STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N026001	A. BUILDING: _____ B. WING _____	05/09/2023

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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with a complaint (#173430) at the above named assisted living facility conducted on 05/02/23 and 05/09/23.	S 000		
S3166 SS=F	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (e) The census equaled 39 residents. The sample included 3 residents. Based on record review and interview for residents requiring "accuchecks" (blood sugar monitoring with a glucometer) and/ or insulin administration, nursing procedures not included in the medication aide curriculum, Administrator A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - The "Resident Roster" obtained on 05/02/23 from Licensed Nurse (LN) B revealed 3 residents	S3166		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N026001	A. BUILDING: _____ B. WING _____	05/09/2023

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) COMPLETE DATE
S3166	Continued From page 1 requiring insulin injection. Review of sampled personnel records on 05/02/23 recorded the following CMA's (Certified Medication Aide) were recently hired. Competency exams for accuchecks and dialing insulin pens were requested from LN B. CMA D, hire date 00/06/22 CMA E, hire date 10/19/21 CMA F, hire date 11/09/21 Interview on 05/02/23 at 11:11 AM with LN B confirmed CMAs conduct accuchecks and further confirmed was unable to locate competency checkoffs for accuchecks for CMA D, CMA E and CMA F. Interview on 05/02/23 at 11:43 AM with CMA F stated she dialed the insulin pen for resident (R)4. Interview on 05/02/23 at 11:45 AM with LN B confirmed unable to locate competency checkoffs for dialing insulin pens for CMA D, CMA E and CMA F. For residents requiring "accuchecks" and/or insulin administration, nursing procedures not included in the medication aide curriculum, Administrator A failed to ensure the licensed nurse delegated the procedure to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N026001	A. BUILDING: _____ B. WING _____	05/09/2023

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) COMPLETE DATE
S3310	Continued From page 2	S3310		

communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;
(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and
(c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105

This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-207 (c)

The census totaled 39 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 4 staff (Certified Nurse Aide (CNA) C, Certified Medication Aide (CMA) D, CMA E and CNA G, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines.

Findings included:

- Review of CNA C's employee record revealed they hired onto the facility on 02/07/23. CNA C's record lacked evidence of completion of the second step of the TB testing upon.

Review of CMA D's employee record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N026001	A. BUILDING: _____ B. WING _____	05/09/2023

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) COMPLETE DATE
S3310	Continued From page 3 they hired onto the facility on 09/06/22. CMA D's record lacked evidence of completion of the second step of the TB testing upon. Review of CMA E's employee record revealed they hired onto the facility on 10/19/21. CMA E's record lacked evidence of completion of a TB questionnaire upon hire. Review of CNA G's employee record revealed they hired onto the facility on 03/21/23. CNA G's record lacked evidence of completion of the second step of the TB testing upon. Interview on 05/09/23 at 09:45 AM with Administrator A confirmed unable to locate second step of the TB testing completed upon hire for CNA C, CMA D and CNA G and further confirmed unable to locate a TB questionnaire completed upon hire for CMA E. The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		