STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175498	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR , HAYS, Kansas, 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
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 1563570, 1563585, 1563571, 1562568, 1563577, 1563564, 1563584, 1563573, 1563574, and 1563575. The 2567 was sent electronically on 08/05/25.	F0000		
F0550 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 or resident of the United States. §483.10(b)(1) The facility must ensure that the	F0550		

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 reverse for further 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.

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

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F0550 SS = D	Continued from page 1 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 had a census of 84 residents. The sample included 27 residents, with one reviewed for dignity. Based on observation, record review, and interview, the facility staff failed to treat Resident (R) 70 (who required assistance with eating) with dignity when staff served R52 and R53, who sat at the same dining room table, their meals without serving R70. This placed the resident at risk for an undignified experience. Findings included: - On 07/22/25 at 07:30 AM, R70 sat in a Geri-chair (a recliner on wheels that can be pushed) around like a wheelchair, usually with a removable tray. at the dining room table with R52 (on her right side) and R53 (across the table). Dietary Staff (DS) CC served R52 and R53 their breakfast, with R70 able to observe them eating. At 08:15 AM, R53 finished her meal and left the dining room, and R52 finished her meal and stayed at the table. At 08:30 AM, staff retrieved R70's meal tray, sat beside her, and assisted her in eating her breakfast. On 07/22/25 at 12:00 PM, R70 sat in a Geri chair at the dining room table with R52 and R53. At 12:01 PM, staff served R52 and R53 their noon meal, with R70 able to observe them eat. At 12:28 PM, R52 and 53 finished their noon meal, and R70 had not been served. At 12:30 PM, staff retrieved a meal tray, sat by R70, and assisted her in eating her meal. On 07/23/25 at 09:46 AM, Licensed Nurse (LN) L stated staff would assist R70 with her meals as soon as they could, but if they have other residents who need to use the bathroom or have their call light on, staff would take care of them first. LN L stated that dietary staff monitor which residents come to the dining room, but waited until the aides can provide staff assistance with R70's meal.	F0550		

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F0550 SS = D	Continued from page 2 On 07/23/25 at 12:45 PM, Administrative Nurse D stated that if staff served R52 and R53 meals at the same table with R70, who required staff assistance, she would expect staff to serve R70 a plate of food and assist R70 with eating at the same time as the other two residents. The facility's "Promoting/Maintaining Resident Dignity Policy," revised 01/01/20, documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.	F0550		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .	F0605		

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F0605 SS = D	Continued from page 3 §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. 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;	F0605		

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F0605 SS = D	Continued from page 4 §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 identified a census of 84 residents. The sample included 27 residents, with six sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 28 was free from psychotropic (a class of medications that alters mood or thought) medication without a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued). The facility failed to ensure the physician provided the risk versus benefit for the continued use of buspirone (anti-anxiety) medication. This deficient practice placed R28 at risk of unnecessary medication administration and related complications. Findings included: - R28's Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), hypertension (elevated blood pressure), auditory and visual hallucinations (sensing	F0605		

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F0605 SS = D	Continued from page 5 things while awake that appear to be real, but the mind created), dementia (progressive mental disorder characterized by failing memory, confusion), chronic pain, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R28's "Quarterly Minimum Data Set" (MDS), dated 06/26/2025, documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired decision making. The MDS documented R28 had no mood or psychosis but did have verbal behaviors. R28 received antidepressant and antianxiety medications with no GDR. R28's "Care Plan," dated 07/03/25, included interventions for behaviors and side effects for R28's medications. Administer psychotropic medications as ordered by the physician. The plan of care directed staff to consult with the pharmacy and the physician to consider dosage reduction when clinically appropriate, at least quarterly. The plan of care directed staff to discuss with the physician and family the ongoing need for use of the medication. The plan of care directed staff to review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. The plan of care directed staff to provide R28 with necessary cues, to stop and ensure her safety, and return if she becomes agitated. R28's plan of care directed staff to monitor R28 for and address episodes of anxiety, fear, or distress. R28's "Physician Order," dated 12/23/24, directed staff to administer Buspirone (antianxiety drug), five milligrams (mg), three times daily (TID) for anxiety and depression. R28's "Physician Order," dated 04/04/25, directed staff to administer Bupropion (antidepressant), 300 mg daily for anxiety and depression. R28's Consultant Pharmacist "Medication Reviews" from 01/01/25 to 07/22/25 documented no irregularities had been found in her medication regimen. On 07/22/25 at 07:45 AM, Licensed Nurse (LN) J administered medications to R28, including bupropion and buspirone. R28 took the pills whole in applesauce without problems. On 07/22/25 at 12:04 PM, R28 sat calmly in her wheelchair throughout the meal, without yelling or other behaviors observed. She did offer the staff a bite of her lunch but accepted their refusal calmly. She was confused but still able to answer most	F0605		

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F0605 SS = D	Continued from page 6 questions appropriately. On 07/23/25 at 11:45 AM, Consultant GG stated the resident had visual and auditory hallucinations. She verified the pharmacist had not recommended a GDR for R28's buspirone. The physician had not written a rationale for continuing the medication. The facility's "Psychotropic Medication" policy, dated 6/2025, stated the residents would only receive psychotropic medications when medically necessary to treat specific conditions for which they are indicated and effective. Residents who use psychotropic medication would receive GDR and behavioral interventions, unless clinically contraindicated in an effort to use the lowest effective dosage and potentially discontinue. GDR would be attempted within the first year in which a resident was prescribed a psychotropic drug. GDR would be attempted in at least two separate quarters unless clinically contraindicated.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy	F0628		

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F0628 SS = D	Continued from page 7 of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F0628		

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F0628 SS = D	Continued from page 8 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F0628		

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F0628 SS = D	Continued from page 9 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F0628		

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F0628 SS = D	Continued from page 10 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to provide a “Bed Hold Notification” for Residents (R) 12 and R20, and the State Ombudsman Agency notifications of R12. This placed the residents at risk of being uninformed. Findings included: - R20's Electronic Health Record (EHR) revealed diagnoses of extended spectrum beta lactamase (ESLB, an infection cause by a bacteria that produces extended-spectrum beta- lactamases enzymes that make certain antibiotics effective such as e coli and klebsiella, making the infection harder to treat and can occur in urinary tract infections or bloodstream infections), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic kidney disease Stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), and major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness). R20's "Quarterly Minimum Data Set" (MDS), dated 05/09/25, recorded R20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded that she was independent with transfers and activities of daily living (ADL). R20's "Care Plan," dated 07/18/25, recorded that R20 was independent with eating, oral hygiene, toilet hygiene, personal hygiene, and walking. The care plan documented that the resident was at risk for CHF, MDD, chronic kidney disease, malnutrition, and was underweight for age. The care plan documented that the resident had a risk for shortness of breath and respiratory complications related to the recent diagnosis of Influenza and acute respiratory failure, and staff would monitor oxygen saturation and administer oxygen per physician order and monitor for	F0628		

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F0628 SS = D	Continued from page 11 shortness of breath or difficulty breathing. The" Nurse's Note" dated 01/31/25 at 08:33 PM documented that the resident complained of urinary tract symptoms and requested the physician to order a urinalysis test and an antibiotic. The nurse's notes documented that the physician assistant was contacted and ordered a urinalysis and would await results before ordering an antibiotic. On 01/31/25 at 03:22 PM, the "Nurses Notes" documented that the facility was awaiting the urinalysis, and R20 was noted to have a cough. The on-call physician ordered Augmentin (antibiotic) 500 milligrams (mg) for seven days to cover the urinary tract infection and respiratory issues. On 02/01/25 at 11:10 AM, the "Nurse's Notes" documented R20 continued with a cough and had received two doses of the antibiotic. The nurse's notes documented that the urinalysis results had not come back to the facility at this time. R20's family was at the facility and requested/urged that R20 be evaluated at the hospital with the following vital signs: blood pressure 144/70 (normal 120/80), pulse 79 (normal 60-100), temperature 98.4 degrees (normal 96.4 degrees to 98.5 degree), and oxygen saturation 86% (normal between 95% and 100%) on room air. R20's respirations were even and not labored. The facility called for ambulance transport to the hospital. On 02/01/15 at the resident was admitted to the hospital with a diagnosis of Influenza A (a viral infection of the respiratory tract caused by the influenza A virus, which is highly contagious and can cause a range of symptoms from mild to severe. Potentially leading to serious complications. Influenza primarily affects the respiratory system, including the nose, throat, and lungs.) On 02/05/25 at 04:06 PM, the "Nurse's Notes" documented R20 returned to the facility per facility staff. R13 entered the facility in a wheelchair with staff assistance. R20 requested oxygen, and it was applied. R20 lungs were clear to auscultation, and no swelling was noted. R20's EHR lacked a bed-hold notification. On 07/21/25 at 12:00 PM, observation revealed that staff delivered R20 her dinner plate to the table that contained chicken, noodles, carrots, and Jello. Continued observation revealed she ate approximately 50 % of the meal.	F0628		

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F0628 SS = D	Continued from page 12 On 07/21/25 at 11:10 AM, Administrative Nurse D verified the facility lacked evidence of a signed bed hold policy notice that had been verbally acknowledged, provided, or signed by the resident's representative when R20 was transferred and admitted to the hospital on 02/01/25. The facility's "Bed Holds and Returns" policy, dated 01/2024, documented that, at the time of transfers for hospitalization or therapeutic leave, the nursing facility must provide to the resident or the resident's representative written notice that specifies the duration of the bed-hold. The current bed-hold return policy established by the state will apply to residents in the community e resident exceed the bed-hold period, he or she will be permitted to return to the community, t his or her previous room (if available) or immediately upon the first availability of a bed in a semi-private room provided that the resident: requires the services of the community and is eligible for Medicare or Medicaid skilled nursing services. - R12's Electronic Medical Record (EMR) included the diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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), pain, acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), and age-related physical debility. R12's "Comprehensive Minimum Data Set" (MDS), dated 04/07/25, documented that R12 had intact cognition. R12's MDS documented R12 required functional range of motion of one side of the upper and lower body extremities, required substantial/maximal assistance with upper and lower body dressing, personal hygiene, bed rolling, and transfers. The MDS further recorded that R12 had occasional pain, which affected sleep and day-to-day activities, shortness of breath or trouble breathing with exertion. R12 received oxygen therapy and had a non-invasive mechanical ventilator. R12's MDSs recorded: On 02/03/25, a Discharge Return Anticipated. On 02/06/25, an Entry. On 03/25/25, a Discharge Return Anticipated. On 03/27/25, an Entry.	F0628		

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F0628 SS = D	Continued from page 13 On 06/26/25, a Discharge Return Anticipated. On 06/27/25, an Entry. The “Progress Note” dated 02/03/25 at 04:22 PM, documented that R12’s Durable Power of Attorney (DPOA) was wanting to hold the bed. The facility failed to provide a written Bed Hold signature from the DPOA. Upon request, the facility failed to provide an Ombudsman notification policy for discharge and transfers. On 07/22/25 at 01:15 PM, Social Service Staff X reported she had not sent a bed hold to the DPOA or had the resident sign one with discharges to the hospital, and lacked notification to the ombudsman for discharges on 03/25/25 and 06/26/25. The facility's "Bed-Holds and Return " policy, dated 01/2024, documented that at the time of transfer for hospitalization or therapeutic leaves, the nursing facility must provide to the residents or resident representative written notice that specifies the duration of the bed-hold.	F0628		
F0657 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	F0657		

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F0657 SS = D	Continued from page 14 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 had a census of 84 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to revise the care plan to include Resident (R) 12's use of oxygen and R49's leg immobilizer. This placed the residents at risk for unmet care needs. Findings included: - The Electronic Medical Record (EMR) for R49, documented diagnoses of hypertension (high blood pressure), muscle weakness, atrial fibrillation (rapid heart rate), and disorders of bone density and structure (a condition where bones become weakened and more prone to fractures due to reduced bone mass and/or changes in bone structure). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS), dated 04/21/25, documented R49 had intact cognition. R49 required staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 had upper functional impairment on one side, lower functional impairment on both sides, was at risk for skin breakdown, and had a surgical wound. R49's "Care Plan," dated 04/15/25, documented she was at risk for pressure ulcers and other skin-related injuries. Staff were directed to observe for redness and breakdown during routine care, follow community skin care protocols, and treat as indicated. They were also to assist her with splinting/bracing and the use of assistive devices. The care plan lacked direction to staff on when to remove her immobilizer and if she had any skin breakdown. The "Braden Scale" (formal assessment for predicting pressure ulcer risk) dated 05/07/25, documented R49 was a mild risk for pressure ulcers. The "Physician's Order" dated 06/20/25, directed staff	F0657		

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F0657 SS = D	Continued from page 15 to leave immobilizer in place unless sleeping, and nwb (non-weight bearing) to LLE (left lower leg). The "Nurse's Notes," dated 07/18/25 at 05:38 PM, documented R49 had two small open sores on her left leg from where her knee brace had been rubbing against her skin. The sore on the outside of her thigh (the part of the human leg between the hip and the knee) measured 0.4 centimeters (cm) x 0.5 cm. The sore on her calf (the back portion of the lower leg) measured 0.5 cm x 0.5 cm. The wounds were cleaned with wound cleanser and covered with a Mepilex (absorbent, bordered foam dressing). The physician and the durable power of attorney (DPOA-a legal document that names a person to make healthcare decisions when the resident is no longer able to) were notified of the skin break. The EMR lacked a skin assessment, directions to staff for monitoring R49's skin daily, or any daily standing orders for dressing changes until further direction from the physician from 07/18/25 to 07/22/25 (five days). The "Nurse's Notes," dated 07/22/25 at 03:45 PM, documented that the physician received the documentation from the facility regarding the sores and had no further orders. On 07/22/25 at 09:37 AM, Licensed Nurse (LN) H stated she did not normally work in that household and was unsure if R49 had a skin breakdown, but would go with this surveyor and assess her skin. Observation revealed R49 had a leg immobilizer on her left leg from mid-thigh to her ankle. R49 stated the immobilizer needed to be repositioned and tightened because it was too loose on her leg and was slipping. Observation revealed nothing between her skin and the immobilizer to protect it from breakdown. R49 had a foam dressing on her left calf but no dressing on the sore on her left thigh. LN H washed her hands and donned clean gloves. She asked R49 if staff were changing the dressing daily, and she replied "No" but did not know when they had changed the dressing last. LN H removed the dressing from the calf, and there was brown in color drainage. LN H did not clean the area but washed her hands and donned clean gloves to put a new foam dressing on her calf. The area on her calf was pink but not open. Further observation revealed the sore on her left thigh was approximately the size of a pencil eraser and was starting to scab. LN H did not put a dressing on the sore. On 07/23/25 at 08:48 AM, Certified Nurse Aide (CNA) N stated, nurse aides were responsible for putting the	F0657		

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F0657 SS = D	Continued from page 16 immobilizer on R49 every morning, but sometimes the night shift forgot to take it off, and she had it on all night. CNA N stated she was unaware of any skin breakdown under the immobilizer. On 07/23/25 at 10:00 AM, LN G stated she had not worked in the household for at least two weeks and did not know that R49 had any skin breakdown. LN G washed her hands, donned clean gloves, and opened the immobilizer from R49's left leg, and there was nothing between her skin and the immobilizer. Observation revealed a dried substance inside the immobilizer, from where it had lain against the sore on her thigh. The sore was scabbed and not actively draining. LN G removed the dressing from her calf, and the skin was slightly pink. LN G washed her hands, donned clean gloves, and placed a clean foam dressing on the calf wound, but did not put one on the sore on her thigh. This surveyor observed a yellow PPE (personal protective equipment) hanging on the back of R49's door and when LN G was asked what it was for, she stated, "Oh, she is on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care), because of wounds, I forgot." LN G further stated there should be a sign on her door that stated that, but there was not. On 07/23/25 at 10:30 AM, Administrative Nurse F stated that she had been made aware of R49's sores on 07/21/25, but had not looked at them yet. Administrative Nurse F stated that today (07/23/25) was the day she would do her weekly skin assessment. Administrative Nurse F further stated that because the sores were not chronic, they did not require staff to wear PPE during care. At 02:30 PM, Administrative Nurse F stated she had looked at R49's wounds and did not feel that the immobilizer had caused the sore on her thigh because R49 had told her she thought she had scratched it, and that was why she got the sore. Administrative Nurse F stated she did not think the immobilizer had dried drainage because the sore was scabbed, but thought it was dried food. Administrative Nurse F stated that R49 told her that R49 would wear thin pajama pants so her leg would be protected when the immobilizer was on and would contact the physician for guidance. On 07/23/25 at 01:49 PM, Administrative Nurse D stated, staff should update the care plan to reflect the resident's condition and problems. The facility's "Comprehensive Person-Centered" policy, dated 09/2023, documented a comprehensive,	F0657		

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F0657 SS = D	Continued from page 17 person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs, which were identified through evaluation and assessment, and was developed and implemented for each resident. Assessments and ongoing care plans are revised as information about the residents and their conditions changes. - R12's Electronic Medical Record (EMR) included the diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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), pain, acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), and age-related physical debility. R12's "Comprehensive Minimum Data Set" (MDS), dated 04/07/25, documented that R12 had intact cognition, functional range of motion of one side of upper and lower body extremities, required substantial/maximal assistance with upper and lower body dressing, personal hygiene, bed rolling, and transfers. The MDS further recorded that R12 had occasional pain, which affected sleep and day-to-day activities, shortness of breath, or trouble breathing with exertion. R12 received oxygen therapy and had a non-invasive mechanical ventilator. R12's "Functional Abilities Care Area Assessment" (CAA), dated 04/09/25, documented R12 had chronic respiratory failure with hypoxia and hypercapnia (a condition in which high levels of carbon dioxide build up in the bloodstream), reduced mobility, and hemiplegia and hemiparesis following a cerebrovascular disease affecting the left non-dominant side. R12's "Care Plan" dated 06/27/25, documented R12 had potential for shortness of breath and/or respiratory complications related to sleep apnea, wore a continuous positive airway pressure (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) at bedtime. The Care Plan directed staff to monitor for complications such as dyspnea (difficulty breathing), shortness of breath, cyanosis (a bluish discoloration of the skin), or tachypnea (rapid breathing). The Care Plan further directed staff to provide pulmonary treatments per the physician's orders and monitor responses. The Care Plan lacked the use of oxygen. The "Physician Order" dated 06/20/25, instructed staff to assess lung sounds, pulse, respirations, and oxygen	F0657		

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F0657 SS = D	Continued from page 18 saturation before and after nebulizer treatments (a device that changes liquid medication into a mist easily inhaled into the lungs) and CPAP every day for respiratory failure. The “Physician Order” dated 07/01/25, directed staff to provide oxygen at three liters via nasal canula to keep oxygen saturations above 90 percent (%). The “Progress Note” dated 07/04/25 at 04:02 PM, documented R12 wore oxygen tubing per nasal canula, was alert and oriented, reported shortness of breath with exertion and when sitting at rest, and was unable to lie flat. R12 had portable oxygen and an oxygen concentrator in her room. The Progress Note further documented that R12 had a nebulizer and CPAP machine in her room. On 07/21/25 at 04:16 PM, R12 was sitting in her recliner, wearing an oxygen canula. R12 had a portable oxygen tank on her wheelchair with the unwrapped tubing and canula wrapped around the top of the canister. R12’s bedside tables had a nebulizer treatment and CPAP equipment not in use, and not wrapped or bagged. On 07/23/25 at 08:30 AM, R12 reported she was doing well, but stated her room was cluttered. On 07/23/25 at 10:13 AM, Licensed Nurse (LN) GG reported that the oxygen tubing and nebulizer, and CPAP equipment should be cleaned and stored in bags when not in use. On 07/23/25 at 01:45 PM, Administrative Nurse D verified oxygen should be included on R12’s “Care Plan.” The facility's "Comprehensive Person-Centered" policy, dated 09/2023, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs, which were identified through evaluation and assessment, and then developed and implemented for each resident.	F0657		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident,	F0686		

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F0686 SS = D	Continued from page 19 the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: The facility has a census of 84 residents. The sample included 27 residents, with five reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to prevent skin breakdown for one resident, Resident (R) 49, who developed two open areas from a leg immobilizer (a brace or support device designed to restrict knee movement and keep the leg straight. This placed the resident at risk for further breakdown. - The Electronic Medical Record (EMR) for R49, documented diagnoses of hypertension (high blood pressure), muscle weakness, atrial fibrillation (rapid heart rate), and disorders of bone density and structure (a condition where bones become weakened and more prone to fractures due to reduced bone mass and/or changes in bone structure). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS). dated 04/21/25, documented R49 had intact cognition. R49 was dependent upon staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 had upper functional impairment on one side, lower functional impairment on both sides, was at risk for skin breakdown, and had a surgical wound. R49's "Care Plan," dated 04/15/25, documented she was at risk for pressure ulcers and other skin-related injuries. Staff were directed to observe for redness and breakdown during routine care, follow community skin care protocols, and treat as indicated. They were also to assist her with splinting/bracing and the use of assistive devices. The care plan lacked direction to staff on when to remove her immobilizer and if she had any skin breakdown. The "Braden Scale" (formal assessment for predicting pressure ulcer risk) dated 05/07/25, documented R49 was	F0686		

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F0686 SS = D	Continued from page 20 a mild risk for pressure ulcers. The "Physician's Order" dated 06/20/25, directed staff to leave immobilizer in place unless sleeping, and nwb (non-weight bearing) to LLE (left lower leg). The "Nurse's Notes," dated 07/18/25 at 05:38 PM, documented R49 had two small open sores on her left leg from where her knee brace had been rubbing against her skin. The sore on the outside of her thigh (the part of the human leg between the hip and the knee) measured 0.4 centimeters (cm) x 0.5 cm. The sore on her calf (the back portion of the lower leg) measured 0.5 cm x 0.5 cm. The wounds were cleaned with wound cleanser and covered with a Mepilex (absorbent, bordered foam dressing). The physician and the durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) were notified of the skin break. The EMR lacked a skin assessment, directions to staff for monitoring R49's skin daily, or any daily standing orders for dressing changes until further direction from the physician from 07/18/25 to 07/22/25 (five days). The "Nurse's Notes," dated 07/22/25 at 03:45 PM documented that the physician received the documentation from the facility regarding the sores and had no further orders. On 07/22/25 at 09:37 AM, Licensed Nurse (LN) H stated she did not normally work in that household and was unsure if R49 had a skin breakdown but would go with this surveyor and assess her skin. Observation revealed R49 had a leg immobilizer on her left leg from mid-thigh to her ankle. R49 stated the immobilizer needed to be repositioned and tightened because it was too loose on her leg and was slipping. Observation revealed nothing between her skin and the immobilizer to protect it from breakdown. R49 had a foam dressing on her left calf but no dressing on the sore on her left thigh. LN H washed her hands and donned clean gloves. She asked R49 if staff were changing the dressing daily, and she replied "No" but did not know when they had changed the dressing last. LN H removed the dressing from the calf, and there was brown in color drainage. LN H did not clean the area but washed her hands and donned clean gloves to put a new foam dressing on her calf. The area on her calf was pink but not open. Further observation revealed the sore on her left thigh was approximately the size of a pencil eraser and was starting to scab. LN H did not put a dressing on the sore.	F0686		

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F0686 SS = D	Continued from page 21 On 07/23/25 at 08:48 AM, Certified Nurse Aide (CNA) N stated, nurse aides were responsible for putting the immobilizer on R49 every morning, but sometimes the night shift forgot to take it off, and she has it on all night. CNA N stated she was unaware of any skin breakdown under the immobilizer. On 07/23/25 at 10:00 AM, LN G stated she had not worked in the household for at least two weeks and did not know that R49 had any skin breakdown. LN G washed her hands, donned clean gloves, and opened the immobilizer from R49's left leg, and there was nothing between her skin and the immobilizer. Observation revealed a dried substance inside the immobilizer, from where it had lain against the sore on her thigh. The sore was scabbed and not actively draining. LN G removed the dressing from her calf, and the skin was slightly pink. LN G washed her hands, donned clean gloves, and placed a clean foam dressing on the calf wound, but did not put one on the sore on her thigh. This surveyor observed a yellow PPE (personal protective equipment) hanging on the back of R49's door and when LN G was asked what it was for, she stated, "Oh, she is on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care), because of wounds, I forgot." LN G further stated, there should be a sign on her door stating that, but there was not. On 07/23/25 at 10:30 AM, Administrative Nurse F stated she had been made aware of R49's sores on 07/21/25, but had not looked at them yet but today was the day she would do her weekly skin assessment. Administrative Nurse F further stated that because the sores were not chronic, they did not require staff to wear PPE during care. At 02:30 PM, Administrative Nurse F stated she had looked at R49's wounds and did not feel that the immobilizer had caused the sore on her thigh because R49 had told her she thought she had scratched it, and that was why she got the sore. Administrative Nurse F stated she did not think the immobilizer had dried drainage because the sore was scabbed, but thought it was dried food. Administrative Nurse F stated, R49 told her that she would wear thin pajama pants so her leg would be protected when the immobilizer was on and would contact the physician for guidance. On 07/23/25 at 12:45 PM, Consultant GG stated, normally there would be standing orders for treatments of skin breakdown while staff waited for doctor orders, but since they were a new company for the facility, all standing orders were sent to the physicians to sign and	F0686		

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F0686 SS = D	Continued from page 22 had not been returned yet. Consultant GG further stated she would have expected staff to protect R49's skin from breakdown when the immobilizer was originally placed on her. Consultant GG further stated that there should be communication to staff related to the breakdown and assessment of the skin daily. On 07/23/25 at 01:49 PM, Administrative Nurse D stated that staff should have protected her skin when she had the immobilizer on and felt that there should have been better communication related to the wounds to the nursing staff. The facility's "Prevention of Pressure Injuries Protocol," dated 01/2024, documented pressure can come from splints, casts, bandages, and wrinkles in the bed linen. If a pressure injury was not treated when discovered, it quickly gets larger, becomes very painful for the resident, and often becomes infected. Staff should routinely assess and document the condition of the resident's skin per the community wound and skin care program. Staff should assess for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury to the supervisor.	F0686		
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents, with one reviewed for foot care. Based on observation, record review, and interview, the facility failed to provide foot care to one resident, Resident (R) 49, whose toenails were long and over the top of her toes. This placed the resident at risk for complications, poor hygiene, discomfort, and injuries.	F0687		

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F0687 SS = D	Continued from page 23 Findings included: - The Electronic Medical Record (EMR) for R49, documented diagnoses of hypertension (high blood pressure), muscle weakness, atrial fibrillation (rapid heart rate), and disorders of bone density and structure (a condition where bones become weakened and more prone to fractures due to reduced bone mass and/or changes in bone structure). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS). dated 04/21/25, documented R49 had intact cognition. R49 required staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 had upper functional impairment on one side, lower functional impairment on both sides, and required assistance with footwear. R49's "Care Plan," dated 04/15/25, documented R49 required assistance from staff for bathing, dressing, putting on and taking off footwear, and personal hygiene. The care plan directed staff to monitor for edema and brittle nails. The "Nurse's Note" dated 07/22/25 at 11:14 AM documented nail care provided and noted curling on the middle toenails. On 07/22/25 at 09:37 AM, Licensed Nurse (LN) H removed R49's socks, and her toenails were long; some of the middle toenails curled over the top of the toes on each foot. LN H asked R49 when the last time she had any foot care. R49 stated she did not know. LN H stated she would come back in and cut her toenails for her because it looked like she had not had them cut for a long time. On 07/22/25 at 12:46 PM, Certified Nurse Aide (CNA) M stated she thought the nurse provided all of R49's nail care. On 07/23/25 at 08:48 AM, CNA N stated R49 had an afternoon shower, and the CNAs were responsible for her nail care. On 07/23/25 at 01:49 PM, Administrative Nurse D stated that staff should make sure her toenails are cut during her shower. The facility's "Nail Care" policy, dated 12/03/24, directed staff to provide routine nail care, to include trimming and filing on a regular schedule and as needed.	F0687		

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F0687 SS = D SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 84 residents, with 10 residents reviewed for accidents and hazards. Based on record review, observation, and interview, the facility failed to follow R49's care plan and failed to transfer R49 with a full lift, which placed R49 at risk for injury. On 06/04/25, two unidentified Certified Nurse's Aides (CNAs) transferred R49 by lifting her under her arms and pivot transferred R49 from her wheelchair to the shower chair. R49's left foot, which had a non-skid slipper on it, caught on the floor and her left knee twisted during the transfer. R49 sustained a left nondisplaced medial tibial plateau fracture (a break in the shinbone at the knee joint). On 06/11/25 two unidentified CNAs transferred R49 again by lifting her up under her arms and pivot transferred R49 from her wheelchair to the shower chair. R49's left leg twisted again during the transfer, and R49 had pain. A follow-up x-ray on 06/20/25 showed R49's previously non-displaced medial tibial plateau fracture was now displaced. This deficient practice caused R49 to sustain a tibial fracture and pain. Findings included: - R49's Electronic Medical Record (EMR) documented diagnoses of anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and foot drop (difficulty in lifting the front part of the foot). The "Quarterly Minimum Data Set (MDS)," dated 05/06/25, documented R49 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS	F0687 F0689		

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F0689 SS = G	Continued from page 25 documented R49 was completely dependent on staff for assistance with toileting, bathing, lower body dressing, donning footwear, sit-to-lying, and transfers. The MDS documented R49 had impaired functional range of motion on one side of her upper extremity and to both sides of her lower extremities. The MDS documented R49 had zero falls during the lookback period. The “Care Area Assessments (CAAs),” dated 03/01/25, lacked any documentation or development. R49’s “Care Plan” documented R49 required total assistance of two staff with a total lift device for transfers, total assistance of one staff for mobility in a wheelchair, extensive assistance of one staff for bathing, extensive assistance of one to two staff for bed mobility, total assistance of one to two staff for toileting, and total assistance of one to two staff for dressing (04/15/25). The care plan documented R49 would demonstrate adequate pain control by verbalizing satisfaction and ability to participate in activities of daily living (ADL) to the best of her ability (04/15/25). The care plan documented R49 would not develop complications from blood-thinning medications and directed staff to monitor for petechiae (tiny round brown-purple spots due to bleeding under the skin, may be in a small area due to minor trauma) and bruises (04/15/25). The EMR lacked any documentation in the skin evaluations of any bruising, purpura (a rash of purple dots due to small blood vessels leaking blood into the skin), or petechiae. The EMR documented R49 had a shower on 06/04/25 and 06/11/25 on the 2 PM to 10 PM shift. The “Nurses Note,” dated 06/06/25, documented the facility received orders from R49’s orthopedic (bone specialist) doctor, which stated “Weight bearing as tolerated, physical therapy for gait training, mobility, and strength exercises. Follow-up in four months.” The “Orthopedic Office Note,” dated 06/06/25, documented R49 presented for follow-up after a left thigh ‘I and D’ (incision and drainage). The note documented R49 told the doctor she was having pain in her left knee from when the staff picked her up to transfer her from her chair to the shower chair. R49 mainly had pain in the medial (middle) aspect of her left knee, and R49 had no pain at the surgical site on her left thigh. X-rays of the left knee were obtained	F0689		

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F0689 SS = G	Continued from page 26 and showed a possible nondisplaced medial tibial plateau fracture. The orthopedic doctor ordered R49 to use ice and rest to help with pain, and noted she was non-weight bearing on her left lower extremity. The office directed staff to follow up in two weeks for repeat X-rays. The “Nurses Note,” dated 06/16/25, documented R49 had a half-dollar-sized irregular-shaped area of reddish purpura to her left inner bicep. R49 did not show any signs of pain when staff touched the area. R49’s family was concerned it was a bruise and the nurse explained purpura could happen for many reasons, like taking blood-thinning medication, which R49 took daily. The plan was to monitor and notify the doctor if new areas or other symptoms occurred. The “Orthopedic Office Note,” dated 06/20/25, documented R49 presented and still noted pain to the medial aspect of her left knee. R49 had a non-weight-bearing status on her left lower extremity and required the use of a full mechanical lift. It was approximately two weeks out from the left medial tibial plateau fracture, and now the fracture was slightly displaced. The note documented they would continue with conservative treatment of the fracture. R49 was placed in a knee immobilizer and was advised to wear it at all times, except when sleeping. R49 would also need to remain non-weight-bearing on her left lower extremity. R49 had a follow-up appointment in two weeks for repeat X-rays and left knee evaluation. The “Nurse’s Note,” dated 06/20/25, documented R49 had an appointment with an orthopedic physician this morning. The staff called and requested the results be faxed to the facility. R49 was to be non-weight-bearing with an immobilizer in place. The order documented R49 could take the immobilizer off at night, but R49 requested to leave it on even when in bed. The “Facility Incident Report,” dated 06/24/25, documented on 06/16/25, R49’s responsible party reported to the Administrative Nurse, at the time, improper transfers and injury. R49’s responsible party stated R49 recalled being manually transferred by two staff members without the use of a mechanical lift on or around 06/06/25 and on or around 06/14/25, during which time R49’s left leg/knee twisted, and a bruise appeared on her left inner arm. Upon assessment, the Administrative Nurse identified an irregularly shaped purpura, rather than a bruise, which typically occurred with trauma. The Administrative Nurse at the time explained purpura could occur spontaneously, particularly in elderly individuals on blood thinners.	F0689		

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F0689 SS = G	Continued from page 27 By 06/18/25, no discoloration was visible, and the assigned CNAs reported proper mechanical lift use. R49's responsible party later took R49 to an orthopedic appointment on 06/20/25 and reported in writing on 06/23/25 that R49's knee was broken. The facility lacked evidence or documentation supporting that a manual transfer occurred. Only one CNA, CNA OO, was unresponsive to the inquiry, creating a partial information gap. On 07/22/25 at 10:30 AM, observation revealed R49 sat in her wheelchair reading a book in her nightshirt. R49's left leg was in an immobilizer and elevated. On 07/22/25 at 10:30 AM, R49 stated that about a month ago, two CNAs did not transfer her with the full mechanical. She reported they picked her up underneath her arms to transfer her from the wheelchair to the bathchair. The staff members did not lift her all the way up; her left leg caught on the floor, and her left knee twisted. R49 stated that a week later, two CNAs came in and transferred her from her wheelchair to the shower chair. She told them they had to use the full mechanical lift, and they said no, it was easier to just do it their way. The staff members lifted her without the use of the mechanical lift again and twisted her left knee. R49 stated she could not walk for three plus years, and her feet did not move at all. R49 stated her knee hurt, she needed pain medication to take care of her pain, and the pain made it hard for her to sleep at night. On 07/22/25 at 01:30 PM, CNA M stated she knew two CNAs who transferred R49 without using the mechanical lift. CNA M stated that CNA MM and CNA OO both transferred R49 manually. On 07/22/25 at 01:35 PM, CNA N stated CNA MM and CNA OO both transferred R49 by lifting her rather than using the full lift. On 07/22/25 at 01:45 PM, Licensed Nurse (LN) H stated R49 had more pain since she sustained the left knee fracture. LN H stated staffing on the living units was poor, and it would not surprise her if the CNAs did not take the time to go and get the mechanical lift to transfer R49. On 07/23/25 at 09:36 AM, CNA MM, who still worked at the facility, stated she always used a full mechanical lift when transferring R49. CNA MM denied ever transferring R49 manually. On 07/23/25 at 12:36 PM, CNA OO, who quit the facility	F0689		

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F0689 SS = G	Continued from page 28 shortly after the incident, stated there were times when CNAs manually transferred R49 with the use of a pivot transfer. CNA OO stated a mechanical lift was to be used on R49 for all transfers. On 07/23/25 at 01:00 PM, Administrative Nurse D stated she expected all staff to follow the care plans for all the residents. Administrative Nurse D stated R49 was care planned to be transferred by a full mechanical lift to avoid any kind of injuries. Administrative Nurse D stated she felt like the previous Administrative Nurse did not investigate the incident fully. The facility's "Safe Lifting and Moving of Patients Policy," dated January 2024, documented in order to protect the safety and well-being of associates and residents, and to promote quality care, this community uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F0692		

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F0692 SS = D	Continued from page 29 This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents, with nine reviewed for nutrition and weight loss. Based on observation, interview, and record review, the facility failed to identify and implement interventions to prevent weight loss for Residents (R) 20. This deficient practice resulted in significant weight loss and placed the resident at risk for further weight loss or health issues. Findings included: - R20's Electronic Health Record (EHR) revealed diagnoses of Extended spectrum beta lactamase (ESLB, an infection cause by a bacteria that produces extended-spectrum beta- lactamases enzymes that make certain antibiotics effective such as e coli and klebsiella, making the infection harder to treat and can occur in urinary tract infections or bloodstream infections,) congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic kidney disease Stage 3 (kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood), and major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness). R20's "Quarterly Minimum Data Set" (MDS), dated 05/09/25, recorded R20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded she was independent with eating and activities of daily living (ADL). The MDS documented R20’s weight at 117.0 lbs. R20's "Care Plan," dated 07/18/25, recorded R20 was independent with eating, oral hygiene, toilet hygiene, personal hygiene, and walking. The care plan documented the resident was at risk for CHF, MDD, chronic kidney disease, malnutrition, and was underweight for age. The care plan directed staff to administer medications as ordered and documented for side effects and effectiveness. The care plan documented the resident had a risk for shortness of breath and respiratory complications related to a recent diagnosis of Influenza and acute respiratory failure, and staff would monitor oxygen saturation and administer oxygen per physician order and monitor for shortness of breath or difficulty breathing. The "Physician Order," dated 02/05/25, 06/11/25, and 07/02/25, directed staff to provide R20 a regular diet, regular texture, and regular consistency.	F0692		

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F0692 SS = D	Continued from page 30 The “Mini Nutritional Assessment” dated 02/05/25, documented R20 weighed 113.9 lbs. and she was at risk for malnutrition. The “Nutritional Risk Assessment” dated 02/11/25 documented R20 weight was 113.0 lbs. and she required 1285-1540 calories, 51-61 grams of proteins, and 1285 to 1540 milliliters (ml) of fluids. The assessment documented the resident had a recent hospitalization with a 5.60% significant weight loss in one month. And she was at risk for unintendedly weight loss. The "Dietician Assessment," dated 07/23/25, documented R20 weighed 108.4 lbs. and her intakes were all adequate, mostly 51-100%. The Registered Dietician (RD) recommended to add meal fortification to R20's diet order and snacks at bedtime with Ensure Enlive (provides advanced nutrition with 20 grams of high-quality protein) supplement daily. R20's EMR documented R20's weights as follows: 04/14/25 120.4 lbs. 04/18/25 117.8 lbs. 04/28/25 117.2 lbs. 05/02/25 117.0 lbs. 05/06/25 117.4 1lbs. 05/16/25 115.6 lbs. = 3.99% weight loss in 30 days. 05/23/25 112.4 lbs. 05/27/25 113.2 lbs. 05/30/25 112.6 lbs. 06/03/25 112.2 lbs. 06/06/25 111.2 lbs. 06/14/25 111.2 lbs. 06/20/25 112.0 lbs.= 6.40% weight loss in 60 days 06/27/25 109.0 lbs. 07/04/25 110.0 lbs. 07/11/25 109.8 lbs.	F0692		

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F0692 SS = D	Continued from page 31 07/17/25 110.8 lbs. 07/18/25 108.4 lbs. 07/23/25 107.0 lbs. = 11.13% weight loss in 90 days. On 07/21/25 at 12:00 PM, observation of R20 revealed that staff delivered her dinner plate to the table that contained chicken, noodles, carrots, and Jello. Continued observation revealed she ate approximately 50 % of the meal. On 07/21/25 at 09:00 AM, Administrative Nurse D stated staff notified the RD of R20's weight loss that week and the weight loss over the last few months, and the RD completed a nutritional assessment with suggestions. On 07/21/25 at 10:00 AM, Administrative Nurse D verified staff had obtained R20's weights weekly or more often and said staff should have notified the physician and the RD earlier of the resident's significant weight loss to obtain orders for recommendations to prevent the continued weight loss. The facility's "Weight Monitoring" policy, dated January 2023, signed 07/2025, documented that appropriate nutritional care shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5% s in 30 days, 7.5% in 90 days, or 10% in 180 days daily for the first 3 days of admission, weekly for the first four weeks, and monthly thereafter. Residents with a weight change of 5 pounds or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record. A report should be generated from the electronic medical record (EMR) system identifying all residents with a significant weight loss in 30 days, 90 days, and /or 180 days. At the weekly Resident at Risk Preview huddle, the IDT team should discuss residents who triggered a significant weight loss and who loss more than five lbs. since the last weight. The RD should make recommendations or nutritional interventions based on the information obtained from the weekly Resident at Risk Review huddle meetings. RD's recommendations should be reviewed and initiated by nursing associates. A nursing or nutritional associate should notify the health care provider of any significant weight change that is unexplained or in which the RD has requested a nutritional intervention.	F0692		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning	F0695		

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F0695 SS = D	Continued from page 32 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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 had a census of 84 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to store oxygen cannula, nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs), and a continuous positive airway pressure (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) equipment in sanitary conditions for Resident (R) 12, which placed the resident at risk of respiratory infections. Findings included: - R12's Electronic Medical Record (EMR) included the diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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), pain, acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), and age-related physical debility. R12's "Comprehensive Minimum Data Set" (MDS), dated 04/07/25, documented that R12 had intact cognition, functional range of motion of one side of upper and lower body extremities, required substantial/maximal assistance with upper and lower body dressing, personal hygiene, bed rolling, and transfers. The MDS further recorded that R12 had occasional pain, which affected sleep and day-to-day activities, shortness of breath or trouble breathing with exertion. R12 received oxygen therapy and had a non-invasive mechanical ventilator. R12's "Functional Abilities Care Area Assessment" (CAA), dated 04/09/25, documented R12 had chronic respiratory failure with hypoxia and hypercapnia (a condition in which high levels of carbon dioxide build up in the bloodstream), reduced mobility, and	F0695		

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F0695 SS = D	Continued from page 33 hemiplegia and hemiparesis following a cerebrovascular disease affecting the left non-dominant side. R12's "Care Plan" dated 06/27/25, documented R12 had potential for shortness of breath and/or respiratory complications related to sleep apnea, wore a CPAP- at bedtime. The Care Plan directed staff to monitor for complications such as dyspnea (difficulty breathing), shortness of air, cyanosis (a bluish discoloration of the skin), or tachypnea (rapid breathing). The Care Plan further directed staff to provide pulmonary treatments per the physician's orders and monitor responses. The Care Plan lacked the use of oxygen. The "Physician Order" dated 06/20/25, instructed staff to assess lung sounds, pulse, respirations, and oxygen saturation before and after nebulizer treatments and CPAP every day for respiratory failure. The "Physician Order" dated 07/01/25, directed staff to provide oxygen at three liters via nasal canula to keep oxygen saturations above 90 percent (%). The "Progress Note" dated 07/04/25 at 04:02 PM, documented R12 wore oxygen tubing per nasal canula, was alert and oriented, reported shortness of breath with exertion and when sitting at rest, and was unable to lie flat. R12 had portable oxygen and an oxygen concentrator in her room. The Progress Note further documented that R12 had a nebulizer and CPAP machine in her room. On 07/21/25 at 04:16 PM, R12 was sitting in her recliner, wearing an oxygen canula. R12 had a portable oxygen tank on her wheelchair with the unwrapped tubing and nasal canula wrapped around the top of the canister. R12's bedside tables had nebulizer treatment and CPAP equipment not in current use, also not wrapped or bagged. On 07/23/25 at 08:30 AM, R12 reported she was doing well, but stated her room was cluttered. On 07/23/25 at 10:13 AM, Licensed Nurse (LN) GG reported that the oxygen tubing and nebulizer, and CPAP equipment should be cleaned and stored in bags when not in use. On 07/23/25 at 01:45 PM, Administrative Nurse D verified that oxygen, nebulizer, and CPAP equipment should be stored in bags when not in use. The facility's "Oxygen Administration" policy, dated 04/09/25, documented that oxygen was administered to	F0695		

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F0695 SS = D	Continued from page 34 residents who needed it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Staff shall keep delivery devices covered in a plastic bag when not in use. The facility's undated "CPAP/BiPAP Cleaning" policy documented common equipment including the machine, tubing, mask, headgear/straps, disposable filters, and humidifier chamber, clean the mask frame daily after use with a CPAP cleaning wipe or soap and water. Dry well. Cover with a plastic bag or completely enclose in machine storage when not in use. The facility's "Nebulizer Therapy" policy, dated 04/09/25, documented it was the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. Store the nebulizer and mouthpiece in a zip-lock bag.	F0695		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides.	F0726		

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F0726 SS = D	Continued from page 35 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents, with one reviewed for competent staffing. Based on observation, record review, and interview, the facility failed to ensure staff possessed the appropriate skills and knowledge to monitor and communicate nursing orders, while waiting for direction from the physician, for one resident, Resident (R) 49, who sustained two open areas from an immobilizer. This placed the resident at risk for further breakdown. - The Electronic Medical Record (EMR) for R49, documented diagnoses of hypertension (high blood pressure), muscle weakness, atrial fibrillation (rapid heart rate), and disorders of bone density and structure (a condition where bones become weakened and more prone to fractures due to reduced bone mass and/or changes in bone structure). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS), dated 04/21/25, documented R49 had intact cognition. R49 was dependent upon staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 had upper functional impairment on one side, lower functional impairment on both sides, was at risk for skin breakdown, and had a surgical wound. R49's "Care Plan," dated 04/15/25, documented she was at risk for pressure ulcers and other skin-related injuries. Staff were directed to observe for redness and breakdown during routine care, follow community skin care protocols, and treat as indicated. They were also to assist her with splinting/bracing and the use of assistive devices. The care plan lacked direction to staff on when to remove her immobilizer and if she had any skin breakdown. The "Braden Scale" (formal assessment for predicting pressure ulcer risk) dated 05/07/25, documented R49 was a mild risk for pressure ulcers. The "Physician's Order" dated 06/20/25, directed staff to leave immobilizer in place unless sleeping, and nwb	F0726		

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F0726 SS = D	Continued from page 36 (non-weight bearing) to LLE (left lower leg). The "Nurse's Notes," dated 07/18/25 at 05:38 PM, documented R49 had two small open sores on her left leg from where her knee brace had been rubbing against her skin. The sore on the outside of her thigh (the part of the human leg between the hip and the knee) measured 0.4 centimeters (cm) x 0.5 cm. The sore on her calf (the back portion of the lower leg) measured 0.5 cm x 0.5 cm. The wounds were cleaned with wound cleanser and covered with a Mepilex (absorbent, bordered foam dressing). The physician and the durable power of attorney (DPOA-a legal document that names a person to make healthcare decisions when the resident is no longer able to) were notified of the skin breakdown. The EMR lacked a skin assessment, directions to staff for monitoring R49's skin daily, or any daily standing orders for dressing changes until further direction from the physician from 07/18/25 to 07/22/25 (five days). The "Nurse's Notes," dated 07/22/25 at 03:45 PM, documented that the physician received the documentation from the facility regarding the sores and had no further orders. On 07/22/25 at 09:37 AM, Licensed Nurse (LN) H stated she did not normally work in that household and was unsure if R49 had a skin breakdown but would go with this surveyor and assess her skin. Observation revealed R49 had a leg immobilizer on her left leg from mid-thigh to her ankle. R49 stated the immobilizer needed to be repositioned and tightened because it was too loose on her leg and was slipping. Observation revealed nothing between her skin and the immobilizer to protect it from breakdown. R49 had a foam dressing on her left calf but no dressing on the sore on her left thigh. LN H washed her hands and donned clean gloves. She asked R49 if staff were changing the dressing daily, and she replied "No" but did not know when they had changed the dressing last. LN H removed the dressing from the calf, and there was brown in color drainage. LN H did not clean the area but washed her hands and donned clean gloves to put a new foam dressing on her calf. The area on her calf was pink but not open. Further observation revealed the sore on her left thigh was approximately the size of a pencil eraser and was starting to scab. LN H did not put a dressing on the sore. On 07/23/25 at 08:48 AM, Certified Nurse Aide (CNA) N stated, nurse aides were responsible for putting the immobilizer on R49 every morning but sometimes the	F0726		

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F0726 SS = D	Continued from page 37 night shift forget to take it off, and she has it on all night. CNA N stated she was unaware of any skin breakdown under the immobilizer. On 07/23/25 at 10:00 AM, LN G stated she had not worked in the household for at least two weeks and did not know that R49 had any skin breakdown. LN G washed her hands, donned clean gloves, and opened the immobilizer from R49's left leg, and there was nothing between her skin and the immobilizer. Observation revealed a dried substance inside the immobilizer, from where it had lain against the sore on her thigh. The sore was scabbed and not actively draining. LN G removed the dressing from her calf, and the skin was slightly pink. LN G washed her hands, donned clean gloves, and placed a clean foam dressing on the calf wound, but did not put one on the sore on her thigh. This surveyor observed a yellow PPE (personal protective equipment) hanging on the back of R49's door and when LN G was asked what it was for, she stated, "Oh, she is on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care), because of wounds, I forgot." LN G further stated, there should be a sign on her door stating that, but there was not. On 07/23/25 at 10:30 AM, Administrative Nurse F stated, she had been made aware of R49's sores on 07/21/25 but had not looked at them yet but today was the day she would do her weekly skin assessment. Administrative Nurse F further stated that because the sores were not chronic, they did not require staff to wear PPE during care. At 02:30 PM, Administrative Nurse F stated she had looked at R49's wounds and did not feel that the immobilizer had caused the sore on her thigh because R49 had told Administrative Nurse F that she thought she had scratched it, and that was why she got the sore. Administrative Nurse F stated she did not think the immobilizer had dried drainage because the sore was scabbed, but thought it was dried food. Administrative Nurse F stated, R49 told her that she would wear thin pajama pants so her leg would be protected when the immobilizer was on and would contact the physician for guidance. On 07/23/25 at 12:45 PM, Consultant GG stated that normally there would be standing orders for treatments of skin breakdown while staff waited for doctor orders, but since they were a new company for the facility, all standing orders were sent to the physicians to sign and had not been returned yet. Consultant GG further stated she would have expected staff to protect R49's skin from breakdown when the immobilizer was originally	F0726		

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F0726 SS = D	Continued from page 38 placed on her. Consultant GG further stated that there should be communication to staff related to the breakdown and assessment of the skin daily. On 07/23/25 at 01:49 PM, Administrative Nurse D stated that staff should have protected her skin when she had the immobilizer on and felt that there should have been better communication related to the wounds to the nursing staff. The facility's "Nursing Services and Sufficient Staff" policy, undated, documented that the facility provided sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility would ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs as identified through resident assessment and described in the plan of care.	F0726		
F0730 SS = E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on record review and interview, the facility failed to ensure the nurse aides received the required number of in-service training hours per year. This placed the residents at risk for impaired care. Findings included: - The facility's employment records documented two nurse aides who were employed at the facility for the last year had not completed the required 12 hours of in-service training in the past year. On 07/23/25 at 08:00 AM, Administrative Nurse D stated Certified Nurse Aide (CNA) PP had completed 6.5 of the 12 hours in-service hours, and CNA QQ had completed 7.5 hours of the required 12 in-service hours, and the aides lacked the required number of in-service hours.	F0730		

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F0730 SS = E	Continued from page 39 On 07/23/25 at 10:00 AM, Administrative Nurse D stated the facility became aware of the lack of aides completing the required in-service hours. Administrative Nurse D stated the facility had recently been bought, and they presently have a new owner. Administrative Nurse D stated the past owner had human resources out of the building, including all the information and record tracking for the in-service hours, and they had to rely on the past company to gather the information, and that was what they were provided. The Facility "Training and Education" policy dated 10/2020, documented the purpose of the policy is to provide specific guidelines with respect to required training and education courses. The facility provides associate training and education to meet job, state, and federal requirements as well as to support career development opportunities. Staff are expected to complete mandatory training courses within the assigned timeline. Staff are expected to complete educational courses within the established timeframe. Full-time, part-time, and PRN staff were expected to comply with the expectations. The manager was responsible for communicating all training and educational requirements to associates. Online course completion or in-person course would be tracked, and the manager was responsible for addressing non-compliance issues in a timely manner in accordance with Associate coaching, counseling, and corrective action policy.	F0730		
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents, of whom one was reviewed for the provision of mental-related social services. Based on observation, record review, and interview, the facility failed to provide adequate medical social services to meet Resident (R) 37's medical health needs. This placed the resident at risk for decreased quality of care and life. Findings included: - R37's Electronic Medical Record (EMR) documented R37	F0745		

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F0745 SS = D	Continued from page 40 had a diagnosis of arthritis (inflammation of a joint characterized by pain, swelling, redness, and limitation of movement). R37's "Quarterly Minimum Data Set" (MDS), dated 05/02/25, documented R37 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented the resident was independent with eating, had broken or loosely fitting full or partial dentures. R37's "Care Plan," revised 07/03/25, documented R37 was edentulous and instructed staff to assess dentures for proper fitting, assist as needed with oral care, and provide dental evaluation by a licensed dentist, if warranted. The plan documented R37 wore upper and lower dentures. The “Progress Note,” dated 05/23/25 at 12:06 PM, documented R37’s durable power of attorney (DPOA) was informed R37 had some broken teeth on her dentures. The note documented R37’s DPOA requested R37 see a dentist and had no preference on a dentist. The note documented the DPOA reported R37 had had the same dentures since she was 18, and the message was sent to the social service designee (SSD). The “Progress Note,” dated 05/27/25 at 01:45 PM, documented R37 reported her upper denture was missing teeth, and a message was sent to determine how to proceed with the repairs. Review of R37’s medical record from 05/27/25 to 07/23/25 revealed a lack of documentation. SSD followed up on getting R37 a dentist appointment to repair or replace her dentures. On 07/22/25 at 10:50 AM, R37 sat in a wheelchair at a dining room table with her dentures in, and staff served R37 two waffles and 240 cc of regular consistency water. R37 applied peanut butter to her waffles and chewed several times when she independently ate her waffles. On 07/23/25 at 10:00 AM, Licensed Nurse (LN) L stated she did not work the 500 unit very often, and R37 had never mentioned to her any issue with her dentures. On 07/23/25 at 03:36 PM, Social Service Designee (SSD) X stated she was aware of R37’s issue with her dentures, and SSD X had tried to get R37 into a local dentist who took R37’s insurance, but they were not taking new patients. SSD X stated she had not tried any other dentist in the nearby towns or talked to R37’s	F0745		

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F0745 SS = D	Continued from page 41 DPOA about taking R37 to the city, where the DPOA was from, which has a dentist who would take her insurance. On 07/23/25 at 12:35 PM, Administrative Nurse D verified the resident had missing teeth in her dentures and stated she was under the impression R37 could not get new dentures due to her bone structure in her mouth. When asked if she had documentation regarding R37's bone structure issue, she stated she would look at her medical records. The facility's "Social Service Policy," revised 02/2017, documented that medically related social services would be provided to maintain or improve each resident's ability to control everyday physical needs.	F0745		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756		

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

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F0756 SS = D	Continued from page 42 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 84 residents. The sample included 27 residents, with six sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility's consultant pharmacist failed to recommend to the physician or the facility's Director of Nursing (DON) a gradual dose reduction (GDR -tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Resident (R) 28's psychotropic (a class of medications that alters mood or thought) medication. The facility failed to ensure the physician provided the risk versus benefit for the continued use of buspirone (anti-anxiety) medication. This deficient practice placed R28 at risk of unnecessary medication administration and related complications. Findings included: - R28's "Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), hypertension (elevated blood pressure), auditory and visual hallucinations (sensing things while awake that appear to be real, but the mind created), dementia (progressive mental disorder characterized by failing memory, confusion), chronic pain, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R28's "Quarterly Minimum Data Set" (MDS), dated 06/26/2025, documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired decision making. The MDS documented R28 had no mood or psychosis but did have verbal behaviors. R28 received antidepressant and antianxiety medications with no GDR. R28's "Care Plan," dated 07/03/25, included interventions for behaviors and side effects for R28's medications. Administer psychotropic medications as	F0756		

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F0756 SS = D	Continued from page 43 ordered by the physician. Consult with the pharmacy and the physician to consider dosage reduction when clinically appropriate, at least quarterly. Discuss with the physician and family the ongoing need for use of the medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Provide R28 with necessary cues, stop, ensure her safety, and return if she becomes agitated. Monitor me for and address episodes of anxiety, fear, or distress. R28's "Physician Order," dated 12/23/24, directed staff to administer Buspirone (antianxiety drug), five milligrams (mg), three times daily (TID) for anxiety and depression. R28's "Physician Order," dated 04/04/25, directed staff to administer Bupropion (antidepressant), 300 mg daily for anxiety and depression. R28's Consultant Pharmacist "Medication Reviews" from 01/01/25 to 07/22/25 documented no irregularities had been found in her medication regimen. On 07/22/25 at 07:45 AM, Licensed Nurse (LN) J administered medications to R28, including bupropion and buspirone. R28 took the pills whole in applesauce without problems. On 07/22/25 at 12:25 PM, R28 sat calmly in her wheelchair throughout the meal, without yelling or other behavior observed. She did offer the staff a bite of her lunch but accepted their refusal calmly. She was confused but still able to answer most questions appropriately. On 07/23/25 at 11:45 AM, Consultant GG stated the resident had visual and auditory hallucinations. She verified the pharmacist had not recommended a GDR for R28's buspirone. The physician had not written a rationale for continuing the medication. The facility's policy for "Consultant Pharmacist," dated 02/2025, stated the pharmacist would report on the Medication Record Review (MMR) and submit recommendations to the physician and the Director of Nursing (DON). The pharmacist would assist with Gradual Dose Reduction (GDR) reviews and recommendations.	F0756		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F0757		

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F0757 SS = D	Continued from page 44 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 had a census of 84 residents. The sample included 27 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold blood pressure medications per the physician-ordered parameters for one resident, Resident (R) 49. This placed the resident at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (EMR) for R49 documented diagnoses of hypertension (high blood pressure), atrial fibrillation (rapid heart rate), and diastolic congestive heart failure (occurs when the left ventricle stiffens and can’t fill with blood properly between heartbeats). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS), dated 04/21/25, documented R49 had intact cognition. R49 was dependent upon staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 received antidepressant (a class of medications used to treat	F0757		

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F0757 SS = D	Continued from page 45 mood disorders, anticoagulant, diuretic (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drugs used to treat pain) medications daily. R49's "Care Plan," dated 04/15/25, documented R49 had hypertension and directed staff to monitor her blood pressure as per physician orders, notify of any changes, and administer medications as ordered. The "Physician's Order," dated 04/15/25, directed staff to administer metoprolol (a high blood pressure medication), 25 milligrams (mg), administer 12.5 mg by mouth, twice daily, for hypertension. Hold the medications if R49's systolic blood pressure (SBP- the top number that measures the force the heart exerts on the walls of the arteries each time it beats) was less than 100 millimeters of mercury (mmHg) or the pulse (a rhythmical throbbing of the arteries as blood is propelled through them, typically felt in the wrist or neck) less than 55 beats per minute (bpm). The order was changed on 06/26/25. The "Physician's Order," dated 06/26/25, directed staff to administer metoprolol, 12.5mg, by mouth, twice per day for hypertension. Hold the medication if the SBP is less than 100 mmHg or the pulse is less than 55 bpm. R49's "Medication Administration Record" (MAR) for May 2025 documented the following days R49 received the metoprolol when the SBP was under the ordered parameters: 05/01/25 – 94/52 mmHg 05/07/25 - 87/47 mmHg 05/08/25 – 91/68 mmHg 05/12/25 – 84/53 mmHg 05/16/25 – 95/53 mmHg 05/18/25 – 98/56 mmHg 05/20/25 – 87/54 mmHg 05/29/25 – 87/47 mmHg R49's "Medication Administration Record" (MAR) for June 2025 documented the following days R49 received the metoprolol when the SBP was under the ordered parameters:	F0757		

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F0757 SS = D	Continued from page 46 06/06/25 – 93/41 mmHg 06/09/25 – 87/60 mmHg 06/12/25 – 91/40 mmHg 06/13/25 – 92/48 mmHg 06/14/25 – 88/42 mmHg 06/15/25 – 98/53 mmHg 06/16/25 – 94/51 mmHg 06/20/25 – 96/60 mmHg 06/21/25 – 86/52 mmHg 06/24/25 – 97/50 mmHg 06/27/25 – 90/51 mmHg 06/29/25 – 94/50 mmHg 06/30/25 – 87/46 mmHg R49's "Medication Administration Record" (MAR) for July 2025 documented the following days R49 received the metoprolol when the SBP was under the ordered parameters: 07/05/25 – 78/44 mmHg 07/15/25 – 85/58 mmHg On 07/22/25 at 07:43 AM, Licensed Nurse (LN) H obtained R49's blood pressure and administered her medication without issue. LN H stated R49 had parameters that were to be followed before administration of her medications. If R49's SBP was less than 100 mmHg, staff should hold the medication and notify the nurse. On 07/23/25 at 01:49 PM, Administrative Nurse D stated R49's medication should be administered as ordered and held if out of parameters. The facility's "documentation of Medication Administration" policy, dated 01/24, directed staff to maintain a medication administration record to document medications administered. Administration of medication is to be documented after it is given, and the reason why a medication was withheld, not administered, or refused.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 47 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 36 residents. Based on observation, interview, and record review, the facility failed to store biologicals as required when staff failed to discard or destroy expired medications and failed to label Resident (R) 12 and R48 insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when the pens expired. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On 07/21/25 at 12:26 PM during the tour of the medication room on the 300 hall/unit, R48 and R12's in use long-acting insulin (a hormone that lowers the level of glucose in the blood) pens (apparatus to inject the insulin) were stored in a cabinet with the blood sugar checking machines. Licensed Nurse (LN) HH stated the insulin pens in use for R48 and R12 should have a label to when the pens were put into use and when the pens would expire.	F0761		

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F0761 SS = D	Continued from page 48 On 07/23/25 at 10:45 AM, Administrative Nurse D verified the insulin pens should have been labeled with dates when put in use for the resident, along with expired dates. The facility's "Insulin Pen" policy, dated 01/01/20, documented that insulin pens must be clearly labeled with a resident's name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. Insulin pens should be disposed of after 28 days or according to the manufacturer's recommendation. - On 07/21/25 at 11:45 AM, observation of the medication cart for the 600-hall revealed on bottle of stock medications Prilosec (antacid) 20 milligrams (mg), 14 count with an expiration date of 05/2025, and one bottle of Maalox (antiacid) 12 ounce (oz), with an expiration date of 11/2024. LN G verified the expiration dates. On 07/23/25 at 08:30 AM, Administrative Nurse D verified that staff were to remove from stock and dispose of expired medications. The facility's "Medication Storage" policy, dated 01/01/20, documented it is the policy of the facility to ensure all medications housed on our premises were stored in the medication carts or medication rooms according to the manufactures recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security medications rooms are routinely inspected by the facility designee for discontinued, outdated, defective or deteriorated medications with worn, illegible, or missing labels, These medications would be destroyed in accordance with the "Destruction of Unused Drugs " policy.	F0761		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791		

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F0791 SS = D	Continued from page 49 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents, of whom one was reviewed for the provision of mental-related social services. Based on observation, record review, and interview, the facility failed to provide dental services to meet Resident (R) 37's, when she reported missing and loose teeth in her dentures. This placed the resident at risk for decreased quality of care and life.	F0791		

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F0791 SS = D	Continued from page 50 Findings included: - R37's Electronic Medical Record (EMR) documented R37 had a diagnosis of arthritis (inflammation of a joint characterized by pain, swelling, redness, and limitation of movement). R37's "Quarterly Minimum Data Set" (MDS), dated 05/02/25, documented that R37 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R37 was independent with eating, had broken or loosely fitting full or partial dentures. R37's "Care Plan," revised 07/03/25, documented R37 was edentulous and instructed staff to assess dentures for proper fitting, assist as needed with oral care, and provide dental evaluation by a licensed dentist, if warranted. The plan documented R37 wore upper and lower dentures. The “Progress Note,” dated 05/23/25 at 12:06 PM, documented R37’s durable power of attorney (DPOA) was informed R37 had some broken teeth on her dentures. The note documented R37’s DPOA requested R37 see a dentist and had no preference on a dentist. The note documented the DPOA reported R37 had had the same dentures since she was 18, and the message was sent to the social service designee (SSD). The “Progress Note,” dated 05/27/25 at 01:45 PM, documented R37 reported her upper denture was missing teeth, and a message was sent to determine how to proceed with the repairs. Review of R37’s medical record from 05/27/25 to 07/23/25 revealed a lack of documentation. SSD followed up on getting R37 a dentist appointment to repair or replace her dentures. On 07/22/25 at 10:50 AM, R37 sat in a wheelchair at a dining room table with her dentures in, and staff served R37 two waffles and 240 cc of regular consistency water. R37 applied peanut butter to her waffles and chewed several times when she independently ate her waffles. On 07/23/25 at 10:00 AM, Licensed Nurse (LN) L stated she did not work the 500 unit very often, and R37 had never mentioned to her any issue with her dentures. On 07/23/25 at 03:36 PM, Social Service Designee (SSD) X stated she was aware of R37’s issue with her dentures, and SSD X had tried to get R37 into a local	F0791		

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F0791 SS = D	Continued from page 51 dentist who took R37's insurance, but they were not taking new patients. SSD X stated she had not tried any other dentist in the nearby towns or talked to R37's DPOA about taking R37 to the city, the DPOA was from, which has a dentist who would take her insurance. On 07/23/25 at 12:35 PM, Administrative Nurse D verified the resident had missing teeth in her dentures and stated she was under the impression R37 could not get new dentures due to her bone structure in her mouth. When asked if she had documentation regarding R37's bone structure issue, she stated she would look at her medical records. The facility's " Social Service Policy," revised 02/2017, documented that medically related social services would be provided to maintain or improve each resident's ability to control everyday physical needs.	F0791		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F0801		

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F0801 SS = F	Continued from page 52 (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified	F0801		

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F0801 SS = F	Continued from page 53 nutrition professional. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on observation, interview, and record review, the facility failed to employ a full-time Certified Dietary Manager (CDM) to supervise the preparation of meals and sanitation in the facility's kitchen. This deficient practice placed the 84 residents of the facility at risk for inadequate nutrition or foodborne illness. Findings included: - On 07/21/25 at 08:30 AM, Dietary Staff (DS) BB was managing the kitchen and overseeing production of meals for the residents of the facility. On 07/21/25 at 08:30 AM, DS BB stated he was not certified as a dietary manager but was currently taking the course. He stated the Registered Dietitian (RD) had been communicating with him weekly, reviewing resident charts remotely, and visiting the facility weekly. On 07/23/25 at 11:36 AM, Administrative Staff A verified that the facility's Dietary Manager was not certified but was taking the certification course. The facility's "Roles of Key Staff" policy, dated 2020, stated the Dining Services Manager provided direction to the employees of the dining services department in all activities of food service to provide safe food and a positive dining experience for residents while meeting their nutritional needs.	F0801		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F0812		

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F0812 SS = F	Continued from page 54 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to store food by professional standards for food service safety in one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness. Findings included: - On 07/22/25 at 11:55 AM, three drawers in the facility's main kitchen had food crumbs and dried liquid spills among the scoops and ladles. On 07/22/25 at 11:55 AM, Dietary Staff BB verified the drawers had dried food spills and needed to be cleaned. The facility's "Sanitation of Dining and Food Service Area" policy, dated 2020, stated that a cleaning schedule would be posted for all cleaning tasks, and staff would initial the tasks as they are completed. Staff would be held responsible for all cleaning tasks.	F0812		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct	F0867		

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F0867 SS = F	Continued from page 55 care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure	F0867		

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F0867 SS = F	Continued from page 56 that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F0867		

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F0867 SS = F	Continued from page 57 This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern for the 84 residents who resided in the facility. This placed all residents at risk for unidentified and ongoing care issues. Findings included: - The facility failed to provide R70 dignified dining when she was not served her noon meal at the same time as her tablemates, and she had to wait to be assisted. Refer to F550. The facility failed to obtain a gradual dose reduction for R28, who was on a psychotropic medication. Refer to F605 The facility failed to provide the bed hold policy and notify the ombudsman for two residents, R12 and R20. Refer to F628. The facility failed to revise care plans for two residents, R12, who was on supplemental oxygen, and R49, who had an immobilizer (a medical device designed to keep the knee in a fixed, straightened position) brace and skin breakdown. Refer to F657. The facility failed to prevent skin breakdown from an immobilizer brace for R49. Refer to F686. The facility failed to provide foot care for R49, who had long toenails. Refer to F687. The facility failed to follow R49's care plan for a transfer, and R49 sustained a knee fracture. Refer to F689. The facility failed to implement nutritional interventions for R20, who had a 9.6% weight loss in three months. Refer to F692. The facility failed to provide instructions to the oncoming staff regarding R49's wounds from her immobilizer. Refer to F686. The facility failed to provide two Certified Nurse Aides with their yearly 12-hour in-services and failed to have a system in place to track in-services. Refer	F0867		

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F0867 SS = F	Continued from page 58 to F730. The facility failed to follow up on R37's request for new dentures. Refer to F745. The facility's Consultant Pharmacist did not recommend a Gradual Dose Reduction for R28, who received a psychotropic medication. Refer to F756. The facility failed to hold R49's hypertension (high blood pressure) medication when her blood pressure was out of the physician-ordered parameters. Refer to F757. The facility failed to label insulin pens when opened and failed to discard an expired over-the-counter medication. Refer to F761. The facility failed to provide dental services for R37. Refer to F791. The facility failed to provide a Certified Dietary Manager. Refer to F801. The facility failed to provide a sanitary kitchen and failed to discard expired nutritional drinks. Refer to F812. The facility failed to ensure staff wore PPE (personal protective equipment) during care for R49, R35, and failed to wear PPE when handling soiled linens. Refer to F880. On 07/23/25 at 03:00 PM, Administrative Nurse F stated, the committee met monthly to go over various items of concern and was excited to have the new company take over. Administrative Nurse F further stated they were excited for the future and the improvements they would make, and the improvements they had already seen. The facility's "Quality Assurance and Performance Improvement Plan," dated 11/24, documented that the scope of the quality program encompasses each type and segment of care and services that impact clinical care, quality of life, resident choice, and care transitions. The team would identify dashboards that are used to monitor and report overall performance. They would report activity results to the team quarterly,	F0867		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880		

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F0880 SS = E	Continued from page 59 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 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	F0880		

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F0880 SS = E	Continued from page 60 (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 IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 84 residents. The sample included 27 residents. Based on observation, interview, and record review, the facility failed to use appropriate barriers while sorting soiled resident laundry and to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) for Residents (R) 35 and R49's wound care. The deficient practice placed the residents who reside in the facility at risk of infectious disease processes. Findings included: - On 07/23/25 at 08:10 AM, Laundry Staff U observed removing soiled resident clothing and placing the items into a washing machine. Laundry Staff U wore gloves only and failed to use a gown or apron as a barrier to her clothing. Laundry Staff U stated the use of gowns or aprons was only for heavily soiled laundry. The facility's "Handling Soiled Linen" policy, dated 11/01/19, documented all linens should be handled using standard precautions and treated as potentially contaminated. Linens should not be allowed to touch the uniform or floor and should be handled as little as possible. - R35's "Electronic Medical Record" documented diagnoses of iron deficiency anemia (inadequate number of healthy red blood cells to carry adequate oxygen to	F0880		

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F0880 SS = E	Continued from page 61 body tissues), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), and dementia (progressive mental disorder characterized by failing memory, confusion). R35's "Quarterly Minimum Data Set" (MDS), dated 05/16/25, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R35 required maximum staff assistance with toileting, bathing, dressing, and mobility. R35 had one venous ulcer and skin lesions requiring dressings and received antibiotics. R35's "Care Plan," dated 07/03/25, directed staff to assess and report signs of impaired skin or breakdown. R35's care plan documented she had impaired skin integrity related to vascular ulcers to both feet and directed staff to provide treatments ordered, provide pain management with wound dressing changes, and provide supplements as ordered. The care plan directed staff to follow infection prevention protocol, including Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact cares), post-EBP signage, and supplies at the entrance to R35's room. Staff were to wear gowns and gloves for high-contact resident care. R35's medical record documented the vascular wounds had been ongoing since July 2024. The "Physician Order," dated 07/01/25, directed staff to perform EBP for wound care, don a gown and gloves with personal care every shift. On 07/21/25 at 12:50 PM, Certified Nurse Aide (CNA) O and Licensed Nurse (LN) J assisted R35 to the toilet with a maximum of two staff assistance and a gait belt. The CNA O and the LN J did not wear EBP gowns during the close contact cares. On 07/22/25 at 09:04 AM, CNA P and CNA O used two staff maximum assistance to transfer R35 from her wheelchair to her recliner. No EBP gowns were worn. On 07/22/25 at 09:38 AM, LN K entered R35's room, did not don an EBP gown, and performed wound care to R35's feet. LN K cleansed between R35's toes, applied calcium alginate maxsorb between the toes for both feet. When	F0880		

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F0880 SS = E	Continued from page 62 LN K was asked what the EBP signage on the doorway was for, LN K stated she thought it might be for the former roommate. On 07/22/25 at 01:20 PM, Administrative Nurse D verified that staff were to wear EBP gown and gloves for high contact care, including dressing changes to R35's wounds. The facility's "Enhanced Barrier Precautions (EBP)" policy, dated 04/01/24, stated it was the policy of the facility to implement enhanced barrier precautions for the prevention of multidrug-resistant organisms (MDRO). The policy stated all staff receive training on high-risk activities and common organisms that require EBP. An order for EBP would be obtained for residents with chronic wounds, indwelling devices, even if the resident was not known to have an infection. Gowns and gloves were to be available near or outside of the resident's room. High contact care activities included dressing, bathing, transfers, providing hygiene, toileting assistance, and any skin opening wound care. EBP should be used for the duration of the resident's stay or until resolution of the wound. - The Electronic Medical Record (EMR) for R49, documented diagnoses of hypertension (high blood pressure), muscle weakness, atrial fibrillation (rapid heart rate), and disorders of bone density and structure (a condition where bones become weakened and more prone to fractures due to reduced bone mass and/or changes in bone structure). The "Quarterly/Five Day Medicare Minimum Data Set" (MDS) dated 04/21/25 documented R49 had intact cognition. R49 was dependent upon staff assistance for lower body dressing, bathing, transfers, mobility, and toileting hygiene. The MDS documented R49 had upper functional impairment on one side, lower functional impairment on both sides, was at risk for skin breakdown, and had a surgical wound. R49's "Care Plan," dated 04/15/25, documented she was at risk for pressure ulcers and other skin-related injuries. R49's plan of care directed staff to observe for redness and breakdown during routine care, follow community skin care protocols, and treat as indicated. The plan of care directed staff to assist her with splinting/bracing and the use of assistive devices. The care plan lacked direction to staff on when to remove her immobilizer and if she had any skin breakdown. The "Braden Scale" (formal assessment for predicting pressure ulcer risk) dated 05/07/25, documented R49 was	F0880		

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F0880 SS = E	Continued from page 63 a mild risk for pressure ulcers. The "Physician's Order" dated 06/20/25, directed staff to leave immobilizer in place unless sleeping, and nwb (non-weight bearing) to LLE (left lower leg). The "Nurse's Notes," dated 07/18/25 at 05:38 PM, documented R49 had two small open sores on her left leg from where her knee brace had been rubbing against her skin. The sore on the outside of her thigh (the part of the human leg between the hip and the knee) measured 0.4 centimeters (cm) x 0.5 cm. The sore on her calf (the back portion of the lower leg) measured 0.5 cm x 0.5 cm. The wounds were cleaned with wound cleanser and covered with a Mepilex (absorbent, bordered foam dressing). The physician and the durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) were notified of the skin break. The EMR lacked a skin assessment, directions to staff for monitoring R49's skin daily, or any daily standing orders for dressing changes until further direction from the physician from 07/18/25 to 07/22/25 (five days). The "Nurse's Notes," dated 07/22/25 at 03:45 PM, documented that the physician received the documentation from the facility regarding the sores and had no further orders. On 07/22/25 at 09:37 AM, Licensed Nurse (LN) H stated she did not normally work in that household and was unsure if R49 had a skin breakdown, but would go with this surveyor and assess her skin. Observation revealed R49 had a leg immobilizer on her left leg from mid-thigh to her ankle. R49 stated the immobilizer needed to be repositioned and tightened because it was too loose on her leg and was slipping. Observation revealed nothing between her skin and the immobilizer to protect it from breakdown. R49 had a foam dressing on her left calf but no dressing on the sore on her left thigh. LN H washed her hands and donned clean gloves. She asked R49 if staff were changing the dressing daily, and she replied "No" but did not know when they had changed the dressing last. LN H removed the dressing from the calf, and there was brown in color drainage. LN H did not clean the area but washed her hands and donned clean gloves to put a new foam dressing on her calf. The area on her calf was pink but not open. Further observation revealed the sore on her left thigh was approximately the size of a pencil eraser and was starting to scab. LN H did not put a dressing on the sore.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175498	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR , HAYS, Kansas, 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
F0880 SS = E	Continued from page 64 On 07/23/25 at 08:48 AM, Certified Nurse Aide (CNA)N stated, nurse aides were responsible for putting the immobilizer on R49 every morning, but sometimes the night shift forgot to take it off, and she had it on all night. CNA N stated she was unaware of any skin breakdown under the immobilizer. On 07/23/25 at 10:00 AM, LN G stated she had not worked in the household for at least two weeks and did not know that R49 had any skin breakdown. LN G washed her hands, donned clean gloves, and opened the immobilizer from R49's left leg, and there was nothing between her skin and the immobilizer. Observation revealed a dried substance inside the immobilizer, from where it had lain against the sore on her thigh. The sore was scabbed and not actively draining. LN G removed the dressing from her calf, and the skin was slightly pink. LN G washed her hands, donned clean gloves, and placed a clean foam dressing on the calf wound, but did not put one on the sore on her thigh. This surveyor observed a yellow PPE (personal protective equipment) hanging on the back of R49's door and when LN G was asked what it was for, she stated, "Oh, she is on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care), because of wounds, I forgot." LN G further stated that there should be a sign on her door stating that, but there was not. On 07/23/25 at 10:30 AM, Administrative Nurse F stated, she had been made aware of R49's sores on 07/21/25, but had not looked at them yet. Administrative Nurse F stated that today (07/23/35) was the day she would do her weekly skin assessment. Administrative Nurse F further stated that because the sores were not chronic, they did not require staff to wear PPE during care. At 02:30 PM, Administrative Nurse F stated she had looked at R49's wounds and did not feel that the immobilizer had caused the sore on her thigh because R49 had told her she thought she had scratched it, and that was why she got the sore. Administrative Nurse F stated she did not think the immobilizer had dried drainage because the sore was scabbed, but thought it was dried food. Administrative Nurse F stated, R49 told her that she would wear thin pajama pants so her leg would be protected when the immobilizer was on and would contact the physician for guidance. On 07/23/25 at 01:49 PM, Administrative Nurse D stated she would contact the physician to see about the EBP precautions and would get everything taken care of for R49.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175498	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

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F0880 SS = E	Continued from page 65 The facility's "Enhanced Barrier Precautions (EBP)" policy dated 04/01/24 stated it was the policy of the facility to implement enhanced barrier precautions for the prevention of multidrug-resistant organisms (MDRO). The policy stated that all staff receive training on high-risk activities and common organisms that require EBP. An order for EBP would be obtained for residents with chronic wounds, indwelling devices, even if the resident was not known to have an infection. Gowns and gloves were to be available near or outside of the resident's room. High contact care activities included dressing, bathing, transfers, providing hygiene, toileting assistance, and any skin opening wound care. EBP should be used for the duration of the resident's stay or until resolution of the wound.	F0880		