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	175539	A. BUILDING _____ B. WING _____	04/04/2024

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F 000	INITIAL COMMENTS The following citations represent Health Resurvey VJTJ11 and Complaints KS00186383 and KS00185701. This 2567 was electronically sent to the facility on 04/09/24.	F 000		
F 689 SS=D	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 reported a census of 72 residents with 18 residents sampled, that included three residents reviewed for accident hazards. Based on observations, interviews, and record review, the facility failed to provide an environment as free of accident hazards as possible for Resident (R)28, when the facility failed to prevent multiple electrical cords plugged into two power strips next to R28's recliner from being strewn about the floor in the walking path between R28's recliner and R28's bed and the oxygen tubing on the floor in the walking path from the bathroom to R28's bed and recliner area. This deficient practice had the potential to create a trip hazard for R28 that could potentially lead to injury. Findings included:	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/09/2024

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.

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- R8's diagnoses from the "Electronic Health Record" (EHR) documented chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), other disorders of the lung, and Parkinson's (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The 09/29/23 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance for all cares except eating and ambulation which were independent. The MDS documented no falls since admission and R8 mobility devices included a walker or wheelchair.

The 09/29/23 "Falls Care Area Assessment" (CAA) documented R8 had a moderate risk for falls due to use of oxygen and long oxygen tubing.

The 03/12/24 "Quarterly MDS" documented a BIMS of 15, which indicated intact cognition. The resident was independent with all cares except bathing, which required partial/moderate assistance of one staff and used a walker or wheelchair for locomotion.

The 04/02/24 "Care Plan" documented an entry on 12/12/23 that R8 had a potential for falls related to change in environment with instructions for staff to keep pathways clear.

On 04/02/24 at 12:15 PM, an observation of R8's room revealed two-four port power strips stored

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next to the recliner with seven items plugged in with cords that laid directly on the floor in the pathway between R8's recliner and R8's bed. R8's oxygen tubing looped on the floor between the resident's bathroom and down the pathway from the bathroom to R8's recliner.

On 04/03/24 at 09:10 AM, an observation of R8's room revealed no difference from the previous observation.

On 04/03/24 at 12:28 PM, observation of R8's room revealed the oxygen tubing and power cords remained in the same stored location.

On 04/04/24 at 08:05 AM, Administrative Nurse B revealed that electrical cords and oxygen tubing on the ground in the walkway could be a trip hazard for residents.

On 04/04/24 at 12:47 PM, Maintenance Staff E revealed the cords on the floor in R8's room were a trip hazard.

The facility's 12/2017 "Safety and Supervision of Residents" policy documented that the facility would provide a safe environment for residents but failed to specifically address power cord or oxygen tubing placement.

The facility failed to provide an environment as free of accident hazards as possible for R 28 when the facility failed to prevent multiple electrical cords plugged into two power strips next to R28's recliner from being strewn about the floor in the walking path between R28's recliner and R28's bed and the oxygen tubing on the floor in the walking path from the bathroom to R28's bed and recliner area. This deficient practice had

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F 689	Continued From page 3 the potential to create a trip hazard for R28 that could potentially lead to injury which would negatively affect the resident's physical and psychosocial wellbeing.	F 689		
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: The facility reported a census of 72 residents with 18 residents selected for review, which included three residents sampled for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory care in maintaining respiratory equipment. for three Residents (R) 223 related to unlabeled nebulizer tubing and mask stored uncovered with unknown liquid remaining in the chamber, hanging on the side of the nebulizer machine and an undated oxygen tubing with nasal cannula, for R 45 with two nebulizers left with unknown clear liquid in nebulizer chambers, the second nebulizer lacked a date to indicate the tubing placement and was stored in an old coffee cup, and R 8 with an unknown clear liquid in the nebulizer chamber, continuous positive airway pressure (CPAP) mask left hanging on the bed rail with undated oxygen tubing/nebulizer/CPAP tubing.	F 695		

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Findings included:

- The "Physician Orders," dated 03/26/24, revealed diagnoses that included intervertebral disc degeneration (a cushion of cartilage between the bones in the spine), fracture T11 and T12 (bones in the spine), and traumatic (injury) subdural hemorrhage (a pool of blood between the brain and its outermost covering).

The "Admission Minimum Data Set" (MDS) dated 03/30/24, documentation included the "Brief Interview for Mental Status" (BIMS) score of seven, indicating moderate cognitive impairment. The resident received oxygen.

The care plan, dated 03/26/24, directed staff the resident had potential for shortness of air (SOA) and/or respiratory complications related to pulmonary fibroids (scarring in the lungs which make it difficult to breath) with oxygen use. He had and upper respiratory infection present on admission. Staff should administer medications and oxygen as ordered.

Review of the "Physician Orders," dated 03/26/24, documented the following orders:

1. DuoNeb inhalation Solution (inhalation treatment), every 4 hours, while awake, for SOA, ordered 03/26/24.
2. Oxygen at two liters/minute per nasal cannula to keep oxygen saturation above 90 percent (%), every shift, ordered 03/25/24.
3. Change oxygen tubing and humidifier bottle weekly , ordered 03/31/24.

On 04/03/24 at 10:02 AM, the resident's oxygen

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tubing and nasal cannula lacked a date to indicate the date it was placed.
Additionally, the resident's uncovered, unlabeled handheld nebulizer inhalation administration appliance hung on the side of the nebulizer machine with an unknown liquid remaining in the medication chamber, while not in use.

On 04/03/24 at 10:12 AM, Certified Nurse Aide (CNA) J, verified the above findings. She stated the CNAs monitor residents with oxygen to make sure the oxygen is on them, and it is going at the right setting. The humidifier bottle on the oxygen concentrator should be filled. The tubing should be labeled with the date it is placed by the third shift. Additionally, the nursing staff should label the oxygen tubing and cannulas when they change them on Sunday nights, and when if the tubing needs to be replaced. If she saw an issue with the oxygen, she would replace the oxygen set up to prevent the spread of infection.

On 04/03/24 at 10:22 AM, Licensed Nurse (LN) C stated staff should change the oxygen and nebulizer tubing weekly on Sunday night. The nurse should date the tubing when initiating or replacing the tubing and or humidifier. The nebulizer medication chamber should be disassembled, cleaned, and left to air dry on a paper towel after each use, to prevent cross contamination and prevent the spread of infection, and should have a date and a time to indicate when last changed.

On 04/03/24 at 10:32 AM, Certified Medication Aide (CMA) K, entered the resident room to administer the resident's 10:00 . She verified the resident's oxygen tubing and nasal cannula lacked a date to indicate the date it was placed.

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Additionally, the resident's uncovered, unlabeled handheld nebulizer inhalation administration appliance hung on the side of the nebulizer machine with an unknown liquid remaining in the medication chamber, while not in use. She stated the CMAs administer the breathing treatments for residents. The nurses were responsible for dating the tubing and humidifier bottles when initiated or changed. The nebulizer medication chamber should be cleaned and air dried after each treatment. CMA verified the above findings were still present.

On 04/03/24 at 01:12 PM, Administrative Nurse B, stated she expected the nursing staff to rinse the nebulizer medication administration appliance and air dry on a paper towel after each use to prevent respiratory infection after each use. Additionally, she stated the oxygen tubing should be changed weekly and the tubing and respiratory equipment should be labeled with the date when initiated or changed.

The facility's 12/2022 "Procedure: Respiratory Care - Prevention of Infection" policy, documented that at the completion of therapy, staff were to remove the nebulizer container, rinse the nebulizer components with tap water and dry on a clean paper towel or gauze sponge.

The facility failed to provide respiratory care consistent with professional standards of care for the resident, regarding the use and cleaning of the nebulizer equipment. This deficient practice had the potential to lead to respiratory illnesses that could negatively affect the physical and psychosocial well-being for the resident.

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- R8's diagnoses from the "Electronic Health Record" (EHR) documented chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), other disorders of the lung and obstructive sleep apnea (OSA - a sleep disorder that causes repeated breathing interruptions during sleep).

The 09/29/23 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance for all cares except eating and ambulation which were independent. The MDS documented no falls since admission and R8 received oxygen and a non-invasive mechanical ventilator via CPAP (continuous positive airway pressure - a ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep).

The 09/29/23 "ADL (activities of daily living, such as combing/brushing hair, brushing teeth, dressing and toileting) Functional / Rehabilitation Potential Care Area Assessment" (CAA) documented R8 had significant COPD and required continuous oxygen and utilized a CPAP machine while sleeping.

The 03/12/24 "Quarterly MDS" documented a BIMS of 15, which indicated intact cognition. The resident was independent with all cares except bathing which required partial/moderate assistance of one staff. R8 received oxygen and a non-invasive mechanical ventilator via CPAP.

The 04/02/24 "Care Plan" documented an entry

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on 12/12/23 that R8 had altered respiratory status related to diagnosis of COPD and instructed staff to administer breathing treatments, oxygen and CPAP as ordered, and to monitor the resident for changes in respiratory status. Staff were to wash and dry the CPAP mask after each use and wash and dry the nebulizer after each use.

R8's "Physician Orders" included:

1. Levalbuterol (a medication used to open and relax airway structures), 1.25 milligrams (mg) in 3 milliter (mL) to be inhaled orally, via nebulizer, two times per day, for asthma and breathing difficulty, related to COPD, ordered 12/12/23.

2. Trilogy Ventilator, (a CPAP device) at night or with sleep with oxygen at six liters per minute (LPM) supplementally added related to OSA, ordered 11/19/22.

On 04/02/24 at 12:15 PM, an observation of R8's room revealed a nebulizer mask stored intact on an over the bed table with an unknown clear liquid inside the nebulizer chamber and a CPAP mask hung from the bedrail.

On 04/03/24 at 09:10 AM, an observation of R8's room revealed a nebulizer mask stored intact on an over the bed table with an unknown clear liquid inside the nebulizer chamber and the CPAP mask hung from the bedrail.

On 04/03/24 at 12:28 PM, an observation of R8's room revealed the nebulizer mask and CPAP mask remained in the same stored location.

On 04/04/24 at 11:50 AM, an observation of R8's room revealed a CPAP mask remained intact and

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stored on the over the bed table.

On 04/04/24 at 08:05 AM, Administrative Nurse B revealed that nebulizers should be cleaned after every use and set on a paper towel to dry. Additionally, staff have the availability of a cleaner to place CPAP masks in for cleaning. The expectation was for staff to clean nebulizers and CPAP masks after every use.

On 04/04/24 at 12:31 PM, Administrative Nurse F revealed that staff should be cleaning nebulizers and CPAP equipment (masks/hoses/nebulizer chambers) after each use due to infection control concerns.

The facility's 12/2022 "Procedure: Respiratory Care - Prevention of Infection" policy, documented that at the completion of therapy, staff were to remove the nebulizer container, rinse the nebulizer components with tap water and dry on a clean paper towel or gauze sponge. The policy lacked guidance for care/cleaning of CPAP equipment except to follow manufacturer's guidelines which were not provided by the facility as requested on 04/04/24 at 12:30 PM.

The facility failed to provide respiratory care consistent with professional standards of care for R8, regarding the use and cleaning of the nebulizer and CPAP equipment. This deficient practice had the potential to lead to respiratory illnesses that could negatively affect the physical and psychosocial well-being of R8.

- R45's pertinent diagnoses from the "Electronic Health Record" (EHR) documented chronic obstructive pulmonary disease (COPD-

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progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The 05/11/23 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 14, indicating intact cognition. The resident required extensive assistance for all cares except eating which was independent. The resident did not receive special treatments or therapies.

The 05/11/23 "Care Area Assessment" (CAA) lacked documentation related to nebulized medication use.

The 01/25/24 "Quarterly MDS" documented a BIMS of 15, which indicated intact cognition. The resident required extensive assistance for all cares except eating which was independent. The resident did not receive special treatments or therapies.
The 04/02/24 "Care Plan" documented an entry on 05/09/23 that R45 had the potential for shortness of breath and respiratory complications related to diagnosis of COPD and instructed staff to administer breathing treatments, and to wash and dry the nebulizer after each use.

R45's "Physician Orders" included:

1. Ipratropium (a longer lasting medication used to open and relax airway structures), 0.5 milligrams (mg) and albuterol (a short- lasting medication used to open and relax airway structures) 3 mg in 3 milliter (mL), to be inhaled orally, via nebulizer, every two hours as needed, for COPD, ordered 09/14/22.

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2. Brovana (a longer lasting medication used to open and relax airway structures),15 micrograms (mcg) in 2 mL solution, to be inhaled orally, via nebulizer, twice per day, for COPD, ordered on 09/14/22.

3. Budesonide (an inhaled steroid to reduce chronic airway inflammation) 0.5 mg in 2 mL suspension, to be inhaled orally, via nebulizer, twice per day, for COPD, ordered on 09/24/22.

On 04/02/24 at 02:08 PM, an observation of R45's room revealed a nebulizer setup sat intact on the bedside table with an unknown clear liquid inside the nebulizer chamber and a second intact nebulizer setup stored inside a porcelain coffee cup. R45 revealed that staff would pre-load her as needed (prn) nebulizer with medications for her to use at her own discretion.

On 04/03/24 at 09:16 AM, an observation of R45's room revealed a nebulizer setup stored intact on the bedside table with an unknown clear liquid inside the nebulizer chamber and a second intact nebulizer setup stored inside a porcelain coffee cup.

On 04/04/24 at 11:47 AM, an observation of R45's room revealed the nebulizers storage unchanged from previous observations.

On 04/04/24 at 08:05 AM, Administrative Nurse B revealed that nebulizers should be cleaned after every use and set on a paper towel to dry. Additionally, staff should not leave intact nebulizer equipment inside coffee cups.

On 04/04/24 at 12:31 PM, Administrative Nurse F revealed that staff should be cleaning nebulizers

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F 695	Continued From page 12 after each use and should not leave intact nebulizer equipment inside coffee cups, due to infection control concerns. On 04/05/24 at 08:32 AM, Administrative Nurse B revealed that R45 did not have a self-administration safety assessment performed to be able to self-administer nebulized medications. The facility's 12/2022 "Procedure: Respiratory Care - Prevention of Infection" policy, documented that at the completion of therapy, staff were to remove the nebulizer container, rinse the nebulizer components with tap water and dry on a clean paper towel or gauze sponge. The facility failed to provide respiratory care consistent with professional standards of care for R45, regarding the use and cleaning of the nebulizer equipment. This deficient practice had the potential to lead to respiratory illnesses that could negatively affect the physical and psychosocial well-being of R45.	F 695		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The facility identified four medication storage rooms and six medication carts used to administer medication to the residents. Based on	F 759		

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

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observations, interviews, and record review, the facility failed to ensure that the medication administration error rate was no greater than five percent (%) when errors occurred with 22 of 27 observed medications had errors when the Licensed Nurse (LN) failed to confirm the medications administered against the physician's order or the eMAR (electronic medication administration record). The medication errors were due to failure follow nursing standard of care which resulted in an error rate of 81.48%.

Findings include:

- On 04/04/24 at 07:30 AM, LN D administered two medications to Resident (R) 8 by removing them from an outer wrapper (which was labeled with the identification of the contents) and removed the medications from their internal wrapping (which were also individually labeled with the identification of the contents) and failed to confirm the medications against the physician's order or the eMAR.

On 04/04/24 at 07:35 AM, LN D confirmed that she had administered the medication without properly confirming the medication against the physician's order or the eMAR.

On 04/04/24 at 07:37 AM, LN D administered a total of 13 medications to R15 by confirming the contents printed on the outer wrapper (which was labeled with the identification of the contents) and removing the medications from their internal wrapping (which were also individually labeled with the identification of the contents) without confirmation the individual medications against the physician's order or the eMAR.

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F 759	Continued From page 14 On 04/04/24 at 07:46 AM, LN D administered a total of seven medications to R3 by confirming the contents printed on the outer wrapper (which was labeled with the identification of the contents) and removing the medications from their internal wrapping (which were also individually labeled with the identification of the contents) without confirmation the individual medications against the physician's order or the eMAR. On 04/04/24 at 07:50 AM, LN D confirmed that she should have compared the individual medication identification labels to the physician's order or eMAR prior to administration to the residents. Additionally, LN D stated that the medication cart she was dispensing medication from serviced 20 residents. On 04/04/23 at 08:05 AM, Administrative Nurse B revealed that the facility's expectation is for staff to confirm the contents of each individual medication's identification label to the physician's order or the eMAR for accuracy since the outer packaging label could potentially be incorrect. The facility failed to provide a policy related to medication administration as requested on 04/04/24. The facility failed to ensure that the medication administration error rate was no greater than 5% when errors occurred with 22 of 27 observed medications had errors due to failure follow nursing standard of care which resulted in an error rate of 81.48%.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 15 §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 census totaled 72 residents residing on four neighborhoods. Based on observation, interview, and record review. the facility failed to secure medications by the failure to lock two medication carts on two separate neighborhoods during administration of medications when nursing staff left the medication cart unlocked and unattended. This had the potential to affect 20 residents residing on neighborhood D2 and 20 residents on B2. Findings included:	F 761		

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- On 04/03/24 at 11:35 AM, the medication cart on D2 neighborhood was unlocked with no nurse in the vicinity of the cart.

On 04/03/24 at 11:35 AM, Licensed Nurse (LN) D reported there were 20 residents on the neighborhood who received medications from the medication cart. LN D stated the cart contained narcotics and insulins as well as other medications. LN D reported that all medication carts should be locked when unattended and confirmed that the medication cart was unlocked and unattended.

On 04/04/24 at 09:12 AM, on B2 neighborhood, a medication cart was noted unlocked and unattended while LN C administered medications to a resident down the hallway.

On 04/04/24 at 09:14 AM, LN C confirmed the medication cart was left unlocked and unattended, and stated he should lock the medication cart when he left the cart to give a resident their medications.

On 04/04/24 at 09:37 AM, Administrative Nurse B stated that all medication carts should be locked when unattended.

The facility policy named Storage of Medications dated 01/24 revealed compartments (including, but not limited to, drawers, cabinets, rooms refrigerators, carts and boxes) containing drugs and biological shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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F 761	Continued From page 17 The facility failed to secure medications by the failure to lock two medication carts on two separate neighborhoods during administration of medications when the nursing staff left the medication cart unlocked and unattended.	F 761		
F 880 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 §483.70(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	F 880		

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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
(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 72 residents with 18 residents sampled. Based on observation, interview, and record review, the facility failed to

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maintain an effective infection control program with the failure of staff to follow infection control standards when delivering meal trays to residents in the dining area, appropriately clean respiratory equipment for Resident (R) 8, R45 and R223 or perform hand hygiene between phases of wound care for R28. This deficient practice has the potential to lead foodborne illness, respiratory illness and wound infections.

Findings include:

- On 04/03/24 at 12:15 PM, Certified Nurse Aide (CNA) G and CNA H observed carrying multiple plates from satellite kitchen area in the D-200 neighborhood to resident tables with their thumbs over the edge of the plate and deep into the eating surface of the plates.

On 04/03/24 at 12:25 PM, CNA G and CNA H revealed staff should carry resident plates by the bottom of the plate, without their fingers on the eating surface of the plates.

On 04/03/24 at 12:36 PM, Dietary Staff I revealed that all staff, regardless of which department they work for, were expected to carry plates to residents by the bottom and keep their fingers off the eating surface of the plates.

On 04/04/24 at 12:31 PM, Administrative Nurse F revealed that staff should carry plates to residents sitting at the tables by either using a tray, or by the bottom of the plate and ensure that their fingers do not contact the eating surface of the plates.

The facility's 01/20/23 "Preventing Food Borne Illness - Associate Hygiene and Sanitary

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Practices" lacked instructions for staff on handling of resident plates.

The facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards when delivering meal trays to residents in the dining area. This deficient practice had the potential to negatively impact the physical and psychosocial health of all 20 residents in the D-200 neighborhood.

- R8's diagnoses from the "Electronic Health Record" (EHR) documented chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and other disorders of the lung and obstructive sleep apnea (OSA - a sleep disorder that causes repeated breathing interruptions during sleep).

R8's "Physician Orders" included:

1. Levalbuterol (a medication used to open and relax airway structures), 1.25 milligrams (mg) in 3 milliter (mL) to be inhaled orally, via nebulizer, two times per day, for asthma and breathing difficulty, related to COPD, ordered 12/12/23.

2. Trilogy Ventilator, (a CPAP device) at night or with sleep with oxygen at six liters per minute (LPM) supplementally added related to OSA, ordered 11/19/22.

On 04/02/24 at 12:15 PM, an observation of R8's room revealed a nebulizer mask stored intact on an over the bed table with an unknown clear liquid inside the nebulizer chamber and a CPAP mask hung from the bedrail.

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F 880	Continued From page 21 On 04/03/24 at 09:10 AM, an observation of R8's room revealed a nebulizer mask stored intact on an over the bed table with an unknown clear liquid inside the nebulizer chamber and the CPAP mask hung from the bedrail. On 04/03/24 at 12:28 PM, an observation of R8's room revealed the nebulizer mask and CPAP mask remained in the same stored location. On 04/04/24 at 11:50 AM, an observation of R8's room revealed a CPAP mask remained intact and stored on the over the bed table. On 04/04/24 at 08:05 AM, Administrative Nurse B revealed that nebulizers should be cleaned after every use and set on a paper towel to dry. Additionally, staff have the availability of a cleaner to place CPAP masks in for cleaning. The expectation was for staff to clean nebulizers and CPAP masks after every use. On 04/04/24 at 12:31 PM, Administrative Nurse F revealed that staff should be cleaning nebulizers and CPAP equipment (masks/hoses/nebulizer chambers) after each use due to infection control concerns. The facility's 12/2022 "Procedure: Respiratory Care - Prevention of Infection" policy, documented that at the completion of therapy, staff were to remove the nebulizer container, rinse the nebulizer components with tap water and dry on a clean paper towel or gauze sponge. The policy lacked guidance for care/cleaning of CPAP equipment except to follow manufacturer's guidelines which were not provided by the facility as requested on 04/04/24 at 12:30 PM.	F 880		

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The facility failed to maintain an effective infection control program with the failure of staff to appropriately clean respiratory equipment for R8. This deficient practice had the potential to lead to respiratory illnesses that could negatively affect the physical and psychosocial well-being of R8.

- R45's pertinent diagnoses from the "Electronic Health Record" (EHR) documented chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

R45's "Physician Orders" included:

1. Ipratropium (a longer lasting medication used to open and relax airway structures), 0.5 milligrams (mg) and albuterol (a short- lasting medication used to open and relax airway structures) 3 mg in 3 milliter (mL), to be inhaled orally, via nebulizer, every two hours as needed, for COPD, ordered 09/14/22.

2. Brovana (a longer lasting medication used to open and relax airway structures),15 micrograms (mcg) in 2 mL solution, to be inhaled orally, via nebulizer, twice per day, for COPD, ordered on 09/14/22.

3. Budesonide (an inhaled steroid to reduce chronic airway inflammation) 0.5 mg in 2 mL suspension, to be inhaled orally, via nebulizer, twice per day, for COPD, ordered on 09/24/22.

On 04/02/24 at 02:08 PM, an observation of R45's room revealed a nebulizer setup sat intact on the bedside table with an unknown clear liquid

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inside the nebulizer chamber and a second intact nebulizer setup stored inside a porcelain coffee cup. R45 revealed that staff would pre-load her as needed (prn) nebulizer with medications for her to use at her own discretion.

On 04/03/24 at 09:16 AM, an observation of R45's room revealed a nebulizer setup stored intact on the bedside table with an unknown clear liquid inside the nebulizer chamber and a second intact nebulizer setup stored inside a porcelain coffee cup.

On 04/04/24 at 11:47 AM, an observation of R45's room revealed the nebulizers storage unchanged from previous observations.

On 04/04/24 at 08:05 AM, Administrative Nurse B revealed that nebulizers should be cleaned after every use and set on a paper towel to dry. Additionally, staff should not leave intact nebulizer equipment inside coffee cups.

On 04/04/24 at 12:31 PM, Administrative Nurse F revealed that staff should be cleaning nebulizers after each use and should not leave intact nebulizer equipment inside coffee cups, due to infection control concerns.

On 04/05/24 at 08:32 AM, Administrative Nurse B revealed that R45 did not have a self-administration safety assessment performed to be able to self-administer nebulized medications.

The facility's 12/2022 "Procedure: Respiratory Care - Prevention of Infection" policy, documented that at the completion of therapy, staff were to remove the nebulizer container,

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rinse the nebulizer components with tap water and dry on a clean paper towel or gauze sponge.

The facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards to appropriately clean respiratory equipment for R45. This deficient practice had the potential to lead to respiratory illnesses that could negatively affect the physical and psychosocial well-being of R45.

- R28's diagnoses from the "Electronic Health Record" (EHR) documented personal history of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain) and 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), vascular dementia (a progressive mental disorder characterized by failing memory, confusion) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The Physician orders documented the following:

1. On 03/22/24, staff were to cleanse the left upper buttock wound and the left lower buttock wound with wound cleaner, apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin), then cover wounds with hydrocolloid (an opaque dressing for wounds that is biodegradable, non-breathable, and adheres to the skin)

On 04/04/24 at 11:15 AM, Licensed Nurse (LN) D performed wound care to areas of moisture associated skin damage (MASD) on R28's buttocks. Staff assisted the resident to the right

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side and removed R28's brief. LN D cleansed the buttock wounds and surrounding skin with bathing wipes. LN D changed gloves and failed to perform hand hygiene. LN D then cleaned upper buttock wound and surrounding skin with wound cleaner then skin prep and placed hydrocolloid dressing. LN D then changed gloves and failed to perform hand hygiene before the transition to wound care from the first treated wound to the second wound on the lower buttock. LN D then cleaned the second wound with wound cleaner then applied skin prep, changed gloves but failed to perform hand hygiene. LN D placed a hydrocolloid dressing on the second wound and changed gloves but failed to perform hand hygiene. LN D applied A&D ointment to the surrounding skin then, without glove change or hand hygiene, removed a permanent marker from her scrubs pocket and dated the dressings, then placed the marker directly onto the resident's bed. LN D then assisted the resident with placement of a new brief, then placed the marker on an over-the-bed table, then removed gloves and removed trash bag to bathroom and hand hygiene performed. LN D then returned to the resident's bedside to place a new trash bag and placed the contaminated marker back into her pocket and left the room.

On 04/04/24 at 11:44 AM, LN D confirmed that she failed to perform hand hygiene when gloves were changed or when she transitioned between phases of wound care.

On 04/04/24 at 12:28 PM, Administrative Nurse F stated that the expectation from staff is that hand hygiene is to be performed whenever gloves are changed during wound care and/or before transition from dirty phase to clean phase of

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F 880	Continued From page 26 wound care. The facility's 05/2023 "Procedure: Wound Care/Dressing Change" policy documented that staff were to perform hand hygiene whenever gloves were changed during wound care and/or dressing changes. The facility failed to maintain an effective infection control program with the failure of staff to follow infection control standards when staff failed to perform hand hygiene between phases of wound care for R28. This deficient practice had the potential to cause wound infections which would negatively affect R28's physical and psychosocial wellbeing.	F 880		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination	F 887		

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 _____	04/04/2024

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 887	Continued From page 27	F 887		

requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 18 residents included in the sample. Based

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F 887	Continued From page 28	F 887		

on interview and record review, the facility failed to ensure the five residents/ resident representatives acknowledged receipt related to COVID-19 (highly contagious respiratory virus) vaccination information/education for five of five residents, that included Resident (R)126, R124, R45, R6, and R16.

Findings included:

- On 04/04/24 at 12:20 PM, Administrative Nurse B provided an electronic spread sheet related to resident immunizations. The following were areas of concern:

Resident (R)126 documentation revealed the COVID vaccination as
"Resident refused", however the facility was unable to provide declination information.

R124 documentation revealed as "resident refused", however the facility was unable to provide declination information.

R45's documentation revealed the resident received a COVID vaccination on 10/13/23, however, lacked education for the risk verses benefits. Furthermore, the facility failed to provide a written consent to administer the vaccination.

R6's documentation revealed the resident received a COVID vaccination on 10/13/23, however, lacked education for the risk verses benefits. Furthermore, the facility failed to provide a written consent to administer the vaccination.

R16's documentation revealed the resident received a COVID vaccination on 10/13/23, however, lacked education for the risk verses

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F 887	Continued From page 29	F 887		

benefits. Furthermore, the facility failed to provide a written consent to administer the vaccination.

On 04/04/24 at 01:45 PM, Administrative Nurse B reported the facility lacked a no acceptance/declination consent form or an education information form, and verified the facility used verbal consents.

The facility policy for Vaccination of Residents (Example: Pneumococcal, Influenza, COVID-19) dated 07/23 revealed residents will be educated about and offered vaccines in accordance to Center of Disease Control (CDC) and attending physician recommendations. Prior to receiving vaccinations, the resident or resident representative would be provided information and education regarding the benefits and potential side effects of the vaccines. Provision of education shall be documented in the resident record. Residents/resident representative may sign a consent/refusal form for vaccines. The resident or representative may refuse vaccines for any reason. Refusals for any immunizations offered will be documented in the medical record indicating the date of refusal.

The facility failed to ensure these five residents/resident representatives acknowledged receipt related to COVID-19 vaccination information/education and/or signed consent verification.