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	175498	A. BUILDING _____ B. WING _____	C 03/28/2023

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

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F 000	INITIAL COMMENTS The following citations are the result of abbreviated complaint investigation KS00179143, KS00179041, KS00178874 and KS00178823. The 2567 was sent electronically on 04/10/23.	F 000		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents with three residents reviewed for dementia services. Based on record review, observation, and interview the facility failed to provide the necessary dementia (progressive mental disorder characterized by failing memory, confusion) care and services to maintain Resident (R) 1's highest practicable physical and mental health and wellbeing. This placed the resident at risk for decreased quality of life and safety. Findings included: - The Electronic Medical Record (EMR) documented R1 had diagnoses of dementia, hallucinations (sensing things while awake that appear to be real, but the mind created), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The "Quarterly Minimum Data Set (MDS)," dated	F 744		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/10/2023

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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01/17/23, documented R1 had a Brief Interview for Mental Status score of four which indicated severe cognitive impairment. The MDS documented R1 required limited to extensive assistance of one to two staff for bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. R1 required supervision of one staff for locomotion. The MDS documented R1 exhibited wandering behavior four to six days during the lookback period.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 10/17/22, documented R1 was oriented only to herself and had a sever decline in cognition. The CAA documented R1 had wandered four to six days during the look back period placing her at risk for entering potentially dangerous areas.

The "Activities of Daily Living (ADL) CAA," dated 10/17/22, documented R1 required extensive staff assistance with bed mobility, transfer, and toilet use. R1 required extensive one staff assistance with locomotion on and off the unity with the use of a wheelchair. The CAA documented R1 had difficulty remembering to follow physician and therapy recommendations for activity.

The "Behavior CAA," dated 10/17/22, documented staff had reported R1 had behaviors of wandering for four to six days during the lookback period that placed R1 at risk for entering potentially dangerous areas.

The "Cognitive Loss/Dementia Care Plan," dated 10/10/22, documented R1 had memory problems, impaired decision-making skills, and impaired ability to comprehend. The care plan directed

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staff to meet R1's basic needs daily, provide cues to promote independence and ensure safety, provide consistent physical environment and daily routine, and to provide supervision.

The "Behavior Care Plan," dated 12/13/22, documented R1 wandered and was on the elopement precaution list and directed staff to ensure R1's whereabouts at all times, round on R1 frequently during the night to ensure that R1 is not wandering. If R1 is found wandering staff are to redirect her back to her room and assist her with going to the restroom, having a drink or a snack or being tucked in.

The "Nurse's Note," dated 02/28/23 documented R1 was wheeling around the unit in her wheelchair. R1 was very restless and could not stop moving around. R1 was going into other resident's rooms, was walking without assistance, and could not be redirected, R1 had a difficult time remembering to leave her mask pulled up out of her room. A call was placed to R1's Durable Power of Attorney (DPOA) to see if he could come up and be with R1. The nurse would place a call to geriatric psych provider to see if an as needed medication could bed prescribed as R1 had not had any sleep through the night. DPOA up to sit with R1.

The "Nurse's Note," dated 02/28/23, documented R1's geri-psych provider had been contacted regarding R1's behavior that morning and how R1 had not been to sleep since the day before. The geriatric psychiatric provider prescribed Xanax (anxiety medication) 0.25 milligrams (mg) twice a day and Zoloft (anti-depressant medication) 25 mg every day.

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The "Nurse's Note," dated 02/28/23 documented Xanax was given at 08:00 AM. Around 09:23, DPOA left and stated R1 had been asleep for 10 minutes. R1 was able to sleep for two hours. Upon awakening, R1 ate lunch in her room. Later in the afternoon, R1 came out of her room and staff educated R1 on the importance of not leaving the unit, not entering others rooms, and wearing a mask. R1 appeared to have improved from her morning anxiousness as she was not trying to go into as many rooms and was just wheeling around the unit in her wheelchair.

The "Nurse's Note," dated 03/01/23, R1 was started on Xanax twice a day and Zoloft daily. Staff reported R1 slept all of last night. R1 complied with wearing her mask in the commons area. R1 ate all her meals at the dining room table furthest away from others. R1 appeared to be content just sitting in her wheelchair and would occasionally wheel around but did not try to go into any other rooms. R1 did not try to leave the unit today. R1 did very well until about 04:00 PM when she appeared to become very anxious as she was quickly wheeling all around the unit and heading towards other residents' rooms. Staff were unable to redirect R1 as she appeared to be on a mission.

The "Nurse's Note," dated 03/08/23, documented R1 was found in a male resident's room. R1 was assisted out of the male residents room. DPOA's of both residents informed of incident and a fax was sent to R1's primary care physician to advise.

The "Nurse's Note," dated 03/09/23, documented R1's primary care physician had returned a fax acknowledging that R1 had wandered into a

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males room and got into his bed.

The "Nurse's Note," dated 03/09/23, documented R1's geriatric psych provided had rounded and increased R1's Zoloft to 50 mg daily.

The "Nurse's Note," dated 03/14/23, documented a head to toe assessment was completed and there were no abnormal findings. No bruising, redness, or edema (swelling) noted.

The "Nurse's Note," dated 03/15/23, documented R1 continued to wander aimlessly throughout the unit via self-propelled wheelchair. R1 continued to go inside other resident's rooms despite them keeping their doors closed because of R1's wandering behavior. R1 opened the doors and went into other resident's room without permission. R1 has impaired hearing and does not hear staff or other residents attempting to redirect her. R1 needs someone very close in distance to re-direct. R1 continues to wander and roam.

The "Progress Note," dated 03/20/23, documented the licensed social worker of the facility spoke to R1's DPOA regarding R1's wandering. DPOA asked if there was a problem and the social worker assured him there was not, but at times R1 wanders into other resident's rooms and the facility was looking for other potential interventions to help keep R1 busy. DPOA suggested having R1 fold clothing.

The "Facility Incident Report," dated 03/20/23, documented on 03/14/23, Licenesed Nurse (LN) G stated that R1 had entered R2's room at approximately 09:00 PM and was found by Certified Nurse Aid (CNA) M. CNA M immediately

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removed R1 from R2's room and notified LN G. Video footage confirmed R1 entered R2's room at 09:12 PM and was removed from R2's room at 09:18 pm. Prior to entering the room, R1 was witnessed propelling in the neighborhood in her wheelchair. LN G stated R1 was found in R2's room with her bra and brief on the floor. R2 was sleeping in his bed with no clothes on (this is how resident always sleeps). R1 was removed from the bed, covered up, and removed from the room. R1 did state she thought R2 was her husband and was upset because she wanted to lay down with him. R1 was able to climb in and out of bed by herself and could undress herself. R1 was assessed with no injuries.

The "Progress Note," dated 03/23/23, documented the leadership team met to discuss R1's wandering behaviors and would have the facility social worker schedule a care plan with R1's family to proceed on how to care plan to keep R1 safe. Staff reported R1 continued to wander in the neighborhood and tried to enter other resident's rooms.

The "Progress Note," dated 03/23/23 documented the facility licensed social worker spoke with R1's DPOA regarding scheduling a care plan due to R1's increased wandering and attempting to wander into other resident's rooms. The licensed social worker explained to R1's DPOA that for R1's safety for the increased wandering it was suggested to have a care plan meeting. DPOA asked the social worker if it was truly necessary as they had recently had a care plan meeting and the licensed social worker told R1's DPOA yes due to R1's increased wandering.

The "Nurse's Note," dated 03/25/23, documented

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R1 only needed to be redirected a few time from going into others rooms and the kitchen. Residents that normally call out and have increased anxiety on the unity were not out in the common's area this evening which could be a result of R1's improved wandering and decreased anxiety of wheeling around the unit aimlessly and sometimes at a pace that is faster than what may be safe for self-propelling her wheelchair but using her legs to accelerate.

The Nurse's Note," dated 03/25/23, documented R1 had attempted to exit the unit multiple times. R1 had attempted to go into other resident's rooms several times. R1 was easily redirected but required frequent monitoring and redirection.

The "Nurse's Note," dated 03/26/23, documented R1 was doing well this shift. R1 walked to church this morning as well as the harp concert. R1 folded laundry for twenty minutes. Staff reported R1 only went into one room this shift and was sitting in her wheelchair next to the resident's bed. R1 appeared calmer today than she has on other days and has not been roaming around the unit much.

The "Nurse's Note," dated 03/26/23, documented R1 had a good day. The nurse walked R1 down to church, R1 ate all her meals in the dining room, R1 sat and worked a puzzle for an hour, folded laundry, played cards with her daughter, and wiped tables with a wet rag. R1 was seen attempting to go into one room but was redirected as soon as she started to enter. R1 appeared content while doing activities.

On 03/28/23 at 11:00 AM, observation revealed R1 wandering in her wheelchair around the

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neighborhood. R1 was re-directed to her lunch table and R1 went to the appropriate table and sat with a table mate.

On 03/28/23 at 10:45 AM, LN H stated R1 wandered quite a bit throughout the neighborhood and sometimes was in and out of other residents' rooms. Depending on the day, R1 could be easily redirected and other days she was not easily redirected. There had been times when R1 had tried to get into the kitchen area.

On 03/28/23 at 11:00 AM, CNA N stated R1 wandered all over the neighborhood in her wheelchair, sometimes self-propelling so fast that she wasn't safe. CNA N stated R1 required a lot of supervision.

On 03/28/23 at 02:30 PM, Administrative Nurse D stated that she expected all staff to supervise residents who wandered to keep them safe from themselves and the environment.

The facility, "Memory Support Policy," revised May 2021, documented the facility would provide services to support the resident's goals, personal preferences, lifelong interests, routines for daily activities, privacy, and freedom of choice. Residents with behavioral expressions and/or anxiety who may benefit from a supportive residence that offers safety, security, meaningful activities, and an environment that minimizes stress.

The facility failed to provide R1 with adequate dementia care and services related to her wandering which placed R1 at risk for injury and psychosocial impairment