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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 The following citations represent the results of a noncompliance revisit and complaint investigation KS00173920, KS00173495, KS00173497 and KS00173347. The 2567 was sent electronically on 08/25/22.	{F 000}		
{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 74 residents. The sample included six residents with six 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 Resident (R) 2, R3, R4, and R5. This placed the residents at risk for impaired dignity, infection, and alteration in skin integrity. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), and major depressive disorder (major mood disorder). R2's "Quarterly Minimum Data Set (MDS)," dated 05/14/22 documented R2 had a Brief Interview for Mental Status (BIMS) score of six which indicated	{F 677}		

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

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

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{F 677}	Continued From page 1	{F 677}		

severely impaired cognition. The MDS further documented R2 required extensive assistance of one to two staff for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene.

The "Activities of Daily Living (ADLs) Care Area Assessment (CAA)," dated 11/11/21, documented R2 required a sit to stand lift for transfers, did not walk, and was incontinent of bladder.

The "ADL Care Plan," dated 01/10/20, directed staff that R2 required total assistance of two staff to transfer to the shower and one staff extensive assistance to complete bathing and R2 preferred to shower.

The facility "Bathing Schedule" documented R2 was to be showered on Sundays and Thursdays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R2 had one bath from August 4, 2022 thru August 15, 2022 (12 days). The record evidence the resident refused bathing.

On 08/16/22 at 10:30 AM, observation revealed R2 sat in a wheelchair at a table. R2 had a long growth of shaggy gray facial hair and his hair was unkempt and oily.

On 08/16/22 at 10:30 AM, R2 stated he was not growing a beard but had not been shaved recently. R2 reached up and rubbed his face and stated, "It's scratchy."

On 08/16/22 at 11:00 AM, Certified Nurse's Aide (CNA) O stated that it was more difficult to get the bathing tasks completed because there didn't seem to be enough time in the day.

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On 08/16/22 at 11:15 AM, CNA P stated bathing the residents was hard to complete in a single shift but staff were doing the best they could.

On 08/16/22 at 11:30 AM, Administrative Nurse D stated that she had been auditing the showers/baths on a daily basis throughout the week and if she was seeing that a resident had not received a shower or a bath at least once in the week she was ensuring the resident received a bath that day. Administrative Nurse D stated that a lot of the bathing was getting completed but not charted so there was an audit completed to ensure all agency staff were able to get on to the EMR to complete charting. Administrative Nurse D stated she expected staff to follow the resident's bathing schedule and chart if the resident refused instead of charting the shower was not given.

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.

- R3's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), and major depressive disorder (major mood disorder).

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R3's "Admission Minimum Data Set (MDS)," dated 07/12/22, documented R3 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS further documented R3 required extensive assistance of two staff for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene.

The EMR lacked an "Activities of Daily Living (ADLs) Care Area Assessment (CAA).

The "Urinary Incontinence Care Area Assessment (CAA)," dated 07/12/22, documented R3 needed extensive assistance from two staff members with toileting and was frequently incontinent of bladder

The "ADL Care Plan," dated 01/10/20, directed staff that R3 required extensive assistance for bathing.

The facility "Bathing Schedule" documented R3 was to be showered on Tuesdays and Fridays on the 02:00 PM to 10:00 PM shift.

The facility "Bathing Reports" documented R3 had zero baths from August 4, 2022 thru August 15, 2022. R3 did not have a bath in twelve days and had no refusals recorded.

On 08/16/22 at 10:30 AM, observation revealed R3 sat in his recliner watching TV. R3 had unkempt hair and dirty fingernails.

On 08/16/22 at 11:00 AM, Certified Nurse's Aide (CNA) O, stated that it was more difficult to get the bathing tasks completed because there did not seem to be enough time in the day.

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On 08/16/22 at 11:15 AM, CNA P stated bathing the residents was hard to complete in a single shift, but staff were doing the best they could.

On 08/16/22 at 11:30 AM, Administrative Nurse D stated that she had been auditing the showers/baths on a daily basis throughout the week and if she was seeing that a resident had not received a shower or a bath at least once in the week she was ensuring the resident received a bath that day. Administrative Nurse D stated that a lot of the bathing was getting completed but no charted previously so there was an audit completed to ensure all agency staff were able to get on to the EMR to complete charting. Administrative Nurse D stated she expected staff to follow the resident's bathing schedule and chart if the resident refused instead of charting the shower was not given.

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 R3. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

- R4's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (rapid, irregular heart beat) and major depressive disorder (major mood disorder).

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R4's "Quarterly Minimum Data Set (MDS)," dated 05/21/22, documented R4 had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS further documented R4 required extensive assistance of one to two staff for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene.

The EMR lacked an "Activities of Daily Living (ADLs) Care Area Assessment (CAA).

The "Urinary Incontinence Care Area Assessment (CAA)," dated 07/12/22, documented R4 needed extensive assistance from two staff members with toileting and was occasionally incontinent of bladder.

The "ADL Care Plan," dated 09/10/21, directed staff that R4 required extensive assistance for bathing.

The facility "Bathing Schedule" documented R4 was to be showered on Sundays and Wednesdays on the 06:00 AM to 02:00 PM shift.

The facility "Bathing Reports" documented R4 had one bath from August 4, 2022 thru August 15, 2022. R4 had one bath in twelve days. The record lacked evidence the resident had refused.

On 08/16/22 at 10:30 AM, observation revealed R4 sat in her wheelchair at a table in the dining room. R4 had a distinct odor of urine about her and her chin had a growth of coarse gray hair.

On 08/16/22 at 11:00 AM, Certified Nurse's Aide (CNA) O stated that it was more difficult to get the bathing tasks completed because there didn't

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seem to be enough time in the day.

On 08/16/22 at 11:15 AM, CNA P stated bathing the residents was getting harder to complete in a single shift, but staff were doing the best they could.

On 08/16/22 at 11:30 AM, Administrative Nurse D stated that she had been auditing the showers/baths on a daily basis throughout the week and if she was seeing that a resident had not received a shower or a bath at least once in the week she was ensuring the resident received a bath that day. Administrative Nurse D stated that a lot of the bathing was getting completed but no charted previously so there was an audit completed to ensure all agency staff were able to get on to the EMR to complete charting. Administrative Nurse D stated she expected staff to follow the resident's bathing schedule and chart if the resident refused instead of charting the shower was not given.

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 R4. This placed the resident at risk for impaired dignity, infection, and alteration in skin integrity.

- R5's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), and major depressive disorder (major mood

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disorder).

R5's "Quarterly Minimum Data Set (MDS)," dated 08/02/22, documented R5 had short- and long-term memory problems. The MDS further documented R5 required extensive assistance of one to two staff for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene.

The EMR lacked an "Activities of Daily Living (ADLs) Care Area Assessment (CAA).

The "Urinary Incontinence Care Area Assessment (CAA)," dated 02/05/22, documented R5 needed extensive assistance from two staff members with toileting and was always incontinent of bladder and bowel.

The "ADL Care Plan," dated 09/10/21, directed staff that R5 required extensive assistance for bathing.

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

The facility "Bathing Reports" documented R5 had one bath from August 4, 2022 thru August 15, 2022. R5 had one bath in twelve days. The record lacked evidence of bathing refusals.

On 08/16/22 at 10:30 AM, observation revealed R5 sitting in her wheelchair at a table in the dining room. R5's hair was unkept and oily and she had a growth of gray hair on her chin.

On 08/16/22 at 11:00 AM, Certified Nurse's Aide (CNA) O stated that it was more difficult to get the bathing tasks completed because there didn't

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{F 677}	Continued From page 8 seem to be enough time in the day. On 08/16/22 at 11:15 AM, CNA P stated bathing the residents was getting harder to complete in a single shift, but staff were doing the best they could. On 08/16/22 at 11:30 AM, Administrative Nurse D stated that she had been auditing the showers/baths on a daily basis throughout the week and if she was seeing that a resident had not received a shower or a bath at least once in the week she was ensuring the resident received a bath that day. Administrative Nurse D stated that a lot of the bathing was getting completed but no charted previously so there was an audit completed to ensure all agency staff were able to get on to the EMR to complete charting. Administrative Nurse D stated she expected staff to follow the resident's bathing schedule and chart if the resident refused instead of charting the shower was not given. 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.	{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 -	{F 689}		

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§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 74 residents with three reviewed for falls. Based on observation, record review and interview, the facility failed to follow the care plan and provide adequate supervision to keep Resident (R) 1 safe from falls which placed R1 at increased risk for falls and related injuries.

Findings Included:

- R1's Electronic Medical Record, (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and unsteadiness on feet.

The "Quarterly Minimum Data Set (MDS)," dated 06/21/22, documented R1 had a Brief Interview for Mental Status Score of eight which indicated R1 had severely impaired cognition. The MDS further documented R1 required limited to extensive assistance of two staff for bed mobility, transfer, ambulation in room, locomotion on unit, dressing, and toileting.

The "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" dated 03/21/22, documented R1 required extensive assistance with all of her activities of daily living and was a high risk for

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falls.

The "Hendrick II Fall Risk Model," dated 03/16/22, documented R1 had a fall risk score of seven which indicated R1 was a high risk for falls.

The "ADL Care Plan," dated 03/15/22, directed staff to provide R1 with two staff assistance for transfers and toileting.

The "Fall Care Plan," dated 03/15/22, directed staff to keep pathways clear and provide adequate lighting, keep R1's bed at the appropriate height, keep personal items within reach, and orient R1 to her room and call light. The intervention put into place on 03/29/22 directed staff to assist R1 to the bathroom around breakfast time. The intervention put into place on 04/30/22 directed staff to perform a complete head to toe assessment for change in condition and increase behaviors that may lead to falls. The intervention put into place on 05/20/22 directed staff to educate and orient R1 to her chair controls. The intervention put into place on 08/09/22 was staff education to be completed regarding R1's transfer status.

The "Fall Documentation Note," dated 08/08/22 documented a Certified Nurse's Aide (CNA) transferred R1 from her wheelchair to the toilet. When R1 was turning towards the toilet R1 stopped and began to turn back to the wheelchair and the CNA had to lower R1 to the floor. R1 was sitting upright on her buttocks. No injury noted at the time of fall.

On 08/15/22 at 11:30 AM, observation revealed R1 sat at a table in her wheelchair and drank water. R1 had scattered light purple bruising to

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her forearms.

On 08/15/22 at 11:45 AM, CNA M stated R1 was transferred with one staff assistance and a gait belt.

On 08/16/22 at 10:30 AM, Administrative Nurse D stated she expected all staff to follow the resident's care plan and use two staff assist for transfers and toileting and agreed the assisted fall could have been avoided if two CNA's had been performing the transfer to the toilet. Administrative Nurse D stated education had been provided to the CNA regarding two assist transfer status of R1.

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.

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{F 689}	Continued From page 12 The facility's "Care Plan" policy, revised October 2021, documented a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident physical, psychosocial, and functional needs, that are identified through evaluation and assessment, is developed and implemented for each resident. Each resident's comprehensive person centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care including the right to: participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the plan of care, participate in establishing the expected goals and outcomes of care, participate in determining the type, amount, frequency, and duration of care, and receive the services and/or items included in the plan of care. The facility staff failed to follow the care plan and provide appropriate services for R1 to keep the resident safe from falls.	{F 689}		