STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 deficiencies represent the findings of a Health Survey and investigation of complaint # 189939. This 2567 was electronically sent to the facility on 10/23/24.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative.	F 553		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/23/2024

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
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VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 553	Continued From page 1	F 553		

(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents with 20 residents selected for review. Based on observation, interview, and record review, the facility failed to provide care plan meetings for four Residents (R) 13, R2, R7 and R57, as required.

Findings included:

- Review of Resident (R)2's medical record revealed diagnosis that included end stage renal (kidney) disease.

The "Admission Minimum Data Set" (MDS), dated 02/29/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail).

The "Quarterly MDS" dated 08/15/24, indicated a BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services.

The "Cognitive Loss Care Area Assessment" (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance.

The "Care Plan" dated 08/20/24, instructed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 553	Continued From page 2	F 553		

the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity.

Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 08/20/24 did not include the resident/responsible party.

The facility policy "Care Plans-Comprehensive Person-Centered" revised 09/2023, instructed staff the resident/resident representative will be encouraged to anticipate in the resident assessment and care planning conference wit the residents' permission.

The facility failed to provide a care plan meeting for this resident/resident representative as required.

- Review of Resident (R)13's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [stroke] - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The "Significant Change Minimum Data Set" (MDS), dated 12/15/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. R13 had functional limitation in range of motion impairment on one side of the upper and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 553	Continued From page 3	F 553		

lower extremities.

The "Communication Care Area Assessment" (CAA), dated 12/15/23, assessed the resident with left sided hemiplegia and required extensive assistance with most activities of daily living.

The "Quarterly MDS" dated 08/22/24, assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had functional limitation in range of motion impairment on one side of the upper and lower extremities. The resident was dependent on staff for personal hygiene.

The "Care Plan", reviewed 08/14/24, instructed staff the resident required extensive assistance with bathing/showering on Monday and Thursday mornings.

Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 08/14/24 did not include the resident/responsible party.

The facility policy "Care Plans-Comprehensive Person-Centered" revised 09/2023, instructed staff the resident/resident representative will be encouraged to anticipate in the resident assessment and care planning conference with the residents' permission.

The facility failed to provide a care plan meeting for this resident/resident representative as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 553	Continued From page 4	F 553		

- Review of Resident (R)7's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) dementia (progressive mental disorder characterized by failing memory, confusion) and diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

The "Significant Change Minimum Data Set" (MDS), dated 04/11/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment.

The "Cognitive Loss Care Area Assessment" (CAA) assessed the resident had continued decline in cognition with severely impaired memory. The resident had difficulty responding with garbled speech.

The "Care Plan" reviewed 09/24/24, instructed staff the resident was dependent on staff for activities of daily living, was incontinent of bowel and bladder, had alteration in mood, at risk for pressure ulcers and included other interventions for medical conditions.

Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 09/24/24 did not include the resident/responsible party.

The facility policy "Care Plans-Comprehensive Person-Centered" revised 09/2023, instructed staff the resident/resident representative will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 553	Continued From page 5	F 553		

encouraged to anticipate in the resident assessment and care planning conference with the residents' permission.

The facility failed to provide a care plan meeting for this resident/resident representative as required.

- Review of Resident (R)57's electronic medical record (EMR) revealed a diagnosis of colon cancer (a disease that occurs when cells in the colon grow out of control).

The "Admission Minimum Data Set" (MDS), dated 06/06/24, documented the resident re-admitted to the facility from an acute hospital. The resident's Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. It was somewhat important to the resident to have a family, or a close friend involved in discussions about his care.

The "Return to Community Referral Care Area Assessment" (CAA), dated 06/06/24, did not trigger.

The "Quarterly MDS," dated 08/29/24, documented the resident had a BIMS score of 15, indicating intact cognition.

Review of the resident's care plan, revised 09/04/04, instructed staff the resident did not plan to remain in the facility long-term, but planned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 553	Continued From page 6 discharge to an assisted living facility when room was available. Review of the resident's EMR, from 01/01/24 through 10/16/24, revealed the resident had not had a care plan meeting since 01/09/24. On 10/14/24 at 08:58 AM, the resident stated he had not had a care plan meeting. On 10/16/24 at 08:21 AM, Social Service Staff X stated the resident had not had a care plan meeting since 01/09/24. He missed care plan meetings in March and July due to the facility not having a social worker for the residents of that neighborhood. Care plan meetings were to be held every three months. On 10/16/24 at 07:39 AM, Administrative Nurse D stated residents should have care plan meetings every three months. The resident had not had a care plan meeting since 01/09/24. The facility policy for "Care Plans", revised 10/2021, included: The resident's representative will be encouraged to participate in the resident's care planning conference with the resident's permission, at least quarterly and with a significant change. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. The facility failed to have care plan meetings every three months for this resident.	F 553		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 656	Continued From page 7	F 656		

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 656	Continued From page 8	F 656		

section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents with 20 residents sampled. Based on observation, interview, and record review, the facility failed to complete a comprehensive care plan for one Resident's (R)27's, regarding the care and maintenance of her personal humidifier.

Findings included:

- Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 01/18/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 01/18/24, documented the resident had a diagnosis of dementia with confusion and forgetfulness.

The "Quarterly MDS," dated 09/26/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment.

The care plan, revised 10/14/24, lacked staff instruction regarding the care and maintenance of the resident's personal humidifier.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 656	Continued From page 9	F 656		

On 10/15/24 at 08:00 AM, the resident had a humidifier in her room in the "on" position with mist coming from the spout of the machine. The spout and nebulizer chamber (a round disc or white circle in the base of the unit that vibrates to create a mist) of the machine had a heavy build-up of a hardened, white substance.

On 10/16/24 at 08:00 AM, the resident's humidifier remained in her room with mist coming out of the spout of the machine. The heavy build-up of the hardened, white substance remained in the spout and nebulizer chamber.

On 10/16/24 at 09:41 AM, Certified Medication Aide (CMA) R stated she believed the night shift staff was responsible for the care of the resident's humidifier.

On 10/16/24 at 09:54 AM, CMA S stated she was unsure of who was responsible for the care of the resident's humidifier.

On 10/21/24 at 09:15 AM, Administrative Nurse E stated the care plan should include staff instruction on the care and maintenance of resident's personal humidifiers.

The facility policy for "Care Plans", revised 10/2021, included: Comprehensive care plans shall be completed for each resident with measurable goals and outcomes. The care plan shall include resident specific care needs.

The facility failed to complete a comprehensive care plan to include staff instruction for the care and maintenance for this dependent resident with a personal humidifier.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 657	Continued From page 10	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 20 residents sampled. Based on observation, interview, and record review, the facility failed to review and revise the care plans for two Residents (R)59 and R 70, regarding footrests for their wheelchairs.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 657	Continued From page 11	F 657		

Findings included:

- Review of Resident (R)59's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 09/26/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She utilized a wheelchair for mobility and was able to mobilize 150 feet with two turns with set-up assistance only.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment" (CAA), dated 09/26/24, documented the resident required extensive assistance of one staff for mobility with the wheelchair.

The "Quarterly MDS," dated 07/04/24, documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She utilized a wheelchair for mobility and required partial to moderate staff assistance with wheeling 150 feet with two turns.

The care plan for ADLs, revised 04/22/24, lacked staff instruction regarding the use of footrests for her wheelchair while being propelled by staff.

Review of the resident's EMR from 10/01/24 through 10/15/24, revealed the resident required limited to total staff assistance with locomotion on the unit with her wheelchair.

On 10/14/24 at 09:40 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 657	Continued From page 12	F 657		

from the commons area to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests.

On 10/15/24 at 12:12 PM, CNA N propelled the resident in her wheelchair from the dining room table to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests.

On 10/16/24 at 09:54 AM, Certified Medication Aide (CMA) S propelled the resident in her wheelchair in the commons area. The resident's shoed feet were tucked underneath the seat of the wheelchair and the toes of her shoes skimmed the floor. The wheelchair lacked footrests.

On 10/14/24 at 09:40 AM, CNA M stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times.

On 10/15/24 at 12:12 PM, CNA N stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times.

On 10/16/24 at 09:54 AM, CMA S stated the resident would self-propel in her wheelchair at times so staff did not use footrests on her wheelchair.

On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had footrests on their wheelchairs when they were being propelled by staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 657	Continued From page 13	F 657		

On 10/21/24 at 08:57 AM, Administrative Nurse E stated all nurses were able to review and revise resident care plans. It was the expectation for the use of footrests to be included on the resident's care plan.

The facility policy for "Care Plans", revised 10/2021, included: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

The facility failed to review and revise this dependent resident's care plan to include staff instruction regarding the use of footrests while being propelled by staff.

- Review of Resident (R)70's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 09/18/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She utilized a wheelchair for mobility with substantial to maximal assistance of staff.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment" (CAA), dated 09/18/24, did not trigger.

The care plan for ADLs, dated 09/11/24, lacked staff instruction regarding the use of appropriate footrests for her wheelchair while being propelled by staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 657	Continued From page 14	F 657		

Review of the resident's EMR, from 10/01/24 through 10/15/24, revealed the resident required limited to extensive assistance with locomotion on the unit with her wheelchair.

On 10/14/24 at 09:24 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the dining room to the shower room to toilet. The resident's right foot lacked support and dangled between the footrests of the wheelchair.

On 10/14/24 at 12:07 PM, the resident sat in her wheelchair at the dining room table. The resident's feet dangled between the footrests of the wheelchair, several inches above the floor.

On 10/16/24 at 07:30 AM, the resident sat in her wheelchair at the dining room table. The resident's right ankle rested on the outer edge of the footrest.

On 10/16/24 at 09:17 AM, the resident sat in her wheelchair at the dining room table. The resident's feet were between the footrests of the wheelchair and only the toes of her feet reached the floor.

On 10/14/24 at 09:24 AM, CNA M stated she had not noticed the resident's feet not resting properly on the footrests of the wheelchair.

On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had appropriate footrests on their wheelchairs when they were being propelled by staff. LN G confirmed the resident's feet did not rest appropriately on the footrests of the wheelchair and one or both feet tended to fall in between the two footrests of the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 657	Continued From page 15 On 10/21/24 at 08:57 AM, Administrative Nurse E stated all nurses were able to review and revise resident care plans. It was the expectation for the use of footrests to be included on the resident's care plan. The facility policy for "Care Plans", revised 10/2021, included: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The facility failed to review and revise this dependent resident's care plan to include staff instruction regarding the use of footrests while being propelled by staff.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 20 residents included for review, which included two residents reviewed for activities of daily living. Based on observation, interview, and record review, the facility failed to ensure two Resident (R)13 and R37 received grooming assistance. Findings included: - Review of Resident (R)13's medical record revealed diagnoses that included hemiplegia	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

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F 677	Continued From page 16	F 677		

(paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [stroke] - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The "Significant Change Minimum Data Set" (MDS), dated 12/15/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. R13 had functional limitation in range of motion impairment on one side of the upper and lower extremities.

The "Communication Care Area Assessment" (CAA), dated 12/15/23, assessed the resident with left sided hemiplegia and required extensive assistance with most activities of daily living.

The "Quarterly MDS" dated 08/22/24, assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had functional limitation in range of motion impairment on one side of the upper and lower extremities. The resident was dependent on staff for personal hygiene.

The "Care Plan", reviewed 08/14/24, instructed staff the resident required extensive assistance with bathing/showering on Monday and Thursday mornings.

Observation, on 10/15/24 at 08:25 AM, revealed the resident positioned in his wheelchair, eating breakfast in the common dining room. The resident's left arm was in a sling. The resident had several days' worth of facial hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

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VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 677	Continued From page 17	F 677		

Observation, on 10/16/24 at 08:08 AM, revealed the resident seated in his wheelchair in the dining room. The resident continued with several days' worth of facial hair and stated his face felt itchy.

Interview, on 10/16/24 at 08:08 AM, with Certified Nurse Aide (CNA) O, revealed the resident was cooperative with bathing, and did not know why he was not shaved on his bath day.

Interview, on 10/16/24 at 10:01 AM, with Licensed Nurse (LN) H, revealed the resident occasionally yelled out at staff, and wanted to go home. LN H stated the resident was independent prior to the CVA and had an adjustment period. LN H stated the resident was generally cooperative with cares and could make his needs known.

Interview on 10/21/22 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide personal hygiene.

The facility policy "Quality of Life-Dignity" date 01/2024, instructed staff to provide care to the residents that promotes and enhances the quality of life, dignity and individuality.

The facility failed to ensure this dependent resident received grooming to maintain personal comfort and appearance to enhance dignity.

- Review of Resident (R) 37's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [stroke] - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 677	Continued From page 18	F 677		

brain) and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS) dated 05/02/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident had no impairment in functional range of motion in extremities. The resident required set up assistance for eating and was dependent on staff for personal hygiene.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 05/02/24, assessed the resident required extensive assistance for most ADLs due to a decline with a recent diagnosis of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). Increased staff support was required to meet ADL's and most care area to maintain a neat, odor free appearance.

The "Cognitive Loss CAA" dated 05/02/24, assessed the resident was able to feed herself.

The "Quarterly MDS" dated 07/25/24, assessed the resident with a BIMS score of 12, which indicated moderate cognitive impairment. The resident required set up assistance for eating and was dependent on staff for personal hygiene.

The "Care Plan" reviewed 08/01/24, instructed staff the resident preferred to feed herself and required staff assistance for supervision and set up for meals and hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 677	Continued From page 19	F 677		

Observation, on 10/14/24 at 09:27 AM, revealed the resident seated in the dining room, finished with breakfast. The resident had a brown substance running down from the left lower lip to bottom of her chin. A laboratory personnel questioned Certified Medication Aide (CMA) T, to identify the resident and then propelled the resident to her room, to obtain a blood sample, then returned the resident to the dining room. CMA T did not wipe the brown substance from the resident's face.

Observation, on 10/16/24 at 11:03 AM, revealed the resident seated in her wheelchair in her room. A red substance was noted from her left lower lip down to the bottom of her chin.

Observation, on 10/16/24 at 11:51 AM, revealed the resident seated in her wheelchair at the dining room table with the red substance still on her face. Licensed Nurse (LN) I, obtained a blood sugar and then administered insulin to the resident and did not wipe the red substance from her face until requested. LN I stated the resident preferred to feed herself, and staff should provide personal hygiene afterward.

Interview on 10/21/22 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide personal hygiene.

The facility policy "Quality of Life-Dignity" date 01/2024, instructed staff to provide care to the residents that promotes and enhances the quality of life, dignity and individuality.

The facility failed to provide personal hygiene related to facial hygiene to this resident that required staff assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 20 residents sampled, including two residents reviewed for positioning. Based on observation, interview, and record review, the facility failed to properly position two Residents (R)59 and R 70, regarding footrests for their wheelchairs. Findings included: - Review of Resident (R)59's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The "Annual Minimum Data Set" (MDS), dated 09/26/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She utilized a wheelchair for mobility and was able to mobilize 150 feet with two turns with set-up assistance only. The "Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment" (CAA), dated 09/26/24, documented the resident	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 684	Continued From page 21	F 684		

required extensive assistance of one staff for mobility with the wheelchair.

The "Quarterly MDS," dated 07/04/24, documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She utilized a wheelchair for mobility and required partial to moderate staff assistance with wheeling 150 feet with two turns.

The care plan for ADLs, revised 04/22/24, instructed staff the resident was independent with her wheelchair.

Review of the resident's EMR from 10/01/24 through 10/15/24, revealed the resident required limited to total staff assistance with locomotion on the unit with her wheelchair.

On 10/14/24 at 09:40 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the commons area to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests.

On 10/15/24 at 12:12 PM, CNA N propelled the resident in her wheelchair from the dining room table to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests.

On 10/16/24 at 09:54 AM, Certified Medication Aide (CMA) S propelled the resident in her wheelchair in the commons area. The resident's shoed feet were tucked underneath the seat of the wheelchair and the toes of her shoes skimmed the floor. The wheelchair lacked footrests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 684	Continued From page 22 On 10/14/24 at 09:40 AM, CNA M stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. On 10/15/24 at 12:12 PM, CNA N stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. On 10/16/24 at 09:54 AM, CMA S stated the resident would self-propel in her wheelchair at times so staff did not use footrests on her wheelchair. On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had footrests on their wheelchairs when they were being propelled by staff. On 10/21/24 at 08:57 AM, Administrative Nurse E stated it was the expectation for staff to use footrests while propelling residents in their wheelchairs. The facility policy for "Safe Patient Transport in Wheelchair", approved 01/2024, included: Staff shall use a safe technique when transporting residents in their wheelchairs, including ensuring the resident's feet rest comfortably on the footrests. The facility failed to properly position this dependent resident in her wheelchair while propelling her by not having footrests for the resident's feet.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 684	Continued From page 23	F 684		

- Review of Resident (R)70's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 09/18/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She utilized a wheelchair for mobility with substantial to maximal assistance of staff.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment" (CAA), dated 09/18/24, did not trigger.

The care plan for ADLs, dated 09/11/24, instructed staff the resident could utilize a wheelchair, as needed (PRN), depending on her steadiness.

Review of the resident's EMR, from 10/01/24 through 10/15/24, revealed the resident required limited to extensive assistance with locomotion on the unit with her wheelchair.

On 10/14/24 at 09:24 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the dining room to the shower room to toilet. The resident's right foot lacked support and dangled between the footrests of the wheelchair.

On 10/14/24 at 12:07 PM, the resident sat in her wheelchair at the dining room table. The resident's feet dangled between the footrests of the wheelchair, several inches above the floor.

On 10/16/24 at 07:30 AM, the resident sat in her wheelchair at the dining room table. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 684	Continued From page 24 resident's right ankle rested on the outer edge of the footrest. On 10/16/24 at 09:17 AM, the resident sat in her wheelchair at the dining room table. The resident's feet were between the footrests of the wheelchair and only the toes of her feet reached the floor. On 10/14/24 at 09:24 AM, CNA M stated she had not noticed the resident's feet not resting properly on the footrests of the wheelchair. On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's feet rested appropriately on the footrest of the wheelchair while being propelled by staff. On 10/21/24 at 08:57 AM, Administrative Nurse E stated it was the expectation for staff to ensure resident's feet reached the footrest of their wheelchairs appropriately. The facility policy for "Safe Patient Transport in Wheelchair", approved 01/2024, included: Staff shall use a safe technique when transporting residents in their wheelchairs, including ensuring the resident's feet rest comfortably on the footrests. The facility failed to properly position this dependent resident in her wheelchair while propelling her.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 695	Continued From page 25	F 695		

The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents with 20 residents sampled, including one resident reviewed for respiratory services. Based on observation, interview, and record review, the facility failed to properly clean and maintain a humidifier (a device for keeping the atmosphere moist in a room) in one Resident's (R)27's room.

Findings included:

- Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 01/18/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 01/18/24, documented the resident had a diagnosis of dementia with confusion and forgetfulness.

The "Quarterly MDS," dated 09/26/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment.

The care plan, revised 10/14/24, lacked staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 695	Continued From page 26	F 695		

instruction regarding the humidifier.

On 10/15/24 at 08:00 AM, the resident had a humidifier in her room in the "on" position with mist coming from the spout of the machine. The spout and nebulizer chamber (a round disc or white circle in the base of the unit that vibrates to create a mist) of the machine had a heavy build-up of a hardened, white substance.

On 10/16/24 at 08:00 AM, the resident's humidifier remained in her room with mist coming out of the spout of the machine. The heavy build-up of the hardened, white substance remained in the spout and nebulizer chamber.

On 10/16/24 at 09:41 AM, Certified Medication Aide (CMA) R stated she believed the night shift staff was responsible for the care of the resident's humidifier.

On 10/16/24 at 09:54 AM, CMA S stated she was unsure of who was responsible for the care of the resident's humidifier.

On 10/21/24 at 09:15 AM, Administrative Nurse E stated she was unsure of how often humidifiers should be cleaned and stated the nurses would be responsible for the care and cleaning of the humidifiers.

The facility policy for "Water Management Program to Reduce Legionella Exposure", revised 0/2018, included: A water management program shall assist in reducing the risk for Legionella from growing and spreading due to residents' usage of devices, such as humidifiers.

The facility failed to properly clean and maintain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 695	Continued From page 27 this dependent resident's personal humidifier.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 20 residents selected for review, which included one resident reviewed for dialysis (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). Based on observation, interview, and record review, the facility failed to ensure staff provided assessment and monitoring for one Resident (R)2 who received dialysis three times a week. Findings included: - Review of Resident (R)2's medical record revealed diagnoses that included end stage renal (kidney) disease. The "Admission Minimum Data Set" (MDS), dated 02/29/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). The "Quarterly MDS" dated 08/15/24, indicated a	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 698	Continued From page 28	F 698		

BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services.

The "Cognitive Loss Care Area Assessment" (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance.

The "Care Plan" date 08/20/24, instructed staff the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity.

Review of the "Dialysis Communication" form revealed staff to assess the resident's pulse, respirations, blood pressure, temperature, pain level. Staff were to access site evaluation and indication of changes in his condition prior to dialysis, and after the resident returned to the facility from the dialysis treatment.

Review of the "Dialysis Communication" form from 09/23/24 through 10/16/24 revealed the following areas of concern:

The form dated 09/30/24, 10/14/24 and 10/16/24 lacked a pre- dialysis and post- dialysis assessment. The forms dated 09/23/24, 09/25/24, 09/27/24, 10/02/24, 10/07/24, 10/09/24 and 10/11/24 lacked post dialysis evaluations.

Review of the "Nurse's Progress Notes" from 09/23/24 through 10/16/24 lacked documentation of pre and or post evaluations of the resident.

Interview, on 10/15/24 at 08:58 AM, with the resident, revealed he received dialysis on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 698	Continued From page 29	F 698		

Monday, Wednesdays, and Fridays. The resident stated he had a fistula (a surgical joining of an artery and vein to use as an access device for the treatment) in his left arm.

Interview, on 10/21/24 at 11:57 AM, with Licensed Nurse (LN) I, revealed licensed staff should assess the resident prior to going to dialysis and upon return and document the assessments on the "Dialysis Communication" form, located in a binder that the resident would take to dialysis with him.

Interview, on 10/21/24 at 12:15 PM, with Administrative Nurse D, revealed she would expect staff to assess the resident pre and post dialysis and document on the "Dialysis Communication" form or in a progress note.

The facility policy "Dialyses" reviewed 01/2024, instructed staff to assess the access site for dialysis, and document on the treatment administration record. The policy instructed staff to utilize the communication tool to receive a report on the resident to the community after each session, or if the dialysis center provided a verbal report, staff instructed to document the report in the resident's medical record.

The facility failed to evaluate this resident's status pre dialysis three out of 10 dialysis treatments from 09/30/24 through 10/16/24 and failed to evaluate this resident's status post dialysis treatment 10 out of 10 times from 09/30/24 through 10/16/24 to ensure the resident had no adverse effects of the treatment.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 20 residents selected for review, that included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure one Resident (R)2, received medications within the physician ordered parameters. Findings included: - Review of Resident (R)2's medical record revealed diagnoses that included end stage renal (kidney) disease.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 757	Continued From page 31	F 757		

The "Admission Minimum Data Set" (MDS), dated 02/29/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail).

The "Quarterly MDS" dated 08/15/24, indicated a BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services.

The "Cognitive Loss Care Area Assessment" (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance.

The "Care Plan" dated 08/20/24, instructed staff the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity.

A "Physician's Order" dated 10/10/24, instructed staff to administer Midodrine, (a medication used to increase blood pressure) 10 milligrams, three times a day for low blood pressure and hold if the systolic blood pressure (SBP the first number of the blood pressure which indicates the pressure in the heart when it pumps out blood) is greater than 140 millimeters of mercury (mmHg).

Review of the October 2024 "Medication Administration Record" (MAR) revealed the following areas of concern:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 757	Continued From page 32	F 757		

On 10/11/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 142/87.

On 10/12/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 161/90.

On 10/13/24 at 10:00 PM, staff administered Midodrine to the resident with a blood pressure of 152/87.

On 10/14/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 152/76.

On 10/15/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 174/74.

On 10/16/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 143/82.

On 10/17/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 175/98.

On 10/17/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 144/81.

On 10/18/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 152/81.

On 10/18/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 153/84.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 757	Continued From page 33 On 10/20/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 168/100. On 10/21/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 145/86. Interview, on 10/21/24 at 10:30 AM, with Administrative Nurse E and Administrative Nurse E, confirmed the above and stated they would expect staff to following the parameters as ordered by the physician. The facility policy "Health Care Provider Orders" reviewed 01/2024, instructed staff to record the medication and any specified parameters with medication orders. The facility failed to ensure staff administered this resident's Midodrine, used to increase blood pressure was administered following the physician's ordered parameters to prevent adverse reactions.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 758	Continued From page 34 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 758	Continued From page 35	F 758		

with 20 residents sampled, that included six residents reviewed for unnecessary medication. Based on observation, interview, and record review, the facility failed to assess one Resident (R)44, for adverse effects of an antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions).

Findings included:

- Review of Resident (R)44's medical record revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear),and pseudobulbar affect (a neurological disorder that causes uncontrollable and inappropriate episodes of laughing or crying).

The "Annual Minimum Data Set" (MDS), dated 06/20/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of one, which indicated severe cognitive impairment. The resident received antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions).

The "Delirium Care Area Assessment" (CAA) assessed the resident received antipsychotic medication daily for violent behaviors and was stable.

The "Quarterly MDS" dated 09/12/24, assessed the resident with a BIMS score of one, and the resident received antipsychotic medications.

The "Care Plan" reviewed 09/12/24, instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 758	Continued From page 36	F 758		

staff the resident received antipsychotic medications with "Black Box" (a safety warning the FDA [Food and Drug Administration] issued for serious side effects of medication) and staff were to monitor for adverse effects due to medications.

A "Physician's order" dated 03/12/24, instructed staff to continue Olanzapine (an antipsychotic) 5 milligrams, daily, for violent behaviors.

Observation, on 10/14/24 at 08:57 AM, revealed the resident seated in her wheelchair in the common living area. The resident was tearful, and unable to respond verbally.

Observation, on 10/15/24 at 08:10 AM, revealed the resident seated in her wheelchair, feeding herself breakfast. The resident had a flat affect and responded with mumbling nonsensically.

Interview, on 10/17/24 at 12:30 PM, with Administrative Nurse E, revealed she would expect staff to assess the resident for antipsychotic side effects using the AIMS (Abnormal Involuntary Movement Scale) tool to determine if the resident was experiencing side effects of Olanzapine which included extra pyramidal (a group of side effects that include involuntary movements, tremors, involuntary movements of the tongue) adverse effects. Administrative Nurse E confirmed staff completed the last AIMS on 03/25/24 and staff should assess the resident with the AIMS every three months.

The facility policy "Behavioral Assessments, Intervention and Monitoring" revise 10/2024, instructed staff to ensure he resident has minimal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 758	Continued From page 37 complications associated with the management of altered or impaired behaviors through nonpharmacological or pharmacological interventions. The Interdisciplinary Team will review and discuss interventions and AIMS or other findings. The facility failed to ensure this resident who received antipsychotic medication did not display adverse effects of the medication through assessment of extra pyramidal movements.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74 residents, with 20 sampled. Based on observation, interview and record review, the facility failed to use proper hand hygiene while completing wound care for one Resident (R)27.

Findings included:

- Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 01/18/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. She was at risk for the development of pressure ulcers (PU) and had no unhealed PU at the time of the assessment.

The "Pressure Ulcer/Injury Care Area Assessment" (CAA), dated 01/18/24, documented the resident spent most of her time in her recliner and required assistance with positioning.

The "Quarterly MDS," dated 09/26/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment. She was at risk for the development of PUs with no unhealed PU at the time of the assessment.

The PU care plan, revised 10/14/24, instructed staff the resident utilized pressure reducing devices for her chair and bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

Review of the resident's EMR revealed a Braden assessment (used to determine the risk of a resident developing a PU), dated 09/24/24, which placed the resident at a high risk for the development of PUs.

Review of the resident's skin assessments, included the following:

On 10/04/24, the resident developed a stage II PU (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed), that measured 1.2 centimeters (cm) in length (L) by 0.5 cm width (W) by 0.1 cm depth (D), to her coccyx (area at the base of the spine).

On 10/09/24, the stage II PU measured 0.8 L by 0.5 cm W by 0.1 cm D.

Review of the resident's EMR revealed the following physician's order:

Cleanse the wound with wound cleanser, pat dry and cover with a bordered foam dressing, ordered 10/06/24.

On 10/16/24 at 09:33 AM, Administrative Nurse F entered the resident's room to change the dressing to her wound. Administrative Nurse F cleansed the wound with wound cleanser and patted the area dry. Administrative Nurse F then measured the wound without changing her gloves or performing hand hygiene.

On 10/16/24 at 09:35 AM, Administrative Nurse F stated she had not changed her gloves after cleansing the resident's wound and before measuring the wound. She stated she should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

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VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 have changed gloves and performed hand hygiene but did not. On 10/21/24 at 09:15 AM, Administrative Nurse D stated it was the expectation for staff to change gloves and perform hand hygiene after cleansing a wound and before measuring the wound. The facility policy for "Wound Care/Dressing Change", revised 05/2023, included: When changing the dressing to a resident's wound staff shall don gloves and cleanse the wound per orders. Staff shall then remove their gloves, perform hand hygiene, and don clean gloves. The facility failed to perform proper hand hygiene while completing this resident's wound care.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. Based on observation, interview, and record review, the facility failed to ensure all resident equipment in one of the four neighborhoods were in clean, safe condition, regarding one toilet seat riser with legs and handles. Findings included: - During a brief environmental tour of "C" Court, on 10/14/24 at 09:25 AM, the following areas of concern were noted:	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	10/21/2024

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F 908	Continued From page 42 A toilet seat riser had multiple rusty areas over all four legs. The plastic toilet seat had a crack where it met residents' buttocks area. On 10/21/24 at 09:49 AM, Housekeeping/Maintenance Staff U stated the toilet seat riser needed to be thrown away.Housekeeping/Maintenance Staff U stated the facility had extra toilet seat risers available for when one needed replaced. The facility lacked a policy for the maintenance and upkeep of resident equipment. The facility failed to ensure all resident equipment in the "C" Court neighborhood was clean and in safe condition.	F 908		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. Based on observation, interview, and record review, the facility failed to ensure a clean environment in one of the four neighborhoods regarding soiled, stained privacy curtains in a shower room in one of the four neighborhoods. Findings included: - During a brief environmental tour of "C" Court, on 10/14/24 at 09:25 AM, the following areas of concern noted:	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 921	Continued From page 43 Two privacy curtains contained multiple areas which were dirty and stained. On 10/21/24 at 09:49 AM, Housekeeping/Maintenance Staff U stated housekeeping was responsible for ensuring the privacy curtains in the shower rooms were clean. The privacy curtains needed to be washed or replaced. The facility lacked a policy regarding the maintenance/cleaning of the shower curtains. The facility failed to ensure a clean environment in one of the four neighborhoods regarding soiled, stained privacy curtains in a shower room in one of the four neighborhoods.	F 921		