STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 10/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00191105 and KS00191144. The 2567 was sent electronically on 11/06/24. A revised 2567 was sent electronically on 11/06/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/06/2024

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.

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or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 90 residents with three residents reviewed for activities of daily living (ADL). Based on observation, record review and interview, the facility failed to provide care per the resident's preferences and to promote dignity for Resident (R) 1, who required extensive staff assistance for dressing and hygiene which resulted in R1 exposed her breast in the dining room. This deficient practice placed R1 at risk for impaired dignity.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (high blood pressure).

R1's "Annual Minimum Data Set (MDS)," dated 07/19/24, documented the Brief Interview for

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Mental Status could not be completed. The MDS documented R1 had short-term and long-term memory problems and had severe cognitive impairment. The MDS documented R1 had physical behavioral symptoms daily during the review period, verbal behavioral symptoms four to six days during the review period, and had other behavioral symptoms not directed towards others one to three days during the review period. The MDS documented R1 required substantial staff assistance for transfer and bed mobility. R1 was dependent on staff for toileting, bathing, dressing, and personal hygiene.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 07/19/24, documented R1 had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia with behavioral disturbance. The CAA documented R1's dementia had become significantly worse. R1 had moderate difficulty hearing, was sometimes understood, could sometimes understand others, and had moderately impaired vision.

The "Activities of Daily Living Functional and Rehabilitation Potential CAA," dated 07/19/24, documented R1 was dependent on staff for ADL cares, was non-ambulatory, used a wheelchair, had visual and hearing difficulties, and had difficulty expressing herself.

R1's "Care Plan" directed staff to meet R1's daily care needs. R1 required extensive staff assistance with bed mobility, toileting, hygiene, dressing, and transfers. The care plan documented R1 preferred to have a bra on.

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On 10/29/24 at 09:30 AM, observation revealed R1 sat at a table in the dining room across from another female resident, who was alert and oriented. R1 lifted her shirt and used it to wipe her nose and mouth. R1 did not have a bra on and when she lifted her shirt, her bare breast was exposed.

On 10/29/24 at 09:50 AM, Certified Nurse's Aide (CNA) M stated that it was her responsibility to protect R1's dignity. She stated R1 should have had a bra on, and staff should put R1's shirt down to cover R1's nudity.

On 10/29/24 at 11:30 AM, R1's responsible party stated she expected the staff at the facility to take care of R1's needs and to ensure care was provided in a way that protected R1's dignity.

On 10/29/24 at 12:15 PM, Administrative Nurse D verified R1's "Care Plan" directed staff that R1 preferred to have a bra on. Administrative Nurse D stated staff should have followed R1's plan of care regarding the resident's preferences and made sure her needs were met to protect her dignity.

The facility's "Resident Rights Policy," dated October 2024, documented it is the facility's policy to promote and protect the rights of residents. The policy documented they will make every effort to assist the resident in exercising his or her rights and to assure that the resident is always treated with respect, kindness, and dignity.

The facility failed to provide care per the resident's preferences and to promote dignity for R1 when they failed to put a bra on R1 per her

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F 550	Continued From page 4 specific preferences which resulted in R1 exposed her breast in the dining room. This deficient practice placed R1 at risk for impaired dignity.	F 550		