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 08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE HAYS KS LLC	**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 complaint investigation 3134620. The census was 93. The sample included 3 residents.	F0000		
F0690 SS = G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F0690	"Past Noncompliance - no plan of correction required"	

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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F0690 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interview, the facility failed to provide urinary catheter care based on current standards of practice for Resident (R) 1 when the facility failed to unclamp the resident's catheter for approximately 8 hours, which caused the resident pain and discomfort. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), overactive bladder, Stage 4 chronic kidney disease (a disease causing severe kidney damage and waste builds up in the blood), and obstructive and reflux uropathy (a blockage that stops urine flowing normally through the urinary tract causing the backflow of urine from the bladder into the kidneys). R1's "Annual Minimum Data Set" (MDS), dated 07/01/2026, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented he had impairment on both sides of his lower extremities and required a manual wheelchair. The MDS documented R1 required substantial staff assistance to total dependence on staff for his activities of daily living (ADLs), except for eating and oral care. The MDS documented R1 had an indwelling urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) and was frequently incontinent of bowel. The MDS documented R1 had a urinary tract infection (UTI-an infection in any part of the urinary system) within the last 30 days. The "Functional Abilities Care Area Assessment" (CAA), dated 07/02/2026, documented R1 required assistance for ADLs due to a decreased ability to care for himself. The "Urinary Incontinence/Indwelling Catheter" CAA, dated 07/02/2026, documented R1 had an indwelling urinary catheter due to neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and obstructive uropathy, and R1 was at risk for UTIs.	F0690		

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F0690 SS = G	Continued from page 2 The “Pain” CAA, dated 07/02/2026, documented R1 had chronic pain and was at risk for ineffective pain relief. R1’s “Care Plan,” initiated 07/21/2026, documented R1 had an indwelling urinary catheter. The care plan documented R1 would be free from catheter-related trauma through the review date. The care plan directed staff to anchor the catheter tubing to prevent injury, provide catheter care every shift and as needed, keep the catheter bag positioned below R1’s bladder, check the catheter tubing for kinks each shift, and monitor R1 for pain related to the catheter. R1’s “August 2026 Treatment Administration Record” (TAR) documented an order with a start date of 05/22/2026 for gentamicin sulfate (antibiotic) solution. The order directed staff to insert 60 milliliters (ml) via catheter tubing into the urethra (small tubular structure that drains urine from the bladder) every day shift on Tuesdays and Fridays for UTI. The medication would be administered while R1 was in bed, prior to getting up in the morning. Staff were to clamp catheter tubing for 15 minutes, then unclamp. The “Nurse’s Note,” dated 08/05/2026, documented R1’s wife voiced concerns at 08:15 AM about R1 not having his call light or water, and having pain in his groin. R1’s wife reported when R1 was transferred back to his bed his catheter tubing was found to be clamped, and once unclamped a large amount of urine drained into the catheter bag. Administrative Nurse E was notified of the complaint. The “Family Grievance Form,” dated 08/05/2026, documented R1’s wife stated when she arrived in R1’s room at 06:00 PM on 08/04/2026, R1’s call light was clipped to the wall, and his table with his water was out of reach. R1’s wife stated when R1 was laid down in bed, his catheter tubing was clipped, and he was feeling a lot of pain in his abdomen. R1’s wife stated when she unclipped the catheter tubing, R1 had 1000 ml of urine output. The investigation revealed R1’s catheter was clamped following a catheter flush for approximately six hours. R1 reported lower abdominal pressure. Upon assessment, the clamp was immediately removed, resulting in the drainage of 1000 ml of urine. R1 reported relief after the clamp was removed.	F0690		

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F0690 SS = G	Continued from page 3 On 08/17/2026 at 10:30 AM, observation revealed R1 sat in a wheelchair in his room. R1's catheter bag was hooked to the wheelchair with a privacy bag over it. R1 watched television. R1's call light was on the bed next to him. On 08/17/2026 at 10:30 AM, R1 stated he was in a lot of pain the day the nurse left his catheter tubing clamped. R1 stated he told staff he was in a lot of pain and no one did anything about it until his wife came in. On 08/17/2026 at 11:00 AM, Administrative Nurse D stated the nurse who forgot to remove the binder clip used to clamp off the catheter tubing did not accept that she had forgotten it, though the nurse was presented with the evidence. Administrative Nurse D stated it was simply human error that caused the incident to happen, but the catheter clamp should have been removed within 15 minutes per the physician's order. Administrative Nurse D said clamping the catheter tube was added to the TAR to help the nurses remember to remove the catheter clamp after the flush. The facility's "Indwelling Catheter Use Policy," dated 11/26/2025, documented the facility will provide appropriate care for catheters in accordance with current professional standards of practice and resident care policies and procedures. The facility completed corrective actions, which included one-on-one education with the nurse who forgot and facility-wide urinary catheter care education and management, including verifying catheter tubing is free of kinks, clamps, and other obstructions during catheter assessment and at least every four hours with all nurses. The facility put in the TAR for nurses to take off the urinary clamp after irrigation twice a day. Urinary catheter audits were completed and are still ongoing to ensure catheter care and monitoring procedures are being followed. Corrective actions included and were completed by 08/05/26: Care plan updated to reflect catheter monitoring interventions. Treatment Administration Record (TAR) updated with a specific intervention reminding staff to remove the catheter clamp immediately following each catheter flush.	F0690		

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F0690 SS = G	Continued from page 4 One-on-one education completed with the involved nurse regarding proper catheter flushing procedures and the importance of immediately removing the clamp following irrigation. Facility-wide education provided to all licensed nursing staff regarding catheter management, including verifying that catheter tubing is free from kinks, clamps, and other obstructions during routine catheter assessments at least every four hours. Catheter audits completed three times per week for four weeks to verify catheter tubing remains patent, free from kinks or clamps, and that catheter care and monitoring procedures are being consistently followed. Audit results will be reviewed for compliance, with additional education provided as indicated. All corrective actions were completed prior to the onsite survey; therefore, the deficient practice was deemed past noncompliance and remained at the scope and severity of a “G” (actual harm, isolated).	F0690		