STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey for the above named Assisted Living Facility conducted on 09/25/24 and 09/26/24.	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (d) The facility reported a census of 59 residents(R). The sample included three residents. Based on interview and record review, the operator failed to ensure designated staff completed two (R3 and R4) of three sample residents "Functional Capacity Screen" accurately to reflect their functional ability related to management of medications, medical treatments, and falls. Findings Included: - R3's Electronic Medical Record revealed she moved into the facility on 07/10/17 with a diagnosis of psychosis. R3's "Functional Capacity Screen" (FCS) dated 04/27/24 identified she was independent with dressing, needed supervision with toileting, was independent with transfers, and frequently incontinent of urine.	S3082		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3082	Continued From page 1 Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document. R3's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 04/27/24 R3 could independently dress herself including putting on her shoes and socks. It directed qualified staff to assist with transfers as needed and provide occasional assistance with ambulation. It also directed qualified staff to provide limited assistance with indwelling catheter care including emptying the leg bag Interview/observation on 09/25/24 at 12:55 PM R3 sat in her recliner with her feet elevated on her electric scooter. R3 reported for the most part she can transfer herself in and out of chairs but when she needs help she will call for staff to help her. R3 reported the staff help with giving her showers and with getting her dressed int he mornings. Interview on 09/26/24 at 09:16 AM Certified Medication Aide (CMA) D reported staff changed out R3's catheter bag, helped her with putting on her bra and socks in the mornings. CMA D reported R3 has needed help off and on since she hurt her shoulder about a year ago. It just depends on how much pain she is in. Interview on 09/26/24 at 10:59 AM Administrative Nurse A reviewed R3's FCS and acknowledged it would not have been a correct assessment related to dressing and bladder incontinence. The executive director failed to ensure designated staff completed R3's FCS accurately to reflect R3's functional ability and her service	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3082	Continued From page 2	S3082		

needs.

- R4's Electronic Record revealed she moved into the facility on 08/06/24 with diagnosis of macular degeneration and dizziness.

R4'a 'Functional Capacity Screen dated 08/06/24 identified she required supervision with dressing and walk/mobility.

Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document.

R4's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 08/06/24 identified R4 was independent with dressing and directed staff to provide occasional assistance with ambulation or use of assistive device.

Interview/Observation on 09/25/24 at 01:09 PM revealed resident sat in her lift chair with her walker in front of her and a wheelchair beside the wall. R4 reported the staff help her get dressed in the mornings and will push her to the meals or activities in her wheelchair.

Interview on 09/26/24 at 08:48 AM Certified Medication Aide C reported staff help her with her showers and she can usually dress herself. R4 uses a walker in her room but we take her to meals using her wheelchair.

Interview on 09/26/24 at 01:57 PM Administrative Nurse A confirmed R4's FCS staff should have coded a "2" for mobility to indicated she needed physical assistance.

The executive director failed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3082	Continued From page 3 designated staff completed R4's FCS accurately to reflect R4's functional ability and her service needs.	S3082		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(2) The facility reported a census of 59 residents (R). The sample included 3 residents. Based on interview and record review the operator failed to ensure designated staff reviewed/revised two (R3 and R4) of three sampled resident's negotiated service agreement following a significant change in condition requiring changes in service needs and service provided. Findings Included:	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3092	Continued From page 4	S3092		

- R3's Electronic Medical Record revealed she moved into the facility on 07/10/17 with a diagnosis of psychosis.

R3's "Functional Capacity Screen" (FCS) dated 04/27/24 identified she required physical assistance with bathing and management of medications and medical treatments. She needed supervision with walking and had a current risk/problem related to falls.

Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document.

R3's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 04/27/24 staff would monitor and identify R3 for fall risks and included multiple interventions related to falls. It also included R3 received therapy services as needed from a local contracted therapy company.

R3's nursing progress notes included documentation of new orders for physical (PT) and or occupational therapy (OT) evaluation and treat three different times in the past year.

On 09/26/24 Administrative Nurse A provided information R3 received either PT or OT from 11/02/23 to 12/26/23, 04/25/24 to 05/21/25, and again on 09/19/24 and continues to receive services.

Review of R3's Electronic Medical Record lacked an Amended NSA/HCSP for when R3 initiated and discontinued therapy services.

On 09/26/24 at 11:03 AM Administrative Nurse A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3092	Continued From page 5	S3092		

checked R3's electronic record and confirmed staff failed to complete an Amended NSA/HCSP to identify the times R3 received skilled therapy services from an outside provider.

The executive director failed to ensure designated staff completed an amended NSA/HCSP when she required a changed in service needs and services provided.

- R4's Electronic Record revealed she moved into the facility on 08/06/24 with diagnosis of macular degeneration and dizziness.

R4'a 'Functional Capacity Screen dated 08/06/24 identified she required physical assistance with management of medications and medical treatments and had a risk for falls and impaired vision.

Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document.

R4's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 08/06/24 identified R4 required services from a local Home Health Agency but failed to identify what services she received.

Interview on 09/26/24 at 08:48 AM Certified Medication Aide reported she did not think R4 received Home Health services any longer.

Phone interview on 09/26/24 with Home Health company revealed R4 the company discharged R4 from services on 09/03/24.

Interview on 09/26/24 at 12:02 PM Administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3092	Continued From page 6 Nurse A acknowledged R4 no longer received Home Health Services and should have had an Amended NSA/HCSP completed when discharged. The executive director failed to ensure designated staff completed an amended NSA/HCSP when R4 required a changed in service needs and services provided.	S3092		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 59 residents(R). Based on observation and interview, the executive director failed to ensure a licensed nurse or pharmacist included the residents full name on all over-the-counter medications, including the original manufacturer's medication	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3211	Continued From page 7 package and the medication container/tube. Findings included: - Observation on 09/25/24 at 09:14 AM Certified Medication Aide (CMA) C unlocked the "East 1" medication cart for inspection. Observations revealed the following medication containers without a resident's full name on them: bottles of : Magnesium, Fish Oil, Tylenol, Tums, Vitamin D3+K, all lacked the resident's full name on the bottles. Observation on 09/25/24 at 09:18 AM CMA D unlocked the "West 1' medication cart contained a bottle of refresh tears with no name and no box. The "West 2" medication cart contained a bottle of Aspirin and vitamin D3 without a full name on the containers. On 09/25/24 at 09:24 AM Administrative Nurse A reported over the counter medications should have the residents full name and room number on them. The executive director failed to ensure a licensed nurse or pharmacist wrote the residents full name on all over-the-counter medications, including the medication package and container.	S3211		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3248	Continued From page 8 employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1) The facility reported a census of 59 residents. Based on record review of five newly hired employees, the operator failed to have evidence of licensure for one of five newly hired staff who required specialized education and training verified upon hire. The findings included: - On 09/25/24 at approximately 2:15 PM review of five newly hired certified staff records revealed the following: Administrative Nurse A hired on 09/16/24 did not	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3248	Continued From page 9 have verification of licensure check completed upon hire. On 09/25/24 at 02:38 PM Administrative Nurse B Provided verification of licensure completed 09/25/24. Administrative Nurse B confirmed designated staff failed to verify licensure that should have been completed upon hire. The Executive Director failed to ensure designated staff conducted registry check for verification of certification for certified and licensed staff prior to working at the facility.	S3248		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 59 residents(R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure three (R3 and R5) of three sampled residents contained documentation of all incidents, symptoms, and other indications of illness or injury, staff action and the results of action taken. Findings included:	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3261	Continued From page 10 - R3's Electronic Medical Record revealed she moved into the facility on 07/10/17 with a diagnosis of psychosis. R3's "Functional Capacity Screen" (FCS) dated 04/27/24 identified she required physical assistance with bathing and management of medications and medical treatments. She needed supervision with walking and had a current risk/problem related to falls. Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document. R3's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 04/27/24 staff would monitor and identify R3 for fall risks and included multiple interventions related to falls. It also identified qualified staff would administer medications and medical treatments. Review of R3's Electronic "ID Notes" revealed the following: 07/07/23- Start Macrobid (antibiotic) status post urinary analysis results. The record lacked follow up if the antibiotic was effective in resolving symptoms that indicated need for antibiotic. 07/10/23 - Started Medrol Dose pack (steroid) for continued pain in right chest area status post lidocaine patch application. The record lacked follow up to identify if the Medrol pack helped to decrease/resolve R4's right sided chest pain. 08/11/23 - Ulcer on left lower side of tongue causing pain, start Orajel to ulcer before meals times seven days.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3261	Continued From page 11 The record lacked follow up if the treatment was effective. 08/19/23 - Sent to emergency room related to bladder spasms and low urinary output. Indwelling catheter placed in emergency room. The record lacked follow up if urinary output improved or if the bladder spasms resolved. 09/18/23 - New order to decrease Losartan (antihypertensive) dosage. The record lacked documentation if decreasing dosage helped with low blood pressure. 11/15/23 - New order to increase Bumex (diuretic) for five days and resume regular dose. The record lacked documentation if increasing the diuretic helped improve edema and weight gain. 03/06/24 - R3 with increased shoulder pain, new order for prednisone (steroid) daily for three days. The record lacked documentation if the prednisone helped to reduce R3's shoulder pain. 05/15/24 - Keflex (antibiotic) started due to cellulitis in right lower extremity. The record lacked documentation of antibiotic follow-up including effectiveness and monitoring for adverse reaction. Interview on 09/26/24 at 11:12 AM Administrative Nurse A and Administrative Nurse B both reported the documentation in the ID notes needed to include any changes in condition, new orders, falls, transfers out of facility and three days follow up post fall. Administrative Nurse A acknowledged the R3's record lacked follow up on results of medications changes, including antibiotic effectiveness. The executive director failed to ensure designated staff documented all symptoms and other indications of illness, what was done and the results of action taken.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3261	Continued From page 12 - R5's electronic medical record revealed she moved into the facility on 04/24/23 with diagnosis of dementia. R5's "Functional Capacity Screen" dated 05/07/24 indicated she needed physical assistance with bathing, management of medications and medical treatments and had impaired cognition. Interview on 09/25/24 at 10:36 AM Administrative Nurse A reported the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document. R5's 'Negotiated Service Agreement and Health Care Service Plan" (NSA/HCSP) dated 05/07/24 indicated qualified staff would administer all medications and medical treatments and monitor resident's gait and risk for falls. Staff also needed to provide cueing, coaching and redirection due to her impaired cognition. Review of R5's "ID Notes" revealed the following documentation: 07/19/23 and 10/09/23 R5 had dental appointments for tooth extractions with no follow up related to possible adverse effects or ability to eat. 11/15/23 - resident complained of abdominal pain and Miralax order three times a day status post KUB (an x-ray study that allows your doctor to assess the organs of your urinary and gastrointestinal systems). The record lacked follow up on the results of the Miralax three times a day. 12/30/23 - New order to decrease Miralax to one time day. The record lacked follow up on the results of decreasing the Miralax.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3261	Continued From page 13 01/16/24 - New order to add Metoprolol (antihypertensive) and decrease Clonidine (antihypertensive). The record lacked documentation in the results of changing blood pressure medications. 07/22/24 - Start Keflex (antibiotic) for urinary tract infection. The record lacked documentation of symptoms or that a urine analysis was obtained to indicate need for an antibiotic and failed to include documentation of antibiotic effectiveness. Interview on 09/26/24 at 11:12 AM Administrative Nurse A and Administrative Nurse B both reported the documentation in the ID Notes needed to include any changes in condition, new orders, falls, transfers out of facility and three days follow up post fall. Interview on 09/26/24 at 02:07 PM Administrative Nurse A acknowledged the R5's record lacked follow up on results of medications changes, including antibiotics to identify effectiveness. The executive director failed to ensure designated staff documented all symptoms and other indications of illness, what was done and the results of action taken.	S3261		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3320	Continued From page 14	S3320		

fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal.

(c) New construction, modifications and equipment shall conform to the following codes and standards:

(1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and

(2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981.

This REQUIREMENT is not met as evidenced by:
KAR 28-39-254 (a)

The facility reported a census of 59 residents(R). The Resident roster provided by Administrative Nurse A identified 18 residents with impaired cognition with 8 of those residents living on the second floor. Based on observation and interview the administrator failed to ensure staff secured all chemicals in the upstairs west laundry room.

Findings included:

- Observation on 09/25/24 at 10:00 AM the laundry room on the west side of the second floor was unlocked and the side door was standing wide open. Three of the double cabinets were locked but one was unlocked. It contained a plastic jug of Downy fabric softener, a spray bottle of Spray and Wash, a spray bottle of Oxivir disinfectant, a bottle of Enzyme , a bottle of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087057	A. BUILDING: _____ B. WING _____	09/25/2024

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

(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) COMPLETE DATE
S3320	Continued From page 15 Emerel multisurface cleanser. Also a jug of Ivory laundry soap was on one of the washers. All of the above chemicals included some type of warning labels to keep out of reach of children, toxic to pets, or eye/skin irritant. interview on 09/25/24 at 03:00 PM Administrative Nurse B confirmed all chemicals needed to be kept secured and not accessible to residents/public. The administrator failed to ensure staff stored chemicals securely for the safety of all residents, personnel, and visitors.	S3320		