STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175539	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	**3636 NORTH RIDGE RD BLDG 400 , WICHITA, Kansas, 67205**

(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(s) 3706757, 3092753, 3050577 and 3769559. The census was 64. The sample included nine residents.	F0000		
F0689 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: Based on observation, interview, and record review, the facility failed to ensure Resident (R) 2 remained free of accident and hazards when on 06/21/2026, at approximately 05:50 AM, R2 fell from his bed and struck his head. R2 sustained a laceration (cut) to the left side of his head which required staples. Findings included: - R2's Electronic Health Record (EHR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), spastic hemiplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and cognitive communication deficit. R2's 05/14/2026 "Annual Minimum Data Set" (MDS) documented that staff assessed R2 to have a memory problem with severely impaired cognition. The assessment documented R2 utilized a	F0689		

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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F0689 SS = G	Continued from page 1 wheelchair for locomotion and was dependent on staff assistance for all cares and transfers. The assessment documented no falls since the previous assessment. R2's 05/14/2026 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R2 had a diagnosis of dementia. R2's 05/14/2026 "Communication CAA" documented that R2's communication was limited to answering questions that required a yes or no answer. R2's "Care Plan," documented on 02/26/2024 and reviewed 11/03/2026, stated that R2 needed assistance with activities of daily living (ADL – routine self-care tasks one must perform every day to live safely and independently) and documented an intervention that he required the total assistance of two staff members for bed mobility. R2's EHR, under the "Progress Notes," documented the following: On 06/21/2026 at 06:44 AM, Licensed Nurse (LN) J documented R2 had a witnessed fall with a laceration to his head. On 06/21/2026 at 10:18 AM, LN K documented R2 left the facility with emergency medical services (EMS) at 06:30 AM and returned from the Emergency Department (ED) at 09:00 AM with three staples on his head related to a laceration from a fall. The "Safety Events – Fall Event" document provided by the facility on 11/03/2026 at 08:13 AM documented that R2 had a witnessed fall from his bed on 06/21/2026 at 06:24 AM and sustained a four-centimeter (cm) laceration to his head. The document did not identify a root cause of the fall. Certified Nurse Aide (CNA) P's signed and notarized "Witness Statement", dated 06/22/2026, documented on 06/21/2026 that she noticed the nurse was busy with another resident. She assisted R2 without assistance even though R2 required two staff members present for cares. CNA P documented that she rolled R2 to his side, then walked to the other side of the bed to fix his brief; before she got to the other side of his bed, R2 had fallen out of the bed and hit his head. CNA P further documented that she left R2 to get the nurse, assisted the nurse to get R2 back into his bed, and obtained his vital signs prior to EMS taking him to the ED for bleeding from the wound.	F0689		

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F0689 SS = G	Continued from page 2 Licensed Nurse (LN) J's signed and notarized "Witness Statement" dated 06/23/2026 documented that on 06/21/2026 at 05:50 AM, CNA P called LN J to R2's room. R2 was on the floor on his back with a laceration on the top of his head. CNA P notified LN J that she was performing cares when R2 fell while CNA P was turning the resident in his bed. On 11/03/2026 at 09:20 AM, Administrative Nurse D stated that during the fall investigation conducted by the facility, CNA P confirmed that she knew she should have waited and had a second staff member present to assist with R2's cares, but CNA P chose not to wait for a second staff member to become available. Administrative Nurse D stated the facility expected staff to follow the care plan. Administrative Nurse D said that if the care plan instructed two staff to provide cares, then two staff should be present. On 11/03/2026 at 01:02 PM, CNA O said that staff were to always follow the care plan, regardless of what the resident or resident's family expresses related to the resident's ability. On 11/04/2026 at 10:32 AM, CNA M said that staff were to always follow the instructions on the care plan and demonstrated how to access the care plan in the EHR. CNA M said if a resident or resident's family said something different than what the care plan's interventions were, staff were still to follow the interventions outlined in the care plan. The facility's "Care Plans – Comprehensive Person-Centered" policy, dated 10/2021, documented that services provided by the community, as outlined by the comprehensive care plan, would meet professional standards of quality and would be provided by qualified persons in accordance with each resident's written plan of care.	F0689		