STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175561	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT ST MARY	**3700 E LINCOLN ST , WICHITA, Kansas, 67218**

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F0000	INITIAL COMMENTS The Risk-Based Survey Process was used to conduct a federal recertification survey. The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 1623539. The census was 20. The sample included 6 residents.	F0000		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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;	F0880		

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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F0880 SS = E	Continued from page 1 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to maintain infection prevention practices designed to provide a safe and sanitary environment. Facility staff did not clean or disinfect a multi resident use Hoyer (total body mechanical lift) lift after it was used to transfer Resident (R) 1. Findings included: On 09/23/2026 at 10:02 AM, R1 Certified Nurse Aide (CNA) M and CNA N used the Hoyer to transfer R1	F0880		

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F0880 SS = E	Continued from page 2 from the bed to the Broda chair (specialized wheelchair with the ability to tilt and recline). CNA M removed the Hoyer from R1's room, placed it in the hallway storage area, and walked away. On 09/23/2026 at 10:07 AM, CNA M stated that the lifts were to be cleaned at the end of each shift, not after each use. On 09/23/2026 at 10:14 AM, CNA N stated that the Hoyer's are not cleaned after each resident use. They were to be cleaned at the end of each shift. On 09/23/2026 at 10:19 AM, Licensed Nurse (LN) G stated that two people were to use the Hoyer. She said that of the two staff who used the Hoyer, one was responsible for making sure that it was cleaned after each resident's use to maintain infection control. On 09/23/2026 at 10:26 AM, Administrative Nurse D stated that it was her expectation that the Hoyer would be cleaned and disinfected after each resident use, not just at the end of each shift. On 09/23/2026 at 11:55 AM, Administrative Nurse E stated that she was not sure if the Hoyer was to be cleaned after each use or just at the end of each shift. She would have to refer to the policy before she could answer that question. On 09/23/2026 at 12:07 PM, Administrative Staff A stated that the Hoyer was to be cleaned after each resident use and referenced the facility policy. The facility's "Cleaning and Disinfection of Resident-Care Equipment" policy, last revised 07/30/2026, directed that each user was responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before each use for another resident. Multi-resident-use equipment should be cleaned and disinfected after each use.	F0880		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate	F0757		

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F0757 SS = D	Continued from page 3 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: Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from unnecessary medications when staff failed to follow physician ordered parameters to monitor the blood pressure and pulse rate for the blood pressure medication R1 was prescribed. Findings included: R1's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and hypertension (elevated blood pressure). R1's "Admission Minimum Data Set" (MDS), dated 07/09/2026, documented a Brief Interview of Mental Status (BIMS) score of 0, which indicated severe cognitive impairment. R1's "Care Plan," revised on 08/07/2026, instructed staff to monitor side effects of medication and to report any concerns to the physician as necessary. R1's EMR documented a "Physicians Order" for Carvedilol (a prescription alpha and beta blocker medication used to treat high blood pressure, heart failure, and heart function issues after a heart attack), oral tablet 6.25 milligrams mg, give one tablet two times a day by mouth for hypertension, ordered 07/01/2026. R1's EMR documented a "Physicians Order" to hold	F0757		

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F0757 SS = D	Continued from page 4 hypertension medications and notify the provider if systolic blood pressure (BP) was less than 90 millimeters (mm) mercury (Hg); notify the provider for blood pressure (BP) greater than 180/110 mm Hg. The MAR lacked documentation that R1's heart rate was monitored for 09/01/2026,09/02/2026, 09/03/2026, 09/04/2026, 09/05/2026, 09/06/2026, 09/07/2026, 09/08/2026, 09/09/2026, 09/10/2026, 09/11/2026, 09/12/2026, 09/13/2026, 09/14/2026, 09/15/2026, 09/16/2026, 09/17/2026, 09/18/2026, 09/19/2026, 09/20/2026, 09/21/2026, 09/22/2026, and 09/23/2026. On 09/23/2026 at 09:53 AM, R1 laid in his recliner asleep. On 09/23/2026 at 10:26 AM, Administrative Nurse D stated that it was her expectation for every physician order to be followed and documented. On 09/23/2026 at 12:07 PM, Administrative Staff A stated that every physician order should be followed and documented, and the physician notified as the order dictated. On 09/23/2026 at 03:14 PM, Licensed Nurse (LN) G stated that the pulse should have been documented by the certified medication aide (CMA) before the medication was given. On 09/23/2026 at 03:19 PM, Administrative Staff A stated that physician orders should have been followed and the heart rate taken, charted, and, if outside the ordered parameters, the physician should have been notified. The facility did not provide a policy for following physician orders.	F0757		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by:	F0881		

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F0881 SS = D	Continued from page 5 Based on observation, interview, and record review, the facility failed to monitor side effects and effectiveness of a prophylactic antibiotic used for Resident (R) 6. Findings included: - R6's electronic medical record (EMR) documented a diagnosis of recurrent urinary tract infection (UTI-an infection in any part of the urinary system). R6's "Significant Change Minimum Data Set" (MDS), dated 04/28/2026, documented that she had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. She received antibiotic therapy during her assessment period. R6's "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA), dated 04/28/2026, documented that she had a history of UTIs. R6's "Quarterly MDS," dated 07/23/2026, documented she had a BIMS score of 14, which indicated intact cognition. She received antibiotic therapy during her assessment period. R6's "Care Plan," revised 08/25/2026, instructed staff that she was on antibiotic therapy and to monitor her for side effects and effectiveness. R6's EMR documented the following physician's order: Cephalexin (an antibiotic), 250 milligrams (mg), by mouth, every day, for prophylaxis of UTI for six months, ordered 07/16/2026. R6's EMR lacked documentation of monitoring for side effects or effectiveness of the medication. On 09/23/2026 at 02:18 PM, Administrative Nurse D stated that staff does not monitor prophylactic antibiotics as that was not their process. The staff would monitor antibiotics used for acute infection, but not prophylactic antibiotics. On 09/23/2026 at 02:25 PM, Consultant Staff GG stated the facility would not monitor prophylactic antibiotics unless the resident developed new symptoms or a recurrence of the original symptoms. The facility policy "Antibiotic Stewardship," implemented 03/01/2018, included: The facility will monitor all adverse reactions/outcomes related to	F0881		

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F0881 SS = D	Continued from page 6 antibiotic therapy.	F0881		