STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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	F 000		

The following citationars the result of a complaint investigation concluded at the facilty on 07/13/22.

On 07/13/22 at 12:00 PM the facilty received a copy of the "Immediate Jeopardy [IJ] Template" and was inormed of the IJ for Resident (R) 1.

On 07/06/22 at 03:36 PM Resident (R)1 had an oxygen saturation below normal parameters at 90%, which was down from the normal reading (96%) the previous day. Staff did not respond or assess this change. On 07/07/22 03:18 PM, R1's oxygen saturation was decreased from the previous day, at 88%. R1's pulse was 102, which was flagged as abnormal and increased from 62 the previous day. Staff did not respond to these changes and/or abnormal findings. On 07/07/22 at 07:33 PM Certified Medication Aid (CMA) M recorded R1's medications were not given at that time due to R1 had labored breathing and was unresponsive to CMA M's attempts to wake the resident. The note documented at 07:33 PM CMA M reported this to Licensed Nurse (LN) G. On 07/07/22 at 09:20 PM, almost two hours after identification of R1's decreased level of consciousness and labored breathing, the facility initiated emergency services. At that time R1 had an oxygen saturation of 64-71% on 5 liters of oxygen. R1 was cyanotic. R1 was transferred via ambulance to an acute center where he was intubated and admitted to critical care with respiratory failure, pneumonia and septic shock. Staff failed to detect, thoroughly assess, and respond to changes in the resident's condition which placed R1 in Immediate jeopardy.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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	Continued From page 1 On 07/13/22 the facility completed the following actions to remove the immediacy: Current licensed nurses will be re-educated by the DON or designee on 07/13/2022 on the community's policy regarding identification and notification of a resident's change in status. Licensed nurses will not be allowed to take an assignment until the education is completed. Interdisciplinary team has reviewed the re-education regarding identification and notification of a resident's change in status. The scope and severity remained at a "G." The 2567 was sent electronically on 07/22/22.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included six residents with three reviewed for recurring falls. Based on	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 2	F 600		

observation, record review, and interview, the facility failed to provide the necessary staff and, care and services including use of a full body lift per the residents' plan of care in order to ensure safety and the residents' highest practicable level of health and well-being. This deficient practice placed Resident (R)2 and R3, at increased risk for injury, fall related complications and impaired dignity.

Findings included:

- R2's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), and history of falling.

R2's "Quarterly Minimum Data Set (MDS)," dated 03/29/22 recorded a Brief Interview for Mental Status (BIMS) score of 13 which indicated R2 had intact cognition. The MDS further documented R2 required extensive assistance of one staff for bed mobility, transfer, walk in room, locomotion on unit, toileting, personal hygiene and bathing. The MDS recorded two or more non-injury falls since the previous assessment.

R2's "Fall Care Area Assessment (CAA)," dated 12/27/21, documented R2's balance was unsteady, and she required staff assistance to be able to stabilize. She was at risk for falls. She had a history of falls in the past six months prior to her admission. She had experienced multiple non-injury falls since her entry to the facility.

R2's "Care Plan" recorded an intervention dated 03/26/22 which directed R2 needed extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 3	F 600		

assistance from two staff members with mobility and used a walker. An intervention dated 03/26/22 directed R2 required assistance of two staff for toileting. The care plan recorded an intervention on 06/26/22 which directed to remind and encourage R2 to alert staff if she felt weak prior to ambulation and recorded R2 became weak during ambulation; she fell on 06/25/22.

The "Care Plan" further recorded an intervention dated 07/07/22 which directed staff to monitor for potential complications related to anemia (condition in which the blood doesn't have enough healthy red blood cells) which included fatigue, weakness, tachycardia (fast heart rate), tachypnea (rapid breathing), and unsteady gait. The plan of care recorded r2 was at risk for complications related to blood thinning medications. An intervention dated 07/07/22 directed staff to prevent falls which could potentially cause high risk of bleeding.

A "Nurse Note" on 06/25/22 at 11:30 AM recorded R2 called to sue the bathroom. The nurse applied a gait belt and prepared the walker. R2 was able to stand and walk approximately three feet before becoming weak. Staff lowered r2 to the floor. R2 had no injuries and her physician was notified.

A "Fall Documentation" note dated 07/06/22 at 06:25 PM recorded R2 was lowered to the floor with the assistance of one staff and a gait belt. By the bathroom door. R2 ambulated with a walker and one staff with gait belt. R2 had dizziness and weakness while returning from toileting. R2 told the staff member she could not make it back to the chair or bed, or back to the toilet. R2 asked staff to help her down. The staff member lowered r2 to the floor in a sitting position next to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 4	F 600		

walker. R2 sustained no injuries from the event. R2 was then assisted by two staff into a chair.

A "Fall Documentation" note dated 07/10/22 at 08:40 AM recorded R2 while she ambulated with a Certified Nurse Aid (CNA). The note recorded R2 ambulated with staff and a walker from her chair to the bathroom. She was lowered to the floor in the bathroom facing the toilet. The CNA called out for assistance and the nurse went to assist. No injury was noted though R2 did complain of hip pain. Staff alerted 911 and the resident was transported to the hospital.

On 07/12/22 at 08:15 PM, observation revealed R2 had a distinct urine odor about her and her hair appeared unclean.

On 07/13/22 at 01:30 PM, CNA Q stated that R2 was a one assist with transfers and ambulation. When CNA Q looked up R2's care plan, she stated, "Oh I guess she is a two assist."

On 07/13/22 at 01:35 PM, CNA MM stated that R2 was a one person assist for transfers and ambulation depending on how she felt; if R2 was feeling weak then staff would use two assist. Upon review of R2's care plan, CNA MM stated, "I guess she is a two assist with transfer and ambulation."

On 07/13/22 at 01:45 PM, Consultant II stated R2 should always have two staff to assist with transfers and ambulation due to R2's weakness and instability.

The facility's "Abuse Prevention," policy, revised April 2020, documented the facilities residents have the right to be free from abuse, neglect,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 5	F 600		

misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraints not required to treat the resident's symptoms. "Neglect" means the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

The facility failed to provide the necessary number of staff to assist R2 with transfers and ambulation and R2 subsequently had three assisted falls to the floor. This placed R2 at risk for injury and complications related to falls and at increased risk for impaired dignity.
- R3's Electronic Medical Record, (EMR) documented R3 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 beat), and heart failure (a condition with low heart output and the body becomes congested with fluid).

The "Significant Change Minimum Data Set (MDS)," dated 05/10/22, documented R3 had a "Brief Interview for Mental Status (BIMS)" score of 15 which indicated R3 was cognitively intact. The MDS further documented R3 required extensive assistance from one staff for bed mobility, transfer, locomotion on unit, dressing, and bathing. R3 required extensive assistance from two staff to meet her toileting needs. The MDS documented R3 was not stabile and was only able to stabilize with staff assistance for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 6	F 600		

moving from a seated to standing position, ambulation, moving on and off the toilet, and surface to surface transfers.

The facility lacked any "Care Area Assessment" (CAA) in the MDS.

The "Activities of Daily Living Care Plan," dated 06/16/22, directed staff to transfer R3 with two staff assistance using a full lift.

The "Fall Care Plan," dated, 06/16/22, directed staff to keep pathways clear and provide adequate lighting, keep bed at the appropriate height, keep personal items within reach, orient to room and call light. The "Care Plan" directed staff to use two person transfers as a fall intervention for a fall on 06/16/22. The "Care Plan" directed staff to use the full lift on every transfer until therapy gave an order for recommended transfer for fall on 06/23/22. The "Care Plan" directed staff to receive education to only use full lift with transfers until therapy determines otherwise for fall on 06/29/22.

The "Hendrich II Fall Risk Model," dated 06/16/22, documented R3 had a fall risk score of eight which indicated she was a high risk for falls.

The "Fall Documentation Note," dated 06/23/22, documented R3 fell while being transferred by one staff assist at 04:30 PM. R3 was lowered to the floor with one assist and gait belt. The resident had returned from an appointment and R3 wanted to get out of the wheelchair. R3 requested a Certified Nurse Aid (CNA) to stand/pivot transfer her to the recliner. When R3 was pivoting, her knee gave out and she was lowered to the floor. No injuries were noted at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 7	F 600		

time of fall.

The "Fall Documentation Note," dated 06/29/22, documented R3 fell when being transferred by assist of one CNA. R3 was transferring to the toilet and fell with her head under the sink, laying perpendicular to the toilet in the bathroom. No injury noted at the time of fall.

On 07/13/22 at 09:30 AM, CNA O stated R3 was a pivot transfer with gait belt with one or two assist. CNA O then looked up the care plan for R3 and stated that she was actually a full lift for transfers. CNA O stated staffing did not allow for two staff assist and full lift usage on the 02:00 PM to 10:00 PM shift.

On 07/13/22, Administrative Nurse D verified the two falls had occurred due to the CNA's not following R3's care plan which clearly stated she was to be a two person assist with a full lift.

The facility's "Abuse Prevention," policy, revised April 2020, documented the facilities residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraints not required to treat the resident's symptoms. "Neglect" means the failure of the community, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pa9in, mental anguish, or emotional distress.

The facility failed to provide the necessary number of staff and the use of a full body lift to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 600	Continued From page 8 assist R3 with transfers.R3 subsequently had two falls. This placed R3 at risk for injury and complications related to falls and at increased risk for impaired dignity.	F 600		
F 677 SS=E	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 had a census of 76 residents. The sample included five residents with five residents reviewed for activities of daily living (ADL's). Based on observation, record review, and interview, the facility failed to ensure staff provided consistent bathing and/or showers for five sampled residents, Resident (R) 7, R2, R1, R5, and R6. This placed the residents at risk for impaired dignity, infection, and alteration in skin integrity. Findings included: - R7's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), and major depressive disorder (major mood disorder). R7's "Quarterly Minimum Data Set (MDS)," dated 07/11/22, recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated R7 had intact cognition. The MDS further documented R7 required extensive assistance of two staff for bed	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 9	F 677		

mobility and transfer. R7 required extensive assistance of one staff for locomotion on and off the unit and personal hygiene. There was no bathing data recorded.

R7's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)," dated 10/15/21, documented R7 required extensive assistance of one staff for mobility and extensive of two staff for bed mobility and transfers.

The "ADL Care Plan," dated 01/11/22, directed staff to shower R7 with one staff assist.

The facility "Bathing Schedule" documented R7 was to be showered on Tuesdays and Fridays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R7 had not had a shower from June 25, 2022 thru July 13, 2022, 19 days without bathing.

On 07/12/22 at 02:00 PM, observation revealed resident having a disheveled appearance and had a distinct odor of urine.

On 07/12/22 at 02:00 PM, R7 stated that there was not enough staff to give her a bath in the evening because she was transferred with a full lift and that took two staff members. R7 stated that she paid over eight thousand dollars a month to stay at the facility and she expected to at least get a shower weekly and for the facility to have enough staff to care for her. R7 stated she had to be in bed by 08:00 PM because 08:00 PM is when the second CNA leaves. R7 stated she felt like she was being punished because she had required a full lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 10	F 677		

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's would have to use the full lift with one staff due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the floor for the two hours that staff had previously used to get showers done, it was impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor (resident care area) to cover the floor in order to get the showers completed. She said on the weekends, there was always a nurse on-call that would come in for coverage in order to complete showers.

The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the residents skin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 11	F 677		

The facility failed to ensure staff provided consistent bathing and/or showers for R7. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

- R2's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heart beat), and history of falling.

R2's "Quarterly Minimum Data Set (MDS)," dated 03/29/22 recorded a Brief Interview for Mental Status (BIMS) score of 13 which indicated R2 had intact cognition. The MDS further documented R2 required extensive assistance of one staff for bed mobility, transfer, walk in room, locomotion on unit, toileting, personal hygiene and bathing.

R2's "Activities of Daily Living (ADL's)Care Area Assessment (CAA)," dated 12/27/21, documented R2 needed assistance with ADL's. R2 needed setup assistance with eating. R2 needed extensive assistance from one staff member with personal hygiene and dressing. R2 needed extensive assistance from two staff members with bed mobility, transfers, walking in her room, locomotion on the unit, bathing and toileting. R2 was occasionally incontinent of bladder and frequently incontinent of bowel.

The "ADL Care Plan," dated 03/26/22, documented R2 needed extensive assistance from two staff for transfers and extensive assistance for bathing by one staff. R2 preferred a shower.

The facility "Bathing Schedule" documented R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 12	F 677		

was to be showered on Mondays, Wednesdays, and Fridays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R2 had not had a shower from June 30, 2022 thru 07/12/22, thirteen days without bathing.

On 07/12/22 at 08:15 PM, observation revealed R2 had a distinct urine odor about her and her hair appeared unclean.

On 07/12/22 at 08:15 PM, R2 stated that she had not had a shower for a while and she felt unclean and wished her hair was clean. R2 stated there was not enough staff to ensure she showered when she was supposed to.

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's would have to use the full lift with one staff due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the floor for the two hours that staff had previously used to get showers done, it was impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 13	F 677		

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor (resident care area) to cover the floor in order to get the showers completed. She said on the weekends, there was always a nurse on-call that would come in for coverage in order to complete showers.

The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the residents skin.

The facility failed to ensure staff provided consistent bathing and/or showers for R2. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

- R1's Electronic Medical Record (EMR) documented diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue).

R1's "Quarterly Minimum Data Set (MDS)," dated 06/11/22 documented R1 was rarely understood, had short term memory problems, had long term memory problems, and had severely impaired cognition. The MDS further documented R1 was totally dependent on two staff for transfers and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 14	F 677		

bathing, required extensive assistance of two staff for bed mobility, dressing, and toilet use, and required extensive assistance of one staff for locomotion on the unit, eating, and personal hygiene.

The "ADL Care Area Assessment (CAA)" was not triggered.

The "ADL Care Plan," dated 03/11/22, directed staff to transfer R1 with two assist and to shower R1 with one assist. R1 preferred a shower.

The facility "Bathing Schedule" documented R1 was to be showered on Tuesdays and Fridays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R1 had not had a bath from June 29, 2022 thru July 7, 2022, nine days without bathing.

R1 was unavailable for observation or interview.

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's would have to use the full lift with one staff due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 15	F 677		

floor for the two hours that staff had previously used to get showers done, it was impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor (resident care area) to cover the floor in order to get the showers completed. She said on the weekends, there was always a nurse on-call that would come in for coverage in order to complete showers.

The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the residents skin.

The facility failed to ensure staff provided consistent bathing and/or showers for R1. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

- R5's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), type 2 diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and atrial fibrillation (rapid, irregular heart beat).

R5's "Quarterly Minimum Data Set (MDS)," dated 07/12/22, recorded a Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 16	F 677		

Status (BIMS) score of 15 which indicated R5 had intact cognition. The MDS further documented R5 required supervision with set up help only for bed mobility, transfer, walk in room, eating, toilet use, and personal hygiene. R5 required one staff limited assistance for dressing. There was no bathing information documented.

R5's "Activity of Daily Living (ADL's) Care Area Assessment (CAA)," dated 10/19/21, documented R5 used a walker for mobility and needed limited staff assist for mobility.

The "ADL Care Plan," dated 05/31/22, documented R5 preferred to have a shower and directed staff to give R5 a shower after 08:00 PM on Saturday as R5 has a show she enjoys watching.

The facility "Bathing Schedule" documented R5 was to be showered on Thursdays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R5 had not had a shower from June 27, 2022 thru July 13, 2022, thirteen days without bathing.

R5 was unavailable for observation or interview.

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's would have to use the full lift with one staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 17	F 677		

due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the floor for the two hours that staff had previously used to get showers done, it was impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor (resident care area) to cover the floor in order to get the showers completed. She said on the weekends, there was always a nurse on-call that would come in for coverage in order to complete showers.

The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the residents skin.The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin.

The facility failed to ensure staff provided consistent bathing and/or showers for R5. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 18	F 677		

- R6's Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (rapid, irregular heart beat), hypertension (high blood pressure), and benign prostatic hypertrophy ((BPH) non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections).

R6's "Quarterly Minimum Data Set (MDS)," dated 04/30/22, documented a Brief Interview for Mental Status (BIMS) score of three which indicated R6 was severely cognitively impaired. The MDS further documented R6 required extensive assistance of one staff for bed mobility, transfer, walk in room, locomotion on unit, dressing, toilet use, personal hygiene, and bathing.

R6's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)," dated 10/14/21, documented R6 needed extensive assistance with ADL's related to weakness and decline in health status.

The "ADL Care Plan," dated 06/14/22, documented R6 would have his daily needs met and needed one to two staff assist with showers.

The facility "Bathing Schedule" documented R6 was to be showered on Wednesdays and Saturdays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R6 had not had a shower from June 6, 2022 thru July 13, 2022, 38 days without bathing.

R6 was unavailable for observation or interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 19	F 677		

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's would have to use the full lift with one staff due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the floor for the two hours that staff had previously used to get showers done, it was impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor (resident care area) to cover the floor in order to get the showers completed. She said on the weekends, there was always a nurse on-call that would come in for coverage in order to complete showers.

The facility's "Shower/Tub Bath Policy," revised December 2017, documented the purpose of the bathing policy was to promote cleanliness, provide comfort to the resident, and to observe the condition of the residents skin..

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 20 The facility failed to ensure staff provided consistent bathing and/or showers for R6. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.	F 677		
F 689 SS=D	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 identified a census of 76 residents. The sample included five residents with three reviewed for falls. Based on observation, interview, and record review the facility to provide adequate supervision to ensure safety for R4 who had seven falls in the last 90 days. This deficient practice placed R4 at increased risk for injury and complications related to falls. Findings included: - R4's Electronic Medical Record, (EMR) documented R4 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, and muscle weakness. The "Admission Minimum Data Set (MDS)," dated 05/24/22, documented R4 had a "Brief Interview for Mental Status (BIMS)" score of seven which indicated R4 had severe cognitive	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

impairment. The MDS further documented R4 required extensive assistance from two staff for bed mobility, transfer, locomotion on unit, dressing, toilet use, dressing, and bathing. R4 required extensive assistance from one staff for eating and personal hygiene. The MDS documented R4 was not stabile and was only able to stabilize with staff assistance for moving from a seated to standing position, ambulation, moving on and off the toilet, and surface to surface transfers.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 05/24/22, documented R4 scored a seven on her BIMS indicating severe cognitive impairment. R4 was alert and oriented to person.

The "Activities of Daily Living CAA," dated 05/24/22, documented R4 required extensive assistance with locomotion, dressing, eating, toileting, personal hygiene, bed mobility, transfers, and walking in her room.

The "Fall CAA," dated 05/24/22 documented R4's "Hendrich Fall Risk Model" scored a two which indicated that she was not a high risk for falls. R4 was documented as having falls prior to her admission to the facility.

The "Activities of Daily Living Care Plan," dated 05/18/22, directed staff R4 needed two staff assist with a full lift for transfers, one staff extensive assistance for eating, bathing, personal hygiene, and mobility in her wheelchair.

The "Fall Care Plan," dated 05/18/22, directed staff to keep pathways clear and provide adequate lighting, keep bed at appropriate height,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

and keep personal items within reach. The intervention put in place on 05/31/22 directed staff to use pillows in bed for positioning. The intervention put in place on 06/14/22 was for staff to assist R4 to the bathroom every morning at shift change and R4 was placed on the falling stars program. The intervention put in place on 06/21/22 was for staff to reposition and change R4 every 2 hours. The intervention put into place on 07/03/22 was for staff to place a floor mat next to R4's bed. The intervention put into place on 07/07/22 was R4 to not use an electric recliner.

The "Hendrich II Fall Risk Model," dated 05/20/22, documented R4 had a fall risk score of two which indicated she was not a risk for falls.

The "Hendrich II Fall Risk Model," dated 07/12/22, documented R4 had a fall risk score of nine which indicated she was a high risk for falls.

The "Fall Documentation Note," dated 05/30/22, documented R4 was found on the floor between the toilet and bed facing the door out to the hall at approximately 07:05 AM. R4's catheter and bag were still on the toilet. Range of motion and vital signs were within normal limits and R4 denied pain. R4 was assisted up off of the floor with gait belt and two staff members. R4 did not want her catheter to be reinserted.

The "Fall Documentation Note," dated 05/30/22, documented R4 was found lying on the floor at 04:45 AM. R4 was laying on her left side with feet toward the foot of the bed and head towards the head of the bed. R4 was laying on the floor next to her bed, on her left side, on top of her bedspread. R4 stated she was trying to change position and rolled out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

The "Fall Documentation Note," dated 06/13/22, documented R4 had a non-injury fall from her bed at 06:20 AM. R4 denied pain or striking her head. R4's range of motion and vital signs were within normal limits.

The "Fall Documentation Note," dated 06/21/22, documented R4 found lying on the floor at 03:00 PM. R4 found on her right side with her feet toward bed and head toward wall in room. R4 was next to her bed. R4 was incontinent. R4 was unable to verbalize what happened. R4 stated, "I think I broke my arm." Upon assessment, R4 denied pain with range of motion. R4 was assisted to her wheelchair with two staff assist and a gait belt.

The "Fall Documentation Note," dated 07/03/22, documented R4 was found lying on the floor at 11:45 PM on 07/02/22. R4 was on her left side with her feet toward the foot end of the bed and head toward head of the bed in her room. R4 was laying next to her bed. R4 had a bruise to her left upper arm and her left forehead. R4 had full range of motion to all extremities. R4 was assisted up by two staff assist to her bed.

The "Fall Documentation Note," dated 07/08/22, documented R4 was found laying on her floor on 07/07/22 at 10:00 PM. R4 was found laying on her right side with her back towards the recliner and facing the wall in her room. R4's legs were out in front of her with her arms at her side. The leg rest of the recliner was noted to be in the up position and R4 is not able to operate the leg rest. The Certified Nurse's Aide (CNA) stated she had just checked on R4 a few minutes prior to the fall and R4 was sitting in her recliner. R4 obtained a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

skin tear to her right wrist and a raised bump to her right forehead. R4 was anxious, restless, and agitated with no change from baseline. R4 was assisted up to her wheelchair by two staff and gait belt.

The "Fall Documentation Note," dated 07/12/22, documented R4 was found crawling on her hands and knees in the hallway. Staff were assisting another resident in their room. R4 denied injury. R4 was unable to explain what happened due to dementia. R4 was assisted up to her wheelchair by one staff using a gait belt.

On 07/12/22 at 08:30 PM, observation revealed R4 sat in her wheelchair outside her door with an automated vital sign machine's blood pressure cuff attached to her arm. R4 was restless and rocking back and forth in her wheelchair, reaching down to the floor, scooting out to the edge of her wheelchair seat. R4 asked to be handed her the shoes that were on the floor. There were no shoes observed on the floor. Further observation revealed one CNA and one Certified Medication Aide (CMA) providing cares at that time. The CNA was in and out of rooms assisting other residents to get ready for bed and the CMA was in and out of residents' rooms passing night time medications. There were no staff observing R4 for safety.

On 07/12/22 at 08:35 PM, CMA S stated R4 was hard to keep track of now that she was better. CMA S stated R4 was admitted on hospice care but was much more active now. CMA S stated R4 had just fell a little bit ago from her wheelchair.

On 07/12/22 at 09:00 PM, Licensed Nurse (LN) H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 stated R4 had just fell from her wheelchair but no one saw what happened because the other staff were in other rooms and LN H had been on another hall. The facility's "Fall Prevention Policy," revised January 2022, documented the intent of the policy was to provide an environment free from accident hazards, over which there is control, and provide supervision and interventions to residents to prevent avoidable accidents. Fall Risk Evaluation: Residents shall be evaluated by a licensed nurse during the admission process, routinely and as indicated to identify potential risk of fall. If the resident scores a higher risk for falls the resident shall be placed on the "Falling Stars Program." Fall Risk Intervention: The Interdisciplinary team shall identify individualized interventions to reduce the risk of falls. If systematic evaluation of a resident's fall risk identifies several possible interventions the associates may choose to prioritize interventions. If falling recurs despite initial interventions, associate shall implement additional, different interventions, or indicate why the current approach is still relevant. This documentation should be maintained in the clinical record The facility failed to provide adequate supervision to ensure safety for R4 who had seven falls in the last 90 days. This deficient practice placed R4 at increased risk for injury and complications related to falls.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 26	F 725		

the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 76 resident and five resident halls. Based on observation, interview, and record review, the facility failed to ensure there were a sufficient number of nursing personnel to provide care and respond to each resident's needs for two of five halls (Walker and Pfeifer). This placed the affected residents at risk for inadequate care and services.

Findings included:

- Review of the facility's staffing sheets for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 27	F 725		

last six months recorded Pfeifer and Walker halls were staffed with two Certified Nurse's Aides (CNA) on the 02:00 PM to 10:00 PM shift. On 07/01/22 through 07/12/22 (12 days) the schedule documented one CNA from 02:00 PM to 04:00 PM, two CNA's from 04:00 PM to 08:00 PM, and one CNA from 08:00 PM to 10:00 PM.

The facility failed to provide the necessary staff and, care and services including use of a full body lift per the residents' plan of care in order to ensure safety and the residents' highest practicable level of health and well-being. This deficient practice placed Resident (R)2 and R3, at increased risk for injury, fall related complications and impaired dignity. (refer to F600)

The facility "Bathing Schedule" documented R1 was to be showered on Tuesdays and Fridays on the 02:00 PM to 10:00 PM shift. The facility "Bathing Reports" documented R1 had not had a bath from June 29, 2022 thru July 7, 2022, nine days without bathing. (Refer to F677)

The facility "Bathing Schedule" documented R2 was to be showered on Mondays, Wednesdays, and Fridays on the 02:00 PM to 10:00 PM shift. The facility "Bathing Reports" documented R2 had not had a shower from June 30, 2022 thru 07/12/22, thirteen days without bathing. (Refer to F677)

The facility "Bathing Schedule" documented R5 was to be showered on Thursdays on the 02:00 PM to 10:00 PM shift. The facility "Bathing Reports" documented R5 had not had a shower from June 27, 2022 thru July 13, 2022, thirteen days without bathing. (Refer to F677)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 28	F 725		

The facility "Bathing Schedule" documented R6 was to be showered on Wednesdays and Saturdays on the 02:00 PM to 10:00 PM shift. The facility "Bathing Reports" documented R6 had not had a shower from June 6, 2022 thru July 13, 2022, 38 days without bathing. (Refer to F677)

The facility "Bathing Schedule" documented R7 was to be showered on Tuesdays and Fridays on the 02:00 PM to 10:00 PM shift. The facility "Bathing Reports" documented R7 had not had a shower from June 25, 2022 thru July 13, 2022, 19 days without bathing. (Refer to F677)

The "Fall Documentation Note," dated 07/12/22, documented R4 was found to be crawling on her hands and knees in the hallway. Staff were assisting another resident in their room. R4 denied injury. R4 was unable to explain what happened due to dementia. R4 was assisted up to her wheelchair by one staff using a gait belt.

On 07/12/22 at 08:30 PM, observation revealed R4 sat in her wheelchair outside her door with an automated vital sign machine's blood pressure cuff attached to her arm. R4 was restless and rocking back and forth in her wheelchair, reaching down to the floor, scooting out to the edge of her wheelchair seat. This surveyor attempted to talk to R4 and R4 asked this surveyor to give her the shoes that were on the floor. There were no shoes observed on the floor. There was one CNA and one Certified Medication Aide (CMA) providing cares at that time on the floor. The CNA was in and out of rooms assisting other residents to get ready for bed and the CMA was in and out of residents' rooms passing nighttime medications. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 29	F 725		

were no staff observing R4 for safety. (Refer to F689)

On 07/12/22 at 02:00 PM, observation revealed R7 had a disheveled appearance and a distinct odor of urine.

On 07/12/22 at 08:15 PM, observation revealed R2 had a distinct urine odor about her and her hair appeared unclean.

On 07/12/22 at 10:30 AM, Consultant HH stated that corporate had told the facility their staffing percentages had to decrease so the decision was made to change staffing ratios on the 2:00 PM to 10:00 PM shift to one CNA from 02:00 PM to 04:00 PM on each unit, two CNA's from 04:00 PM to 08:00 PM, and then one CNA from 08:00 PM to 10:00 PM. There seemed to be more down time from 02:00 PM to 04:00 PM and 08:00 PM to 10:00 PM.

On 07/12/22 at 02:00 PM, R7 stated that there was not enough staff to give her a bath in the evening because she was transferred with a full lift and that took two staff members. R7 stated that she paid over eight thousand dollars a month to stay at the facility and she expected to at least get a shower weekly and for the facility to have enough staff to care for her. R7 stated she had to be in bed by 08:00 PM because 08:00 PM is when the second CNA leaves. R7 stated she felt like she was being punished because she required a full lift.

On 07/12/22 at 08:15 PM, R2 stated that she had not had a shower for a while and she felt unclean and wished her hair was clean. R2 stated there was not enough staff to ensure she showered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 30	F 725		

when she was supposed to.

On 07/12/22 at 03:00 PM, Certified Nurse's Aide (CNA) O stated that the showers and baths on the evening shift were not getting done like they should be because the staffing had changed at the beginning of July down to one CNA from 02:00 PM to 04:00 PM and then a second CNA would come in from 04:00 PM to 08:00 PM, and then staffing went back down to one CNA from 08:00 PM to 10:00 PM. She also stated the CNA's are having to use the full lift with on staff due to staffing shortages.

On 07/12/22 at 03:15 PM CNA P stated staff had not been able to get the showers completed due to the staffing change on the 02:00 PM to 10:00 PM shift. CNA P stated with only one CNA on the floor for the two hours that staff had previously used to get showers done it is impossible to do. CNA P stated they could not leave the floor to do showers and leave the unit without any CNA available for the residents.

On 07/12/22 at 09:00 PM, Licensed Nurse (LN) H stated R4 had just fallen from her wheelchair but no one saw what happened because the staff were in other rooms and he had been on another hall.

On 07/13/22 at 11:00 AM, Administrative Nurse D stated that she was unaware that showers and bathing were not being completed. Administrative Nurse D stated if the CNA's could not get showers completed they could always call administrative nursing to the floor to cover the floor in order to get the showers completed and on the weekends, there was always a nurse on-call that would come in for coverage in order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 725	Continued From page 31 to complete showers. Upon request, the facility failed to supply a staffing policy. The facility failed to ensure that there were a sufficient number of nursing personnel to provide care and respond to each resident's needs for two of five halls (Walker and Pfeifer). This placed the residents at risk for inadequate care and services.	F 725		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 32	F 726		

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 76 residents with three residents reviewed for neglect. Based on observation, record review, and interview, the facility failed to ensure licensed nursing staff possessed the skills, and knowledge necessary to detect and respond to changes in a resident's condition. On 07/06/22 at 03:36 PM Resident (R)1 had an oxygen saturation below normal parameters at 90 percent (%), which was down from the normal reading (96%) the previous day. Staff did not respond to or assess this change. On 07/07/22 03:18 PM, R1's oxygen saturation was decreased from the previous day, at 88%. R1's pulse was 102 (normal adult range 60-100), which was flagged as abnormal and increased from 62 the previous day. Staff did not respond to these changes and/or abnormal findings. On 07/07/22 at 07:33 PM Certified Medication Aide (CMA) M recorded R1's medications were not given at that time due to R1 had labored breathing and was unresponsive to CMA M's attempts to wake the resident. A note documented at 07:33 PM CMA M reported this to Licensed Nurse (LN) G. On 07/07/22 at 09:20 PM, almost two hours after identification of R1's decreased level of consciousness and labored breathing, the facility initiated emergency services. At that time R1 had an oxygen saturation of 64-71% on 5 liters (l) of oxygen. R1 was cyanotic (bluish colored skin as a result of oxygen deprivation). R1 was transferred via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 33	F 726		

ambulance to an acute center where he was intubated (placement of a tube in a person's airway to maintain patency) and admitted to critical care with respiratory failure, pneumonia (lung inflammation caused by bacterial or viral infection) and septic shock (a life-threatening condition caused by a severe localized or system-wide infection that requires immediate medical attention). Staff failed to detect, thoroughly assess, and respond to changes in the resident's condition which placed R1 in Immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented diagnoses of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue).

R1's "Quarterly Minimum Data Set (MDS)," dated 06/11/22 documented R1 was rarely understood, had short term memory problems, had long term memory problems, and had severely impaired cognition. The MDS further documented R1 was totally dependent on two staff for transfers and bathing, required extensive assistance of two staff for bed mobility, dressing, and toilet use, and required extensive assistance of one staff for locomotion on the unit, eating, and personal hygiene. The MDS recorded R1 did not have any shortness of breath and required no respiratory treatments during the look back period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 34	F 726		

R1's "Cognitive Loss Care Area Assessment," dated 12/16/21, documented R1 had short- and long-term memory problems and was rarely/never understood.

R1's "Cognitive Loss/Dementia Care Plan," dated 09/09/17, documented R1 had memory problems, impaired decision-making skills and impaired ability to comprehend and documented R1 would have his needs met daily and directed staff to anticipate his needs and monitor for non-verbal cues.

R1's "Infection/IV's Care Plan," dated 04/08/20, directed staff to monitor for signs and symptoms of infection, document signs and symptoms of infection, and promptly report signs and symptoms of infection. The care plan directed staff to monitor for fever, coughing, sneezing, sore throat, and respiratory issues; respiratory assessment per facility protocol. The care plan directed staff to report change of condition to R1's primary care physician and resident representative.

R1's "Electronic Medication Administration Record (EMAR)," dated 06/28/22 directed nursing staff to monitor R1's respiratory status including vital signs and if there were any abnormal results for R1's baseline to contact R1's primary care physician.

On 07/06/22 at 03:36 PM, R1's EMR under the "Vital Stats" tab documented R1 had an oxygen saturation below normal parameters at 90%, which was down from the normal reading (96%) the previous day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 35	F 726		

Review of the resident's clinical record revealed the record lacked evidence staff assessed R1 in regard to the above change and/or notified the physician of the finding.

On 07/07/22 03:18 PM, the "Vital Stats" tab recorded R1's oxygen saturation was decreased from the previous day, at 88%. R1's pulse was 102, which was flagged blue as abnormal and increased from 62 the previous day.

Review of the resident's clinical record revealed LN I signed off on the respiratory observation, which lacked information whether R1 had a cough or respiratory distress. The record lacked evidence staff responded to changes and/or abnormal findings.

On 07/07/22 at 07:33 PM Certified Medication Aid (CMA) R recorded on the EMAR R1's medications were not given at that time due to R1 had labored breathing and was unresponsive to CMA M's attempts to wake the resident. The note documented at 07:33 PM CMA M reported this to Licensed Nurse (LN) G.

On 07/08/22 at 01:19 AM, the "Progress Note" documented CMA R notified LN G R1's respirations were labored and congested. LN G went and assessed the resident and advised CMA R to get a set of vital signs while LN G started checking R1's chart. When LN G got back to R1's room, he checked on R1's vital signs and called for LN H to come and assist him. LN H noted R1's oxygens saturation to be 64% and told CMA R to get oxygen. CMA R returned to R1's room with an oxygen concentrator and 5 Liters (L) of oxygen was administered to R1. R1's oxygen saturation rose to 71% on 5 L of oxygen via nasal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 36	F 726		

cannula. LN G noted rhonchi (continuous gurgling or bubbling sounds typically heard during both inhalation and exhalation) to the right upper lobe of the lung. R1 was cyanotic. 911 was called and LN H sent CMA R to meet Emergency Medical Staff (EMS) at the front door. LN G stayed with R1 until EMS arrived. After EMS arrived, R1's oxygen saturation was still at 71%. R1 was admitted to acute care facility at 11:39 PM with the diagnoses of pneumonia, respiratory failure, and septic shock.

On 07/12/22 at 01:30 PM Resident D stated that R1 hollered out, screamed all day long, and told the aides and the nurse that something was wrong with R1 because he couldn't speak, but he never screamed out like that. Resident D stated the nurse told her R1was fine and she should not worry about him.

On 07/12/22 at 08:55 PM LN H stated he was unaware of any changes to the resident's condition until LN G came to get him to assist in R1's care. When he got to the room R1 was struggling to breathe, EMS was called, and the crash cart was obtained. LN H stated that if a resident's pulse of 102 and an oxygen saturation of 88% were reported to him he would immediately call the doctor and report the findings because those are signs of sepsis. LN H stated respiratory assessments and vital signs were performed at 04:00PM every day in the facility.

On 07/13/22 at 05:30 AM LN G stated that he had not assessed R1 prior to the change in condition but he had seen R1 out at the dinner table and R1 appeared to be fine. LN G said that he did not get any information in the change of shift report that would make him suspect any change in R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 37	F 726		

condition until the CMA R came to get him. LN G stated when he got to the room R1 was struggling to breath and was lethargic. LN G stated if a pulse of 102 and an oxygen saturation of 88% had been reported to him, he would have immediately went to assess R1 and called to doctor to report the findings.

On 07/13/22 at 09:30 AM CNA M stated that the day before R1 was sent to the hospital, CNA M had noticed a change in R1 as he wasn't moving around in bed like he normally did, had liquid diarrhea, and when she checked R1's blood pressure she could not obtain a reading in either leg. The legs had to be used because R1 was so contracted in his arms. CNA M reported her finding to the nurse and she did not observe the nurse perform an assessment on R1.

On 07/13/22 at 09:30 am CNA N stated she had noticed a change in R1 prior to him being sent out to the hospital. R1 was much more lethargic than normal and was not eating like he normally would when she assisted him. R1's head was rolling back like he didn't have any strength. CNA N stated she reported her findings to the nurse and never observed the nurse assess R1.

On 07/13/22 at 12:20 PM, Consultant GG stated she had nothing to say about R1's situation or lack of notification by the facility of R1's change in condition.

On 07/13/22 at 02:00 PM Administrative Nurse D stated the respiratory assessments and vitals signs were assigned daily on the 2-10 shift and they are scheduled for 04:00 PM. The nurses were supposed to assess the respiratory status of all of the residents to ensure they were not having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 38	F 726		

respiratory distress. Administrative Nurse D verified the abnormal vital signs should have been reported to R1's primary care physician and the respiratory assessment should have been performed on R1.

On 07/13/22 Consultant Emergency Services HH stated in a telephone interview the emergency call was placed to 911 at 09:20 PM on 07/07/22.

The facilities "Change in a Resident's Condition or Status Policy," reviewed March 2022, documented the facility shall promptly notify the resident, his or her health care provider, and representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's health care provider or physician on call when there has been a(an): accident or incident involving the resident, discover of injuries of unknown source, adverse reaction to medication, significant change in the resident's physical/emotional/mental condition, need to alter the resident's medical treatment significantly, need to transfer the resident to a hospital/treatment center, discharge without proper medial authority, and/or specific instruction to notify the health care provider of changes in the resident's condition. A "significant change" of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by associate or implementing standard disease-related clinical intervention.

The facility failed to ensure licensed nursing staff possessed the skills, and knowledge necessary to detect and respond to changes in R1's condition. Staff failed to detect, thoroughly assess, and respond to changes in the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 726	Continued From page 39 condition which placed R1 in Immediate Jeopardy. On 07/13/22 the facility completed the following actions to remove the immediacy: Current licensed nurses will be re-educated by the DON or designee on 07/13/2022 on the community's policy regarding identification and notification of a resident's change in status. Licensed nurses will not be allowed to take an assignment until the education is completed. Interdisciplinary team has reviewed the re-education regarding identification and notification of a resident's change in status and it is in compliance with the CMS regulation F726. The scope and severity remained at a "G."	F 726		