls.

On 10/27/21 at 03:07 PM, R7 was in his bed, his call light was within reach, the overbed table by his bed, however the bed was not in a low position.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 25	F 689		

On 10/27/21 at 03:08 PM, R7 reported he fell yesterday due to "clumsiness." He reported he walked, and he was on his way to the "Casino."

On 10/28/21 at 03:29 PM, R7 was in his bed, which was in a low position, the overbed table was next to his bed, and his phone was on the bedside table, out of his reach. A sign was in his room that had a diagram to indicate where the overbed table should be placed next to the bed and another sign that indicated his fluids, and phone should be on top of the overbed table in reach. The facility failed to follow the care plan and keep items within his reach.

On 11/01/21 at 10:12 AM, R7 was in his bed, the bed was in a low position, the overbed table was next to the bed. However, the resident's phone was on the bedside table out of his reach. The facility failed to follow the care plan and keep items within his reach.

On 11/01/21 at 01:11 PM, CNA O was told by an unidentified facility staff member that R7 was attempting to stand from his wheelchair in the living room area by his room. CNA O then assisted R7 to his room and to his bed.

On 11/01/21 at 01:27 PM, CNA O stated R7 was a fall risk, as he would try to stand up in the dining room on his own, but she had never seen him try to get out of his bed. R7 fell because he was in the wheelchair and wanted to be in his bed, so staff would not leave him in his room in the wheelchair by himself. Staff would do a room to room report, so staff would be informed if a resident had a fall and what the intervention would be.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 26	F 689		

On 11/02/21 at 10:14 AM, Licensed Nurse (LN) G stated after a resident would fall, staff would attempt to determine the cause of the fall and then update the care plan with a new intervention. Staff should report the residents falls and intervention in their shift to shift report.

On 11/02/21 at 10:25 AM, CNA M stated she was made aware of fall interventions by communication with the nurses. Staff review a binder that included the residents falls interventions, and staff could check the Kardex (contains resident information) to see if a resident had a fall. CNA M stated R7 was a fall risk, and staff should make sure his call light was in reach, put him to bed after meals, and provide activities to keep him busy. The bed should be kept against the wall and kept as low as possible, and the overbed table next to him with his water and his phone.

On 11/02/21 at 03:13 PM, Administrative Nurse D stated nurses should place immediate interventions after a fall, however, they (nurses) do not put the intervention on the care plan. Administrative Nurse D reported she was responsible to place fall interventions on the care plan "As quick as possible". The nurses should pass on to the CNA's what the interventions were, and staff talk about it in "Huddles" (team meetings) as well.

The "Accidents and Occurrences Policy," undated, instructed the licensed nurse to communicate to the staff immediately the interventions to prevent further occurrences or injury and update the care plan. The Director of Nursing or designee would ensure relevant,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 27	F 689		

individualized interventions have been added to the care plan to prevent re-occurrence and complete a thorough investigation of the occurrence to determine casual factors.

The facility failed to implement immediate interventions following eight falls from 04/27/21 through 10/08/21 and failed to follow care plan interventions to prevent further falls for this resident to prevent further falls.

- The "Order Summary Report," dated 10/04/21, for Resident (R)10, included diagnoses of repeated falls, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), other reduced mobility, other abnormalities of gait and mobility, altered mental status, and difficulty in walking.

The "Quarterly Minimum Data Set" (MDS), dated 11/19/20, indicated R10 had a "Brief Interview of Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment.

The "Quarterly MDS, " dated 02/15/21, lacked a cognitive assessment. R10 was independent and required no set up assistance for bed mobility, transfer, walking in his room, and locomotion. He was independent with set up assistance for walking in the corridor, required extensive assistance of one staff for dressing, and limited assistance of one staff for toilet use and personal hygiene. R10's balance was not steady but could stabilize himself without staff assistance during transitions and walking. He had impairment to his range of motion of both lower extremities and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 28	F 689		

used a walker for mobility. He was frequently incontinent of bowel and bladder and had two or more non-injury falls since the prior assessment.

The "Quarterly MDS," dated 05/16/21, assessed R10 with a "BIMS" score of 13, indicating intact cognition. He remained independent with bed mobility and transfers and required supervision for walking in his room. There were no changes with assistance needed for dressing and toilet use, supervision and setup for walking, and supervision and one assist for hygiene. His balance continued to be unsteady and he required staff to stabilize when moving on/off the toilet. There was no change in his range of motion to his lower extremities, he continued to use a walker for mobility, he was always incontinent of bladder and frequently of bowel and had two or more non-injury falls since the prior assessment.

The "Annual MDS," dated 08/12/21, assessed R10 with a "BIMS" score of 11, indicating moderate cognitive impairment. He required limited assistance of one staff for bed mobility, transfers, and personal hygiene, no change to dressing and toilet use, and required supervision and one assist for walking. There were no changes to his range of motion, and he used a walker and a wheelchair for mobility. His balance was unsteady, but he could stabilize himself when walking and turning around but required staff to help stabilize him when moving from seated to standing, moving on/off the toilet, and surface to surface transfers. He was frequently incontinent of bowel and bladder and had two or more non-injury falls since the last assessment.

The "Falls Care Area Assessment," dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 29	F 689		

08/30/21, indicated he required extensive assistance of one with his activities of daily living and had a potential to fall due to his diagnosis of Parkinson's disease and his unsteady gait. Staff were to assist him with bed mobility, transfers, and toilet use to prevent further falls/injuries.

The "Care Plan," dated 09/10/21, included, but was not limited to these interventions due to his fall risk:

1. Staff were to remind R10 to always use his walker even if only ambulating in his room for balance and safety, dated 05/07/20.

2. Encourage and assist R10 in keeping obstacle such as furniture placed to keep walkways free, dated 11/03/20.

3. Ensure his call light was within reach and staff encouraged him to use it for assistance as needed. Staff should remind him each time they were in his room to use his walker as he would frequently leave it at the end of his bed and moved about his room independently, dated 05/29/21.

4. Physical Therapy/Occupational Therapy to evaluate and treat upon arrival of new "U-step" walker "Within the next week", dated 08/10/21.

5. Staff should re-educate R10 to call for assistance, especially in the early morning hours due to tremors, dated 09/21/21.

The "Morse Fall Scale," dated 03/09/21, assessed R10 as a high risk for falling.

The "Progress Notes" revealed the resident fell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 30	F 689		

11 times from 04/30/21 to 10/23/21. The resident fell on these dates: 04/30/21, 06/12/21, 07/20/21, 08/02/21, 08/08/21, 08/15/21, 08/18/21, 08/30/21, 09/16/21, 10/19/21, and 10/23/21.

The "Progress Note," dated 04/30/21 at 01:45 PM, revealed R10 was on the floor at 01:20 PM, sitting with his back against the trash can that was close to the wall. R10 said he was eating his lunch, tried to get up, and his feet got caught on something. The "Occurrence Follow-up" report, dated 05/04/21, indicated he had been sitting in his chair at the bedside table eating lunch, he stood up, and caught his foot on the bar of the bedside table. The facility concluded that he tried to ambulate before his feet were firmly in place, and the intervention was to re-educate to make sure his feet were firmly in place on the floor prior to starting to stand/ambulate. At that time, R10 had impaired cognition (BIMS=11).

The "Progress Note," dated 06/12/21 at 07:00 PM, revealed the spouse called staff to the resident's room and R10 had fallen to the floor. The resident's walker was not in reach. R10 said he was watching television and wanted to walk to the table a few feet away to drink some water without using the walker. His legs were swollen, and they were heavy, and he dragged them on the carpet and finally gave up. He received a bruise (lacked measurement) on his left wrist. The "Occurrence Follow-up" report, dated 06/13/21, indicated he lost his balance getting a drink and the intervention, dated 06/12/21, (but was not on the care plan until 10/23/21,) was staff to remind him to always use his walker even if only ambulating in his room for balance and safety. The intervention was in place to the care plan with an original date of 05/07/20, the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 31	F 689		

failed to implement a new immediate intervention following the fall to prevent further falls.

The "Progress Note," dated 07/20/21 at 04:30 PM, indicated R10 fell at 04:30 PM in his room. He had a two by two (lacked unit of measurement) skin tear to his left wrist, and a two by two (lacked unit of measurement) abrasion (scraping or rubbing away of a surface, such as skin, by friction) on his left leg below his knee. R10 said he tripped over the legs of the room tray as he was walked with the walker. Staff reminded him to take his time and be patient when walking, walk when there is a clear path, and use the call light when he needed assistance. The "Occurrence Follow-up" report, dated 08/21/21 (greater than one month after the fall), concluded that the resident did not move the tray table sufficiently out of the way and tripped over the legs of the tray table. The resident does not activate the call light, and required frequent education to do so when he stands to ambulate on his own with the walker. The intervention was to encourage and assist him in keeping obstacles such as furniture placed to keep walkways free. This was a duplicate intervention as this intervention was in place for a date of 11/03/20. The facility failed to implement a new immediate intervention following the fall to prevent further falls.

The "Progress Note," dated 08/03/21 at 12:49 AM, revealed at 09:30 PM R10 fell in his room. The resident did not have his walker within reach. He reported to the staff he opened the refrigerator, lost his balance and fell. Staff reminded him to call for help and keep his call light within reach. The "Occurrence Follow-up" report, dated 08/21/21 (18 days after the fall),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 32	F 689		

concluded that he tried to open the refrigerator which was a low level, which caused him to bend over to open the door when he lost his balance and fell. Repeated education for the resident to call for assistance but he does not choose to do so. The intervention was to frequently re-educate him to always call for assistance due to increased unsteadiness. The care plan included an intervention, dated 05/29/21, to be sure his call light was in reach and encourage him to use it for assistance as needed. The facility failed to implement an appropriate intervention to prevent further falls as past education on using the call light was not effective.

The "Progress Note," dated 08/08/21 at 06:11 AM, indicated R10 fell in his room. He reported he thought he stepped on his left shoelace, which was not tied, and at the same time he was having tremors, which made him lose his balance and fall. He received a small skin tear (lacked measurement) on his left elbow. The "Occurrence Follow-up" report, dated 08/21/21 (13 days after the fall), indicated the intervention was to install a camera per family request to get better clarity on the cause of his frequent falls and to refer to the medical doctor/nurse practitioner regarding need for a neurology (branch of medicine that deals with disorders of the nervous system or medication adjustment related to his Parkinson's. The facility failed to implement an appropriate intervention to prevent further falls.

The "Progress Note," dated 08/15/21 at 06:11 AM indicated at 05:20 AM R10 fell. He received a skin tear (lacked measurement) to his right elbow. He reported to staff that he was walking from the bed to the recliner when his tremors got worse and he decided to stop, lost his balance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 33	F 689		

and fell. The "Occurrence Follow-up" report, dated 09/21/21 (greater than a month after the fall), concluded that tremors were the cause of the fall and that he chose to get up without activating the call light. The intervention was to re-educate him to call for assistance, especially in the early morning hours, due to his tremors, (which was on the care plan dated 09/21/21 [more than a month after the fall]). The care plan intervention, dated 08/15/21, was to request to view the camera in his room for better understanding of the fall, had a resolved date of 09/21/21. The facility failed to implement a new appropriate intervention to prevent further falls for this cognitively impaired resident.

The "Progress Note," dated 08/18/21 at 06:59 AM, indicated R10 was on the floor in front of his recliner when his family came in the room. R10 reported to staff that he did not fall he was halfway seated on his chair and halfway out of it, so he slid himself to the floor and thought he had pressed the call light for help. The fall lacked an "Occurrence Follow-up" report for the fall. The facility failed to investigate the fall and implement a new intervention to prevent further occurrence of falls.

The "Progress Note," dated 08/30/21 at 02:03 AM, indicated R10 was in his room walking, without his walker, and his legs began to have tremors. He "slipped" to the floor, that resulted in a skin tear (lacked measurement) to his left arm. The fall lacked an "Occurrence Follow-up" report for the fall and the facility lacked an intervention to prevent further falls.

The "Progress Note," dated 09/16/21 at 09:28 PM, indicated R10 fell in his room. He reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 34	F 689		

that he was standing in front of the recliner trying to reach a glass of drinking water from the table which was in front of him when both legs gave up and he "Sat" on the floor. He pulled himself back up to the recliner and called his family, who was there within minutes. Staff reminded R10 to call for help. The "Occurrence Follow-up" report, dated 09/20/21, indicated the facility purchased a specialized "U-step" walker for his use and would work with therapy when it came in. That intervention had a date on 09/22/21. The care plan included an intervention, dated 08/10/21, for Physical Therapy/Occupational Therapy to evaluate and treat upon arrival of the new "U-step" walker within the next week. The facility failed to implement a new intervention following the fall to prevent further falls.

The "Progress Note," dated 10/19/21 at 12:50 PM, indicated R10 fell in his room. His was o walker placed off to the side. The facility lacked an "Occurrence Follow-up" report for the fall until 11/03/21, after requested. The report indicated he had a moveable desk that he tripped over the leg when walking with the walker to throw away trash, the resident often did not use his walker or call for staff assistance. The report included an intervention, dated 10/19/21, for staff to encourage and assist him in keeping obstacles such as furniture placed to keep walkways free. The care plan included this intervention, initiated on 07/20/21 and revised on 08/21/21. The facility failed to investigate the fall in a timely manner and implement a new intervention to prevent further falls.

The "Progress Note," dated 10/23/21 at 01:36 PM, indicated R10 fell at approximately 01:00 PM in his room between his recliner and the edge of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 35	F 689		

the bed. He reported to staff he was trying to look for something in those bags and pointed at a bag by the bedside table, and when coming back to sit down he tripped on the bed frame, lost his balance, and fell. The fall resulted in three skin tears on the back of his left hand (lacked measurements) and a small abrasion (lacked measurements) on his left knee. The "Occurrence Follow-up", dated 10/24/21, revealed that R10 chose to be independent and was often found ambulating in his room without his walker, and his Parkinson's caused him to have times of unsteady gait. The report included the intervention implemented was to staff to remind him to always use his walker even if only ambulating in his room for his balance and safety. This was a duplicate intervention from the fall on 06/12/21 that did not get added to the care plan and reminders of using the walker had not been effective in the past. The facility failed to implement a new immediate intervention to prevent further falls.

On 10/27/21 at 04:04 PM, observed R10 ambulating independently in the hallway with a walker, gait slow and steady. He had a loose dressing in place to his left hand and a dressing in place to his left knee.

On 10/28/21 at 09:06 AM, observed R10 in his room. He had steri-strips (a tape used to keep the wound edges closed) to his left hand and a dressing to his left knee. There were several signs in his room regarding using his walker. R10 was in the recliner with an overbed table in front of him, with a breakfast tray in place. The walker was at the foot of the bed approximately six feet away from him at the foot of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 36	F 689		

On 10/28/21 at 09:08 AM, R10 stated he had a fall and that was the reason for the steri-strips to his left hand and the dressing to his knee. Furthermore, he stated that he does not always use his walker.

On 11/01/21 at 09:20 AM, observed R10 in his room. He had to take several steps to get to his walker, then used it to ambulate ad lib in his room.

On 11/01/21 at 09:25 AM, observed R10 standing at his dresser with the walker at the foot of the bed. He moved away from the dresser and placed his hand on the wheeled overbed table and walked over by a straight chair, then back over to his walker. He used the walker to move around in the room a short distance, then locked the walker, turned around and walked away from it and walked around in a circle, then walked back to the walker. The resident walked around the room some more, then he shut the door to his room.

On 11/02/21 at 10:14 AM, Licensed Nurse (LN) G stated R10 was a fall risk, he was to walk with a walker in his room, however he would forget to use it at times. Furthermore, LN G stated after a resident would fall, staff should attempt to determine the cause of the fall and then update the care plan with a new intervention. Staff pass it on in report if a resident had a fall and what the new intervention should be.

On 11/02/21 at 10:25 AM, CNA M stated she was made aware of fall interventions by communication with the nurses. There was also a binder that included the interventions and could check the Kardex (contains resident information)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 37	F 689		

to see if a resident had a fall. Furthermore, CNA M stated R10 was a fall risk. Staff try to remind him to use his walker and they go in often to make sure items are off the floor, the call light is in reach, and that his walker in with him. He will walk without the walker at times and will toilet himself. CNA M stated he fell one time when she was on duty, he was trying to go to the bathroom and did not activate his call light, and he tripped over the chair or the walker.

On 11/02/21 at 03:13 PM, Administrative Nurse D reported staff should immediately place an intervention after a resident fell, however, floor staff did not put the intervention on the care plan. Administrative Nurse D reported she was responsible to place fall interventions on the care plan "As quick as possible". The nurses should pass on to the CNA's what the interventions were, and staff talk about it in "Huddles" (team meetings) as well.

On 11/03/21 at 01:28 PM, Administrative Nurse D stated R10 lacked an investigation post fall for 08/18/21 and 08/30/21, and that neurological checks (an assessment of mental status, vital signs, pupil response, motor and sensory function) were done after the fall on 08/30/21. Staff were doing "Frequent checks" at the time of the neurological assessments and staff re-educated him to use the call light, especially during early morning hours due to his Parkinson tremors. Staff should always remind him to use a walker in his room.

The "Accidents and Occurrences Policy," undated, instructed the licensed nurse to communicate immediately interventions to prevent further occurrences or injury to the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 689	Continued From page 38 and update the care plan. The Director of Nursing or designee would ensure relevant, individualized interventions have been added to the care plan to prevent re-occurrence and complete a thorough investigation of the occurrence to determine casual factors. The facility failed to implement immediate and or appropriate interventions following 11 falls from 04/30/21 through 10/23/21forthis resident, to prevent further falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 690	Continued From page 39	F 690		

prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 37 residents with 12 selected for review including two reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). Based on observation, interview, and record review, the facility failed to keep the drainage bag from touching directly on the floor and anchoring the catheter tubing for one of the residents, Resident (7) with a history of urinary tract infections (UTI), creating a risk for developing further UTI's.

Findings included:

- The "Order Summary Report," dated 10/04/21, for Resident (R)7, included diagnoses of personal history of urinary tract infections, retention of urine, and obstructive and reflux uropathy (blockage in the urinary tract).

The "Admission Minimum Data Set" (MDS), dated 11/22/20, assessed R7 with a "Brief Interview of Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment. He required extensive assistance of two staff for toilet use, had an indwelling catheter in place, had a diagnosis of a urinary tract infection in the past

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 690	Continued From page 40	F 690		

30 days, and received and antibiotic for seven days of the assessment period.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 12/07/21, revealed he admitted to the facility post hospitalization for a UTI and had a history of UTI's. He required extensive assistance of two staff for toilet use and had a urinary catheter in place.

The "Care Plan, " dated 08/12/21, indicated that R7 had an indwelling catheter related to urinary retention, the catheter should be changed on the 21st of each month and to perform catheter care minimally every shift as needed. The care plan lacked instruction to ensure the catheter tubing had an anchor in place to secure the tubing or to keep the catheter collection bag off the floor.

The "Order Summary Report," dated 10/04/21, included an order for Levaquin (antibiotic-used to treat bacterial infections), 750 milligrams (mg), in the evening, every other day, for UTI, for one week, ordered on 09/28/21.

The "Physician Order," dated 09/29/21, instructed the staff to give R7 one liter of intravenous (IV-in the vein) normal saline, 0.9 percent, at 100 milliliters (ml) an hour, for acute kidney injury. The "Progress Note," dated 10/01/21 at 03:24 PM, revealed that R7 had a new order to discontinue the Levaquin and start cefdinir (antibiotic-used to treat bacterial infections), 300 mg, every 12 hours, for 10 days.

On 10/28/21 at 11:32 AM, R7 was in his bed, the bed was in a low position, the urinary catheter drainage bag directly touched the carpeted floor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 690	Continued From page 41	F 690		

and the urine in the drainage bag was the color of tea.

On 11/01/21 at 10:12 AM, R7 was in bed with his eyes closed, the bed was in a low position, the catheter drainage bag directly touched the floor, the urine in the drainage bag was dark yellow.

On 11/01/21 at 12:39 PM, Certified Nurse Aide (CNA) O assisted R7 with a transfer from his wheelchair to his bed. CNA O placed the catheter drainage bag on the frame of the bed, lowered the bed, which allowed the drainage bag to have direct contact with the carpeted floor.

On 11/01/21 at 01:19 PM CNA O stated that the urinary catheter bag should not touch the floor, the drainage bag should be kept in a privacy bag, and she did not know that he did not have one.

On 11/02/21 at 07:46 AM, R7 was resting in bed, the bed was in a low position, and the urinary catheter drainage bag touched directly on the floor. The privacy bag was attached to the bed frame, however, staff failed to place the urinary catheter drainage bag into the privacy bag.

On 11/02/21 at 10:00 AM, Licensed Nurse (LN) G, stated the urinary catheter drainage bag should not touch the floor, should be in a privacy bag, and the catheter tubing should be anchored to secure the tubing from possible trauma.

On 11/02/21 at 10:05 AM, R7 was in his bed, the bed was in a low position, the urinary catheter drainage bag directly touched the carpeted floor, and was not in a privacy bag to prevent the catheter bag from direct contact to the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 690	Continued From page 42 On 11/02/21 at 10:06 AM, upon request, LN G assessed R7 to see if a catheter anchor was in place and confirmed he lacked an anchor to secure the tubing. On 11/02/21 at 11:21 AM, Administrative Nurse D stated her expectations would be that a urinary catheter drainage bag should be in a privacy bag and should not touch the floor. Furthermore, the catheter tubing should be anchored. On 11/02/21 at 12:12 PM, Administrative Staff A stated that the competency for urinary and suprapubic catheter care is the facility policy. On 11/02/21 at 12:15 PM, Administrative Nurse E stated that R7 had repeated UTI's and that the staff had been educated on catheter care. The facility "Competency Assessment Catheter Care, Urinary," dated 09/2014, revealed that the purpose of the procedure was to prevent catheter-associated urinary tract infections, be sure the catheter drainage bag was kept off of the floor, and ensure the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. The facility failed to ensure that the urinary drainage bag was kept from directly touching the floor and an anchor was in place for the catheter tubing for this resident, who had a history of UTI's, creating a risk of developing further UTI's.	F 690		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 880	Continued From page 43	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 880	Continued From page 44	F 880		

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 37 residents. The facility identified one Resident (R)13, on transmission-based precautions. Based on observation, interview, and record review, the facility failed to ensure the housekeeping staff cleaned a contact precaution room in a sanitary manner to ensure effective/appropriate disposal of the trash in the room and the cleaning cloths in the appropriate receptacle. These failures had the potential for affect all residents in the facility.

Findings included:

- The physician "Progress Note," dated 11/01/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 880	Continued From page 45	F 880		

for Resident (R)13, included a diagnosis of clostridium difficile (contagious bacteria characterized by foul smelling frequent bowel movements).

On 11/02/21 at 10:55 AM, R13's room observed to have a covered bin with a red bag and a covered bin with a yellow bag near the room door. A sign on the door indicated contact enteric (intestinal) precautions.

On 11/02/21 at 10:56 AM, Housekeeping staff V identified that R13 was on precautions for clostridium difficile.

On 11/02/21 at 10:58 AM, Housekeeping staff V placed trash from R13's bathroom into the trash receptacle in the housekeeping cart receptacle outside of the resident's room. In addition, housekeeping staff V removed his soiled gloves, and placed the soiled gloves into the housekeeping cart receptacle.

On 11/02/21 at 11:05 AM, Housekeeping staff V placed the soiled cleaning cloths used to clean the outside of R13's toilet and other cloths used to clean surfaces in the bathroom and the room, in the soiled linen receptacle of the housekeeping cart located outside of R13's room, and continued to place the soiled gloves in the trash receptacle in the housekeeping cart.

On 11/02/21 11:54 AM, Housekeeping staff U stated that the trash and cleaning cloths were to be discarded in the biohazard bins inside of the room, the trash in the red-lined bag bin and the cleaning cloths in the yellow-lined bag bin.

On 11/03/21 at 02:36 PM, Administrative staff A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 880	Continued From page 46 revealed the last housekeeping training for isolation room cleaning was on 10/13/21. Administrative Nurse E would remind staff, both nursing and housekeeping, when the facility had resident going on isolation. The facility "Isolation Room Cleaning" daily task, dated 06/13/17, instructed staff that all linens, cleaning towels, and mop heads would go into the contaminated laundry bag located in the room, and all trash would be placed in the red hazard trash bag located in the room. The facility failed to ensure the housekeeping staff cleaned a contact precaution room in a sanitary manner to ensure effective/appropriate disposal of the trash in the room and the cleaning cloths in the appropriate receptacle.	F 880		