STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 000	INITIAL COMMENTS The following citations represent the findings of Health Resurvey and Complaint Investigations KS00170651 and KS00170627.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 67205

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F 550	Continued From page 1	F 550		

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 reported a census of 61 residents with 15 sampled. Based on observation, interview, and record review the facility failed to promote dignity when staff failed to empty a suction canister for Resident (R) 10, which contained yellow liquid and was visible to all visitors who entered the room, through three days of observations.

Findings included:

- Review of R10's pertinent diagnoses from the "Electronic Health Record" (EHR) documented: dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The 10/25/21 "Significant Change Minimum Data Set" (MDS) documented a staff assessment indicated long and short-term memory problem with severely impaired cognition. R10 received hospice services.

The 01/28/22 "Quarterly MDS" documented R10 received hospice services and suctioning.

The 01/22/22 "Care Plan" documented R10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 67205

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F 550	Continued From page 2	F 550		

received hospice services and as of 10/29/21 the resident had suctioning available, as needed (PRN).

The "EHR" documented an order on 10/16/21 for orally suction PRN.

The January through April 2022 "Treatment Administration Record" (TAR) documented only one suctioning documented as completed on 01/15/22.

On 04/04/22 at 03:32 PM observed R10's room with a suction canister on suction machine. There was yellow liquid in the canister, which sat on the bedside table. The tubing and a Yankauer (an oral suctioning tool used in medical procedures) suction catheter tip were set directly on the bedside table, with no barrier noted, and visible to anyone who entered the room.

On 04/05/22 at 01:09 PM observed R10's room with a suction canister on suction machine. There was yellow liquid in the canister, which sat on the bedside table. The tubing and a Yankauer suction catheter tip were set directly on the bedside table, with no barrier noted, and visible to anyone who entered the room.

On 04/06/22 at 09:33 AM observed R10's room with a suction canister on suction machine. There was yellow liquid in the canister, which sat on the bedside table. The tubing and a Yankauer (an oral suctioning tool used in medical procedures) suction catheter tip were set directly on the bedside table, with no barrier noted, and visible to anyone who entered the room.

Interview on 04/05/22 at 01:21 PM with "Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 550	Continued From page 3 Nurse Aide" (CNA) K revealed she did nothing with the suctioning for R10. Interview on 04/06/22 at 09:35 AM with Licensed Nurse (LN) D revealed she had not suctioned R10. LN D said she believed the canister and Yankauer suction catheter should be cleaned and stored covered after each use. Interview on 04/06/22 at 10:24 AM with Administrative Nurse B confirmed following suctioning, the canister and Yankauer should be cleaned and stored next to the bed. Administrative Nurse B confirmed she would not expect the Yankauer to be set on the bedside table with no barrier and she expected the canister to be cleaned and not contain any fluids. The 12/2021 "Quality of Life- Dignity" policy documented each resident should be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. The 01/2022 "Suctioning the Upper Airway (oral pharyngeal Suctioning)" documented the purpose of the procedure was to clear the upper airway of mucous secretions and prevent the development of respiratory distress ... staff were to empty and rinse the collection container, if necessary, or as indicated by community protocol and place catheter in a clean, dry area. The facility failed to promote dignity for R10 when staff did not empty the suction canister.	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 4	F 657		

§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 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 reported a census of 61 with 15 residents in the sample. Based on observation, interview, and record review the facility failed to revise a care plan for one Resident (R) 30 regarding the use of a nebulizer (a respiratory treatment).

Findings included:

- The "Physician Order" dated 03/02/22 indicated the following diagnoses: viral pneumonia (an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 657	Continued From page 5	F 657		

infection in the lungs) and chronic respiratory failure (chronically poor airflow).

The "Admission Minimum Data Set" dated 03/07/22 indicated R30 received oxygen therapy.

The 03/07/22 "Care Plan" indicated R30 had a potential for shortness of breath and/or respiratory complications related to pneumonia and chronic bronchitis. Staff were to provide treatment per physicians' orders and monitor the resident for response. The 03/07/22 "Care Plan" lacked interventions related to the use of the nebulizer and/or the care of the nebulizer after each treatment

The 03/07/22 "Physician Order" included the medication Albuterol Inhalation Solution 0.083% to be delivered by nebulizer at 2.5 mg (milligrams) in 3 milliliters (mL) inhalation, every 12 hours for interstitial lung disease.

Observation on 04/04/22 at 04:45 PM revealed the nebulizer set next to the equipment, with the face mask and tubing still attached, and not in use at the time of observation.

Observation on 04/06/22 at 11:33 AM revealed the nebulizer equipment remained attached to the tubing and not in use. The medication bowl had clear fluid in the bottom of the bowl, and not in use at the time of observation.

Observation on 04/06/22 at 11:22 AM revealed the nebulizer equipment had tubing and mask attached with liquid from the treatment in the base of the bowl, and not in use at the time of observation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 6 Interview on 04/06/22 at 11:34 AM with Licensed Nurse (LN) I indicated the correct process included rinsing the nebulizer after each treatment and to place it on a towel to air dry. Interview on 04/06/22 at 11:53 AM with Administrative Nurse B indicated the facility did not include the nebulizer on the care plan because it was considered a standard of practice. The facility's 07/2020 "Care Plans" policy revealed the plan of care included the instructions needed to provide effective and person-centered care of the resident. The baseline care plan should include a review of the health care provider's orders and be implemented to meet the resident' immediate care needs until a comprehensive assessment can be developed. The facility failed to revise R30's care plan to include the care of the nebulizer after each treatment.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 61 residents with 15 sampled. The facility failed to ensure that	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 684	Continued From page 7	F 684		

residents received treatment and care in accordance with professional standards of practice for three residents. The facility failed to notify the provider of weight fluctuations greater than two pounds (lbs.) as ordered and failed to document the application of ace wraps and tubigrip bandages (an elasticated tubular bandage used for support) for Resident (R) 16. The facility also failed to document treatments as ordered by the provider for R15 and failed to change the wound dressing daily, as ordered for R25.

Findings included:

- Review of R16's pertinent diagnoses from the "Electronic Health Record" (EHR) documented: heart failure (a condition with low heart output and the body becomes congested with fluid) and lymphedema (swelling caused by accumulation of lymph).

The "Annual Minimum Data Set" (MDS) dated 11/09/21 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two staff for all activities of daily living (ADL). R16 received a diuretic medication for six days of the seven-day look back period.

The 04/28/22 "Quarterly MDS" documented a BIMS of 15, indicating intact cognition.

The 02/05/22 "Care Plan" for R16 documented staff were to apply ace wraps/tubigrips as ordered.

The "Orders" in the EHR documented on 02/01/19 the staff were to obtain weights daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 8	F 684		

and notify the provider of fluctuation of two lbs in 24 hours. On 01/31/19 staff were to apply ace wraps to both legs in the morning and remove at hour of sleep, discontinued on 03/23/22. On 03/23/22, the staff were to apply tubigrips to both of R16's legs in the morning and remove them at hour of sleep.

The January through April 2022 "Treatment Administration Record" (TAR) documented 14 occasions of a fluctuation of two lbs. or greater, with the highest fluctuation of five lbs. noted. The TAR lacked documentation on 15 occasions to apply or remove ace wraps, and four occasions for application or removal of tubigrips.

R16's EHR for January through April 2022, lacked documentation of provider notification for the 14 occasions of weight fluctuations.

On 04/05/22 at 10:30 AM R16 sat in her wheelchair in her room with tubigrips to both legs and declined staffs offer to sit in her recliner and elevate her legs at the time.

On 04/30/21 at 10:20 AM Certified Nurse Aide (CNA) C revealed staff were to apply the tubigrips in the morning and removed at bedtime. CNA C stated she did not document this but informed the nurse of the need. CNA C stated R16 was compliant with the tubigrips, but R16 did not like the ace wraps.

On 04/06/22 at 09:35 AM Licensed Nurse (LN) D revealed R16's weights were obtained daily and if ordered, staff reported to the physician. When the staff reported the weights to the physician, the staff made a note in the EHR. LN D stated R16 had ace wraps she stated hurt and she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 684	Continued From page 9	F 684		

refuse to have them applied. LN D said R16 did better with the tubigrips.

On 04/11/22 at 10:57 AM Administrative Nurse B revealed she expected the treatments to be initialed in the TAR. She expected resident weights to be obtained and staff to notify the physician when ordered. If the treatment was out of the Certified Medication Aid (CMA) scope of practice, she would expect them to contact the on-call nurse to complete the task. There were nurses on other units the CMA could also inform to complete the task.

The 12/2021 "Clinical Protocol: Heart Failure" policy documented that the physician would review and make recommendations for relevant aspects of the nursing care plan, such as weight monitoring and when to report findings to the physician, etc.

The facility failed to provide R16 care and treatment in accordance with standards of practice by the failure to apply and remove ace wraps/tubigrips, as ordered and the failure to notify the physician for out of parameter weights as ordered.

- Review of R15's pertinent diagnoses from the "Electronic Health Record" (EHR) documented: dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and major depressive disorder (major mood disorder).

The 11/07/21 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 684	Continued From page 10	F 684		

(BIMS) score of nine, indicating severely impaired cognition.

The 02/05/22 "Care Plan" for R15 documented staff were to administer treatments as ordered.

The "Orders" in the EHR documented on 03/11/20 staff were to check R15's skin weekly and apply skin prep to both heels at bedtime (HS). The 09/02/21 order instructed staff to apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to medial (the middle) skin on knees where they touch for wound prevention.

The February through April 2022 "Treatment Administration Record" (TAR) lacked documentation on three occasions to check R15's skin weekly, lacked documentation on 12 occasions to apply skin prep to medial skin on knees where they touch for wound prevention, and lacked documentation on 12 occasions to apply skin prep to both heels at HS.

On 04/05/22 at 12:26 PM R15 sat in her wheelchair in her room having her noon meal. R15 wore shoes and her knees were touching at the time. R15 had no open skin wounds visible.

On 04/06/22 at 09:35 AM Licensed Nurse (LN) D revealed treatments were documented in the TAR when completed. She stated she completed her tasks and the on-call nurses were available when needed, as well.

On 04/11/22 at 08:25 AM Administrative Nurse B revealed she expected the treatments to be initialed in the TAR. If the treatment was out of the Certified Medication Aid (CMA) scope of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 684	Continued From page 11	F 684		

practice, she expected the CMA to contact the on-call nurse to complete the task, and there were nurses on other units the CMA could also inform to complete the task.

The 01/2022 "Wound Care/ Dressing Change" policy documented staff were to document treatments in the resident's medical record.

The facility failed to provide R15 care and treatment in accordance with standards of practice when staff failed to document treatments as ordered.

- R25's signed "Physician Orders" dated 04/05/22 revealed the diagnosis of Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder).

The 12/11/21 "Quarterly Minimum Data Set" (MDS) revealed a "Brief Interview for Mental Status" (BIMS) score of six, indicating severely impaired cognition. The resident required extensive assistance of two staff for all daily care. The resident had one non-injury fall and one minor injury fall.

The "Annual MDS" dated 03/05/22 revealed a BIMS score of three, indicating severely impaired cognition. The resident received limited assistance of one staff for all daily care. The resident had two non-injury and two minor injury falls.

The "Falls Care Area Assessment" (CAA) dated 03/27/22 revealed the resident had a walker for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 684	Continued From page 12	F 684		

mobility assistance. He would often rise and ambulate by himself without his walker. The resident had a history of falls and was at high risk for falls.

The "Care Plan" dated 05/26/21 revealed the resident would have falls related to desire for independence. The approaches included the resident wanted to remain free from injury related to falls over the next review period and the resident stated he wished to complete ADLs independently and preferred to risk falling rather than ask for staff assistance.

The "Nurse's Progress Notes "dated 03/27/22 at 11:31 PM revealed the resident fell and sustained a skin tear to the right arm.

The "Nurse's Progress Notes" dated 03/28/22 revealed the resident's right arm with a dressing clean, dry, and intact.

The "Physician Order" dated 04/05/22 revealed wound care every day and directed the facility to cleanse the resident's right arm skin tear with wound cleanser, apply non-adherent dressing, cover with kerlex (stretchy gauze roll wrap), and change daily.

The "Treatment Administration Record" (TAR) revealed a CMA initialed the dressing was changed on 04/04/22 and 04/05/22.

Observation on 04/05/22 at 12:20 PM revealed the resident sat at the dining table eating. The resident had a large dressing on his right arm with a date of 03/30/22. The dressing appeared dry and intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 684	Continued From page 13	F 684		

On 04/06/22 at 07:33 AM the resident sat at the ding table in a wheelchair and had a large bandage on his right arm with date of 03/30/22. The dressing appeared clean and dry.

On 04/06/22 01:07 PM Licensed Nurse (LN) E went in the resident's room to change the dressing on the resident's right arm. The dressing was dated 03/30/22. With gloves on the Allevyn (hydrocellular wound) dressing was peeled back and removed to reveal an open wound on his arm approx 2.5 centimeters. An area of scab on one side of the wound and the other side open and bleeding. The wound was cleaned with wound cleaner and skin prep around the wound and an Allevyn dressing applied. (No order to apply that type of dressing found).

During an interview on 04/05/22 at 10:00 AM Certified Nurse Aide (CNA) F reported the resident wants to do things by himself. CNA F said the staff try to sit him in the living room where we can keep a closer eye on him and R25 would not use his call light and tried to get up on his own if he is in his room.

During an interview on 04/06/22 at 12:35 PM LN E reported it was a job to keep the resident from falling. He refused to ask for assistance and was determined to get up on his own. LN E said she put a dressing on the wound but did not call for an order the day she put it on. She assumed the dressing in place was the right dressing so that is what she replaced the old one with. She did not check the order for the correct dressing.

On 04/06/22 at 02:30 PM Administrative Nurse B reported the dressing that was on the resident was a seven- day dressing and that was probably

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 684	Continued From page 14 why it was not changed. The CMA could not change the dressing and she did not know why the CMA signed the TAR. Administrative Nurse B stated she expected the CMA to notify another nurse of treatments that needed done and verified that did not happen. Review of the facility policy for "Wound Care" dated 08/21 revealed nurses were to review and verify physician orders for dressing changes. The facility failed to provide wound care in a timely manner and according to physician orders.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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: - R20's "Electronic Health Record" (EHR) documented the following diagnoses under the medical diagnoses tab: chronic obstructive pulmonary disease (COPD, progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The 11/20/21 "Annual Minimum Data Set" (MDS)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 695	Continued From page 15	F 695		

documented R20 had a Brief Interview for Mental status (BIMS) score of four, indicating severely impaired cognition, with use of oxygen noted.

The 02/15/22 "Care Plan" documented staff were to provide R20 treatments as ordered and monitor for response.

The "EHR" documented an order for R20 on 07/14/21 for albuterol sulfate (bronchodilator-works by relaxing and opening air passages to the lungs) nebulization (electrically powered machine that turns liquid medication into a mist) solution 2.5 milligrams (mg)/milliliter (ml) two times daily and as needed (PRN).

On 04/05/22 at 01:52 PM, observation revealed R20's O2 mask for nebulized medication sat on her bed with no barrier and no bag for storage and had white, crusty substance on the inside of the mask.

On 04/06/22 at 02:31 PM observation revealed R20's O2 mask for nebulized medication sat with no barrier on the bedside table, and continued with the white, crusty substance on inside of mask.

On 04/11/22 at 09:24 AM Certified Medication Aid (CMA) L revealed nebulizer masks should be cleaned after each use and allowed to dry. CMA L said the masks should be stored in a plastic bag when not in use.

On 04/06/22 at 09:35 AM Licensed Nurse (LN) D stated all nebulizer as well as O2 tubing and masks should be stored in a plastic bag when not in use. LN D said the nebulizer masks should be cleaned after each use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 695	Continued From page 16	F 695		

On 04/06/22 at 11:56 AM Administrative Nurse B confirmed all tubing should be kept in a storage bag when not in use and nebulizer tubing should be stored the same. Administrative Nurse B said all nebulizer masks should be cleaned after each use.

The 12/2021 "Administering Medications Through a Small Volume Handheld Nebulizer" policy documented the purpose of the procedure was to safely and aseptically administer aerosolized particles of medication into the residents airway. When treatment was complete, staff were to turn off the nebulizer, disconnect the mouthpiece and medication cup, and then rinse and disinfect the nebulizer equipment according to manufacturer's guidelines. When equipment was completely dry, staff were to store them in a plastic bag with the residents' name and date on it.

The facility failed to provide respiratory care consistent with professional standards of practice for R20 by not cleaning the nebulizer mask after each use.

The facility reported a census of 61 with 15 residents in the sample. Based on observation, interview, and record review the facility failed ensure staff rinsed the nebulizer a respiratory treatment) after each use for two residents R30 and R 20.

Findings included:

- The "Physician Order" dated 03/02/22 indicated the following diagnoses: viral pneumonia (an infection in the lungs) and chronic respiratory failure (chronically poor airflow).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 695	Continued From page 17	F 695		

The "Admission Minimum Data Set" dated 03/07/22 revealed R30 received oxygen therapy.

The "Care Plan" dated 03/07/22 indicated R30 had a potential for shortness of breath and or respiratory complication related to pneumonia and chronic bronchitis. (inflammation of the bronchial tubes) The staff were to provide treatment per physicians' orders and monitor for response. The care plan lacked interventions to include the use of the nebulizer and/or the care of the nebulizer after each treatment

The "Physician Order" dated 03/07/22 included the following nebulizer treatment: Albuterol Inhalation Solution 0.083% nebulizer 2.5 milligrams (mg) in 3 milliliters (ml) inhalation every 12 hours for interstitial lung disease (cause shortness of breath and or cough).

Observation on 04/04/22 at 04:45 PM revealed the nebulizer set on the window shelf attached to the face mask and tubing with clear fluid in base of bowl

Observation on 04/06/22 at 11:33 AM revealed the nebulizer equipment on window shelf still attached to the tubing and the medication bowl had clear fluid in the bottom of bowl.

Observation on 04/06/22 at 11:22 AM revealed the nebulizer equipment on window shelf attached to the tubing and mask, with liquid in the base of the nebulizer bowl.

Interview on 04/06/22 at 11:34 AM, Licensed Nurse I (LN) indicated the correct process would be to not only check her lungs before and after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 695	Continued From page 18 the treatment but to also rinse the nebulizer after treatment and place it on a towel to air dry. Interview on 04/06/22 at 11:53 AM, Administrative Nurse B expected the staff to rinse the nebulizer after each treatment. The policy "Administrating Medications Through a Small Volume Handheld Nebulizer" dated 12/21 revealed the purpose of the procedure was to safely and aseptically (free from contamination) administer aerosolized particles of medication into the resident airway. After treatment was complete, turn off the nebulizer and disconnect mouthpiece and medication cup, rinse and disinfect the nebulizer equipment per manufacturers guidelines, and when the equipment was completely dry, store in a plastic bag with resident name and date on it. The facility failed to rinse the nebulizer after each treatment for resident R30.	F 695		
F 757 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 drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 757	Continued From page 19	F 757		

§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 reported a census of 61 residents, with 15 in the sample, and five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to report three blood sugars over the parameters of 290 milligrams per deciliter (mg/dL) as ordered by the physician for Resident (R) 4.

Findings included:

- R 40's signed "Physician Orders" dated 03/15/22 revealed the diagnosis of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).

The "Admission Minimum Data Set" (MDS) dated 03/19/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 13, indicating intact cognition. Medications received included insulin injections daily in the seven-day observation period.

The "Care Plan" dated 03/14/22 revealed R40 had a potential for complications from diabetes. Approaches included the staff were to administer medications per physician orders, monitor for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 757	Continued From page 20	F 757		

side effects and notify physician as needed (PRN), monitor for signs of hyperglycemia including increased thirst, increased urination, weight loss, ketone breath, lethargy, and notify the physician as needed.

Review of the "Physician Orders" revealed:
03/14/22, the resident received Levemir (insulin-medication used to control blood sugars), at bedtime (HS) for diabetes mellitus.
03/15/22, the resident received Novolog (insulin -medication used to control blood sugars), three times day prior to meals for diabetes mellitus
06/01/22, the staff were to check R40's blood glucose before meals and bedtime and document results on Treatment Administration Record (TAR). The staff were to notify the physician for blood sugars greater than 290 mg/dL.

Review of the Medication Administration Record (MAR) for 03/15/22-04/06/22 revealed the following blood glucose levels above the parameters:
0n 03/30/22, a blood glucose of 310 mg/dL.
On 03/31/22, a blood glucose of 302 mg/dL.
On 04/04/22, a blood glucose of 364 mg/dL.

The "EHR" lacked evidence of physician notification for the out of parameter blood glucose levels on 03/30/22, 03/31/22 or on 04/04/22.

Observation on 04/06/22 at 12:20 PM revealed the resident slept in her recliner covered up with a blanket. Licensed Nurse (LN) in the resident room attempted to wake the resident and convince her to eat lunch, the resident refused, and the LN administered five units of insulin SQ as ordered stating R40's blood sugar was okay to give the insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 757	Continued From page 21 During an interview on 04/05/22 at 01:40 PM Certified Nursing Assistant (CNA) F reported the resident had behaviors of refusing meals and care at times. It was hard to get the resident to eat at times. On 04/05/22 at 12:25 PM LN E reported the resident would refuse meals and the staff would re-offer and she generally ate something from the meal if you serve her what she wants. LN E said R40's blood sugars remained good with no concerns with insulin given. On 04/11/22 at 10:20 AM LN G reported she did not know why the high blood sugars on those days were not called to the physician. On 04/11/22 at 10:30 AM Administrative Nurse B was going to check the physician log to see why the blood glucoses were not reported to the physician. Review of the facility policy named "Diabetes" dated 04/22 revealed the healthcare provider orders desired parameters for monitoring and reporting information related to diabetes or blood sugar management. The facility failed to notify the physician of blood sugars that were higher than parameters ordered by the physician..	F 757		
F 880 SS=D	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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 880	Continued From page 22	F 880		

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 §483.70(e) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 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
F 880	Continued From page 23	F 880		

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:
The facility reported a census of 61 residents. Based on observation, interview, and record review the facility failed to ensure nursing staff stored a suction catheter sanitarily to prevent infection for Resident (R) 10. The facility further failed to clean a glucometer (instrument used to calculate blood glucose) after use to reduce the risk of spread of infectious diseases.

Findings Included:

- On 04/04/22 at 03:32 PM observed R10's room with a suction canister on suction machine, with yellow liquid in the canister and sitting on the bedside table with the tubing and a Yankauer (an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 880	Continued From page 24	F 880		

oral suctioning tool used in medical procedures) suction catheter tip set directly on the bedside table, with no barrier noted.

On 04/05/22 at 01:09 PM observed R10's room with a suction canister on suction machine, with yellow liquid in it, sitting on the bedside table and the tubing with a Yankauer suction catheter tip set directly on the bedside table, with no barrier noted.

On 04/06/22 at 09:33 AM observed R10's room with a suction canister on suction machine, with yellow liquid in it, sitting on the bedside table and the tubing with a Yankauer suction catheter tip set directly on the bedside table, with no barrier noted.

On 04/05/22 at 01:22 PM Certified Nurse Aid (CNA) K confirmed she was educated on infection control procedures but did nothing with the suctioning equipment for residents.

On 04/06/22 at 09:35 AM Licensed Nurse (LN) D confirmed if a resident was suctioned, the canister should be emptied and cleaned, and the suction catheter should be replaced and all stored covered. LN D confirmed she had not suctioned R10.

On 04/06/22 at 10:24 AM Administrative Nurse B stated her expectation would be that a suction canister and catheter be stored sanitarily. Administrative Nurse B confirmed on a bedside table with no barrier was not sanitary.

The 06/2021 "Infection Prevention and Control Program" documented objectives were to prevent, detect, investigate, and control infections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 880	Continued From page 25	F 880		

in the community. Staff were to be educated regarding proper techniques and procedures.

The facility failed to ensure staff emptied a used suction canister and store a suction catheter in a sanitary manner.

- On 04/06/22 at 08:14 AM Observation of Licensed Nurse (LN) E revealed the nurse doing an accucheck on R 12. LN E donned gloves and gathered her equipment and went to the resident room. She cleaned the resident's finger on his left hand and used a lancet to obtain a blood sample. The blood was put on the accucheck strip and read a blood sugar of 120. The nurse then removed the strip from the machine and wiped the resident's finger off. She then gathered the accucheck and placed it in the tote that contained lancets, alcohol pads and another glucometer. The nurse failed to clean the machine before putting it in with the other equipment.

Interview on 04/06/22 at 08:18 AM LN E reported she should have cleaned the glucometer after use before putting it in the tote with other equipment. She then used a sanitizing wipe and cleaned the machine.

On 04/11/22 at 12:30 PM Adminisrative Nurse B reported the glucometer should have been cleaned before returning it to the tote.

The Facility policy on Obtaining a Fingerstick Glucose Level dated 2022 revealed clean and disinfect reusable equipment between uses according to the manufactures instructions and current infection control standards of practice.

The facility failed to clean and sanitize the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175539	A. BUILDING _____ B. WING _____	04/11/2022

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

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F 880	Continued From page 26 glucometer after using on a resident to prevent the spread of infectious disease.	F 880		