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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Pittsburg Inc	1502 E Centennial Pittsburg, KS 66762

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 74 residents with 20 residents selected for review. Based on observation, interview, and record review, the facility failed to provide care plan meetings for four Residents (R) 13, R2, R7 and R57, as required. Findings included: - Review of Resident (R)2's medical record revealed diagnosis that included end stage renal (kidney) disease. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). The Quarterly MDS dated [DATE], indicated a BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services. The Cognitive Loss Care Area Assessment (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance. The Care Plan dated 08/20/24, instructed staff the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity. Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 08/20/24 did not include the resident/responsible party. The facility policy Care Plans-Comprehensive Person-Centered revised 09/2023, instructed staff the resident/resident representative will be encouraged to anticipate in the resident assessment and care planning conference wit the residents' permission. The facility failed to provide a care plan meeting for this resident/resident representative as required. (continued on next page)

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.

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident (R)13's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [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). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. R13 had functional limitation in range of motion impairment on one side of the upper and lower extremities. The Communication Care Area Assessment (CAA), dated 12/15/23, assessed the resident with left sided hemiplegia and required extensive assistance with most activities of daily living. The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had functional limitation in range of motion impairment on one side of the upper and lower extremities. The resident was dependent on staff for personal hygiene. The Care Plan, reviewed 08/14/24, instructed staff the resident required extensive assistance with bathing/showering on Monday and Thursday mornings. Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 08/14/24 did not include the resident/responsible party. The facility policy Care Plans-Comprehensive Person-Centered revised 09/2023, instructed staff the resident/resident representative will be encouraged to anticipate in the resident assessment and care planning conference with the residents' permission. The facility failed to provide a care plan meeting for this resident/resident representative as required. - Review of Resident (R)7's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) dementia (progressive mental disorder characterized by failing memory, confusion) and diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The Cognitive Loss Care Area Assessment (CAA) assessed the resident had continued decline in cognition with severely impaired memory. The resident had difficulty responding with garbled speech. The Care Plan reviewed 09/24/24, instructed staff the resident was dependent on staff for activities of daily living, was incontinent of bowel and bladder, had alteration in mood, at risk for pressure ulcers and included other interventions for medical conditions. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview, on 10/16/24 at 10:07 AM, with Social Service Staff X, revealed several care plan meetings with the resident/responsible party were not completed and confirmed the care plan updated on 09/24/24 did not include the resident/responsible party. The facility policy Care Plans-Comprehensive Person-Centered revised 09/2023, instructed staff the resident/resident representative will be encouraged to anticipate in the resident assessment and care planning conference with the residents' permission. The facility failed to provide a care plan meeting for this resident/resident representative as required. 34056 - Review of Resident (R)57's electronic medical record (EMR) revealed a diagnosis of colon cancer (a disease that occurs when cells in the colon grow out of control). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident readmitted to the facility from an acute hospital. The resident's Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. It was somewhat important to the resident to have a family, or a close friend involved in discussions about his care. The Return to Community Referral Care Area Assessment (CAA), dated 06/06/24, did not trigger. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating intact cognition. Review of the resident's care plan, revised 09/04/04, instructed staff the resident did not plan to remain in the facility long-term, but planned to discharge to an assisted living facility when room was available. Review of the resident's EMR, from 01/01/24 through 10/16/24, revealed the resident had not had a care plan meeting since 01/09/24. On 10/14/24 at 08:58 AM, the resident stated he had not had a care plan meeting. On 10/16/24 at 08:21 AM, Social Service Staff X stated the resident had not had a care plan meeting since 01/09/24. He missed care plan meetings in March and July due to the facility not having a social worker for the residents of that neighborhood. Care plan meetings were to be held every three months. On 10/16/24 at 07:39 AM, Administrative Nurse D stated residents should have care plan meetings every three months. The resident had not had a care plan meeting since 01/09/24. The facility policy for Care Plans, revised 10/2021, included: The resident's representative will be encouraged to participate in the resident's care planning conference with the resident's permission, at least quarterly and with a significant change. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to have care plan meetings every three months for this resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 74 residents with 20 residents sampled. Based on observation, interview, and record review, the facility failed to complete a comprehensive care plan for one Resident's (R)27's, regarding the care and maintenance of her personal humidifier. Findings included: - Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/18/24, documented the resident had a diagnosis of dementia with confusion and forgetfulness. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of one, indicating severe cognitive impairment. The care plan, revised 10/14/24, lacked staff instruction regarding the care and maintenance of the resident's personal humidifier. On 10/15/24 at 08:00 AM, the resident had a humidifier in her room in the on position with mist coming from the spout of the machine. The spout and nebulizer chamber (a round disc or white circle in the base of the unit that vibrates to create a mist) of the machine had a heavy build-up of a hardened, white substance. On 10/16/24 at 08:00 AM, the resident's humidifier remained in her room with mist coming out of the spout of the machine. The heavy build-up of the hardened, white substance remained in the spout and nebulizer chamber. On 10/16/24 at 09:41 AM, Certified Medication Aide (CMA) R stated she believed the night shift staff was responsible for the care of the resident's humidifier. On 10/16/24 at 09:54 AM, CMA S stated she was unsure of who was responsible for the care of the resident's humidifier. On 10/21/24 at 09:15 AM, Administrative Nurse E stated the care plan should include staff instruction on the care and maintenance of resident's personal humidifiers. The facility policy for Care Plans, revised 10/2021, included: Comprehensive care plans shall be completed for each resident with measurable goals and outcomes. The care plan shall include resident specific care needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to complete a comprehensive care plan to include staff instruction for the care and maintenance for this dependent resident with a personal humidifier.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 74 residents with 20 residents sampled. Based on observation, interview, and record review, the facility failed to review and revise the care plans for two Residents (R)59 and R 70, regarding footrests for their wheelchairs. Findings included: - Review of Resident (R)59's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She utilized a wheelchair for mobility and was able to mobilize 150 feet with two turns with set-up assistance only. The Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA), dated 09/26/24, documented the resident required extensive assistance of one staff for mobility with the wheelchair. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She utilized a wheelchair for mobility and required partial to moderate staff assistance with wheeling 150 feet with two turns. The care plan for ADLs, revised 04/22/24, lacked staff instruction regarding the use of footrests for her wheelchair while being propelled by staff. Review of the resident's EMR from 10/01/24 through 10/15/24, revealed the resident required limited to total staff assistance with locomotion on the unit with her wheelchair. On 10/14/24 at 09:40 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the commons area to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests. On 10/15/24 at 12:12 PM, CNA N propelled the resident in her wheelchair from the dining room table to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests. On 10/16/24 at 09:54 AM, Certified Medication Aide (CMA) S propelled the resident in her wheelchair in the commons area. The resident's shoed feet were tucked underneath the seat of the wheelchair and the toes of her shoes skimmed the floor. The wheelchair lacked footrests. On 10/14/24 at 09:40 AM, CNA M stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 12:12 PM, CNA N stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. On 10/16/24 at 09:54 AM, CMA S stated the resident would self-propel in her wheelchair at times so staff did not use footrests on her wheelchair. On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had footrests on their wheelchairs when they were being propelled by staff. On 10/21/24 at 08:57 AM, Administrative Nurse E stated all nurses were able to review and revise resident care plans. It was the expectation for the use of footrests to be included on the resident's care plan. The facility policy for Care Plans, revised 10/2021, included: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The facility failed to review and revise this dependent resident's care plan to include staff instruction regarding the use of footrests while being propelled by staff. - Review of Resident (R)70's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She utilized a wheelchair for mobility with substantial to maximal assistance of staff. The Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA), dated 09/18/24, did not trigger. The care plan for ADLs, dated 09/11/24, lacked staff instruction regarding the use of appropriate footrests for her wheelchair while being propelled by staff. Review of the resident's EMR, from 10/01/24 through 10/15/24, revealed the resident required limited to extensive assistance with locomotion on the unit with her wheelchair. On 10/14/24 at 09:24 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the dining room to the shower room to toilet. The resident's right foot lacked support and dangled between the footrests of the wheelchair. On 10/14/24 at 12:07 PM, the resident sat in her wheelchair at the dining room table. The resident's feet dangled between the footrests of the wheelchair, several inches above the floor. On 10/16/24 at 07:30 AM, the resident sat in her wheelchair at the dining room table. The resident's right ankle rested on the outer edge of the footrest. On 10/16/24 at 09:17 AM, the resident sat in her wheelchair at the dining room table. The resident's feet were between the footrests of the wheelchair and only the toes of her feet reached the floor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 09:24 AM, CNA M stated she had not noticed the resident's feet not resting properly on the footrests of the wheelchair. On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had appropriate footrests on their wheelchairs when they were being propelled by staff. LN G confirmed the resident's feet did not rest appropriately on the footrests of the wheelchair and one or both feet tended to fall in between the two footrests of the wheelchair. On 10/21/24 at 08:57 AM, Administrative Nurse E stated all nurses were able to review and revise resident care plans. It was the expectation for the use of footrests to be included on the resident's care plan. The facility policy for Care Plans, revised 10/2021, included: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The facility failed to review and revise this dependent resident's care plan to include staff instruction regarding the use of footrests while being propelled by staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 74 residents with 20 residents included for review, which included two residents reviewed for activities of daily living. Based on observation, interview, and record review, the facility failed to ensure two Resident (R)13 and R37 received grooming assistance. Findings included: - Review of Resident (R)13's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [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). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. R13 had functional limitation in range of motion impairment on one side of the upper and lower extremities. The Communication Care Area Assessment (CAA), dated 12/15/23, assessed the resident with left sided hemiplegia and required extensive assistance with most activities of daily living. The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had functional limitation in range of motion impairment on one side of the upper and lower extremities. The resident was dependent on staff for personal hygiene. The Care Plan, reviewed 08/14/24, instructed staff the resident required extensive assistance with bathing/showering on Monday and Thursday mornings. Observation, on 10/15/24 at 08:25 AM, revealed the resident positioned in his wheelchair, eating breakfast in the common dining room. The resident's left arm was in a sling. The resident had several days' worth of facial hair. Observation, on 10/16/24 at 08:08 AM, revealed the resident seated in his wheelchair in the dining room. The resident continued with several days' worth of facial hair and stated his face felt itchy. Interview, on 10/16/24 at 08:08 AM, with Certified Nurse Aide (CNA) O, revealed the resident was cooperative with bathing, and did not know why he was not shaved on his bath day. Interview, on 10/16/24 at 10:01 AM, with Licensed Nurse (LN) H, revealed the resident occasionally yelled out at staff, and wanted to go home. LN H stated the resident was independent prior to the CVA and had an adjustment period. LN H stated the resident was generally cooperative with cares and could make his needs known. Interview on 10/21/22 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Quality of Life-Dignity date 01/2024, instructed staff to provide care to the residents that promotes and enhances the quality of life, dignity and individuality. The facility failed to ensure this dependent resident received grooming to maintain personal comfort and appearance to enhance dignity. - Review of Resident (R) 37's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) after cerebral infarction (cerebrovascular accident (CVA) [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) and dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident had no impairment in functional range of motion in extremities. The resident required set up assistance for eating and was dependent on staff for personal hygiene. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 05/02/24, assessed the resident required extensive assistance for most ADLs due to a decline with a recent diagnosis of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). Increased staff support was required to meet ADL's and most care area to maintain a neat, odor free appearance. The Cognitive Loss CAA dated 05/02/24, assessed the resident was able to feed herself. The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of 12, which indicated moderate cognitive impairment. The resident required set up assistance for eating and was dependent on staff for personal hygiene. The Care Plan reviewed 08/01/24, instructed staff the resident preferred to feed herself and required staff assistance for supervision and set up for meals and hygiene. Observation, on 10/14/24 at 09:27 AM, revealed the resident seated in the dining room, finished with breakfast. The resident had a brown substance running down from the left lower lip to bottom of her chin. A laboratory personnel questioned Certified Medication Aide (CMA) T, to identify the resident and then propelled the resident to her room, to obtain a blood sample, then returned the resident to the dining room. CMA T did not wipe the brown substance from the resident's face. Observation, on 10/16/24 at 11:03 AM, revealed the resident seated in her wheelchair in her room. A red substance was noted from her left lower lip down to the bottom of her chin. Observation, on 10/16/24 at 11:51 AM, revealed the resident seated in her wheelchair at the dining room table with the red substance still on her face. Licensed Nurse (LN) I, obtained a blood sugar and then administered insulin to the resident and did not wipe the red substance from her face until requested. LN I stated the resident preferred to feed herself, and staff should provide personal hygiene afterward. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/22 at 10:30 AM, with Administrative Nurse D, revealed she would expect staff to provide personal hygiene. The facility policy Quality of Life-Dignity date 01/2024, instructed staff to provide care to the residents that promotes and enhances the quality of life, dignity and individuality. The facility failed to provide personal hygiene related to facial hygiene to this resident that required staff assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 74 residents with 20 residents sampled, including two residents reviewed for positioning. Based on observation, interview, and record review, the facility failed to properly position two Residents (R)59 and R 70, regarding footrests for their wheelchairs. Findings included: - Review of Resident (R)59's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. She utilized a wheelchair for mobility and was able to mobilize 150 feet with two turns with set-up assistance only. The Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA), dated 09/26/24, documented the resident required extensive assistance of one staff for mobility with the wheelchair. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating severe cognitive impairment. She utilized a wheelchair for mobility and required partial to moderate staff assistance with wheeling 150 feet with two turns. The care plan for ADLs, revised 04/22/24, instructed staff the resident was independent with her wheelchair. Review of the resident's EMR from 10/01/24 through 10/15/24, revealed the resident required limited to total staff assistance with locomotion on the unit with her wheelchair. On 10/14/24 at 09:40 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the commons area to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests. On 10/15/24 at 12:12 PM, CNA N propelled the resident in her wheelchair from the dining room table to the shower room to toilet. The resident's shoed feet skimmed the floor during the transport. The wheelchair lacked footrests. On 10/16/24 at 09:54 AM, Certified Medication Aide (CMA) S propelled the resident in her wheelchair in the commons area. The resident's shoed feet were tucked underneath the seat of the wheelchair and the toes of her shoes skimmed the floor. The wheelchair lacked footrests. On 10/14/24 at 09:40 AM, CNA M stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. On 10/15/24 at 12:12 PM, CNA N stated the resident's wheelchair did not have footrests because the resident would propel herself in the wheelchair at times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 09:54 AM, CMA S stated the resident would self-propel in her wheelchair at times so staff did not use footrests on her wheelchair. On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's had footrests on their wheelchairs when they were being propelled by staff. On 10/21/24 at 08:57 AM, Administrative Nurse E stated it was the expectation for staff to use footrests while propelling residents in their wheelchairs. The facility policy for Safe Patient Transport in Wheelchair, approved 01/2024, included: Staff shall use a safe technique when transporting residents in their wheelchairs, including ensuring the resident's feet rest comfortably on the footrests. The facility failed to properly position this dependent resident in her wheelchair while propelling her by not having footrests for the resident's feet. - Review of Resident (R)70's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She utilized a wheelchair for mobility with substantial to maximal assistance of staff. The Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA), dated 09/18/24, did not trigger. The care plan for ADLs, dated 09/11/24, instructed staff the resident could utilize a wheelchair, as needed (PRN), depending on her steadiness. Review of the resident's EMR, from 10/01/24 through 10/15/24, revealed the resident required limited to extensive assistance with locomotion on the unit with her wheelchair. On 10/14/24 at 09:24 AM, Certified Nurse Aide (CNA) M propelled the resident in her wheelchair from the dining room to the shower room to toilet. The resident's right foot lacked support and dangled between the footrests of the wheelchair. On 10/14/24 at 12:07 PM, the resident sat in her wheelchair at the dining room table. The resident's feet dangled between the footrests of the wheelchair, several inches above the floor. On 10/16/24 at 07:30 AM, the resident sat in her wheelchair at the dining room table. The resident's right ankle rested on the outer edge of the footrest. On 10/16/24 at 09:17 AM, the resident sat in her wheelchair at the dining room table. The resident's feet were between the footrests of the wheelchair and only the toes of her feet reached the floor. On 10/14/24 at 09:24 AM, CNA M stated she had not noticed the resident's feet not resting properly on the footrests of the wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 09:39 AM, Licensed Nurse (LN) G stated the staff should ensure resident's feet rested appropriately on the footrest of the wheelchair while being propelled by staff. On 10/21/24 at 08:57 AM, Administrative Nurse E stated it was the expectation for staff to ensure resident's feet reached the footrest of their wheelchairs appropriately. The facility policy for Safe Patient Transport in Wheelchair, approved 01/2024, included: Staff shall use a safe technique when transporting residents in their wheelchairs, including ensuring the resident's feet rest comfortably on the footrests. The facility failed to properly position this dependent resident in her wheelchair while propelling her.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 74 residents with 20 residents sampled, including one resident reviewed for respiratory services. Based on observation, interview, and record review, the facility failed to properly clean and maintain a humidifier (a device for keeping the atmosphere moist in a room) in one Resident's (R)27's room. Findings included: - Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/18/24, documented the resident had a diagnosis of dementia with confusion and forgetfulness. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of one, indicating severe cognitive impairment. The care plan, revised 10/14/24, lacked staff instruction regarding the humidifier. On 10/15/24 at 08:00 AM, the resident had a humidifier in her room in the on position with mist coming from the spout of the machine. The spout and nebulizer chamber (a round disc or white circle in the base of the unit that vibrates to create a mist) of the machine had a heavy build-up of a hardened, white substance. On 10/16/24 at 08:00 AM, the resident's humidifier remained in her room with mist coming out of the spout of the machine. The heavy build-up of the hardened, white substance remained in the spout and nebulizer chamber. On 10/16/24 at 09:41 AM, Certified Medication Aide (CMA) R stated she believed the night shift staff was responsible for the care of the resident's humidifier. On 10/16/24 at 09:54 AM, CMA S stated she was unsure of who was responsible for the care of the resident's humidifier. On 10/21/24 at 09:15 AM, Administrative Nurse E stated she was unsure of how often humidifiers should be cleaned and stated the nurses would be responsible for the care and cleaning of the humidifiers. The facility policy for Water Management Program to Reduce Legionella Exposure, revised 0/2018, included: A water management program shall assist in reducing the risk for Legionella from growing and spreading due to residents' usage of devices, such as humidifiers. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to properly clean and maintain this dependent resident's personal humidifier.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 74 residents with 20 residents selected for review, which included one resident reviewed for dialysis (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). Based on observation, interview, and record review, the facility failed to ensure staff provided assessment and monitoring for one Resident (R)2 who received dialysis three times a week. Findings included: - Review of Resident (R)2's medical record revealed diagnoses that included end stage renal (kidney) disease. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). The Quarterly MDS dated [DATE], indicated a BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services. The Cognitive Loss Care Area Assessment (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance. The Care Plan date 08/20/24, instructed staff the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity. Review of the Dialysis Communication form revealed staff to assess the resident's pulse, respirations, blood pressure, temperature, pain level. Staff were to access site evaluation and indication of changes in his condition prior to dialysis, and after the resident returned to the facility from the dialysis treatment. Review of the Dialysis Communication form from 09/23/24 through 10/16/24 revealed the following areas of concern: The form dated 09/30/24, 10/14/24 and 10/16/24 lacked a pre- dialysis and post- dialysis assessment. The forms dated 09/23/24, 09/25/24, 09/27/24, 10/02/24, 10/07/24, 10/09/24 and 10/11/24 lacked post dialysis evaluations. Review of the Nurse's Progress Notes from 09/23/24 through 10/16/24 lacked documentation of pre and or post evaluations of the resident. Interview, on 10/15/24 at 08:58 AM, with the resident, revealed he received dialysis on Monday, Wednesdays, and Fridays. The resident stated he had a fistula (a surgical joining of an artery and vein to use as an access device for the treatment) in his left arm. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 10/21/24 at 11:57 AM, with Licensed Nurse (LN) I, revealed licensed staff should assess the resident prior to going to dialysis and upon return and document the assessments on the Dialysis Communication form, located in a binder that the resident would take to dialysis with him. Interview, on 10/21/24 at 12:15 PM, with Administrative Nurse D, revealed she would expect staff to assess the resident pre and post dialysis and document on the Dialysis Communication form or in a progress note. The facility policy Dialyses reviewed 01/2024, instructed staff to assess the access site for dialysis, and document on the treatment administration record. The policy instructed staff to utilize the communication tool to receive a report on the resident to the community after each session, or if the dialysis center provided a verbal report, staff instructed to document the report in the resident's medical record. The facility failed to evaluate this resident's status pre dialysis three out of 10 dialysis treatments from 09/30/24 through 10/16/24 and failed to evaluate this resident's status post dialysis treatment 10 out of 10 times from 09/30/24 through 10/16/24 to ensure the resident had no adverse effects of the treatment. .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 74 residents with 20 residents selected for review, that included six residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure one Resident (R)2, received medications within the physician ordered parameters. Findings included: - Review of Resident (R)2's medical record revealed diagnoses that included end stage renal (kidney) disease. The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident received dialysis services (a procedure to remove excess toxins and waste products from the blood when the kidneys fail). The Quarterly MDS dated [DATE], indicated a BIMS score of 12, which indicated moderate cognitive impairment. The resident received dialysis services. The Cognitive Loss Care Area Assessment (CAA), dated 02/29/24, assessed the resident received dialysis treatments and was at risk for nutritional and fluid volume imbalance. The Care Plan dated 08/20/24, instructed staff the resident received dialysis treatments and staff were to assess the access site for bleeding and to make sure the blood pressure was stable before the resident resumed activity. A Physician's Order dated 10/10/24, instructed staff to administer Midodrine, (a medication used to increase blood pressure) 10 milligrams, three times a day for low blood pressure and hold if the systolic blood pressure (SBP the first number of the blood pressure which indicates the pressure in the heart when it pumps out blood) is greater than 140 millimeters of mercury (mmHg). Review of the October 2024 Medication Administration Record (MAR) revealed the following areas of concern: On 10/11/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 142/87. On 10/12/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 161/90. On 10/13/24 at 10:00 PM, staff administered Midodrine to the resident with a blood pressure of 152/87. On 10/14/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 152/76. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 174/74. On 10/16/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 143/82. On 10/17/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 175/98. On 10/17/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 144/81. On 10/18/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 152/81. On 10/18/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 153/84. On 10/20/24 at 02:00 PM, staff administered Midodrine to the resident with a blood pressure of 168/100. On 10/21/24 at 06:00 AM, staff administered Midodrine to the resident with a blood pressure of 145/86. Interview, on 10/21/24 at 10:30 AM, with Administrative Nurse E and Administrative Nurse E, confirmed the above and stated they would expect staff to following the parameters as ordered by the physician. The facility policy Health Care Provider Orders reviewed 01/2024, instructed staff to record the medication and any specified parameters with medication orders. The facility failed to ensure staff administered this resident's Midodrine, used to increase blood pressure was administered following the physician's ordered parameters to prevent adverse reactions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 74 residents with 20 residents sampled, that included six residents reviewed for unnecessary medication. Based on observation, interview, and record review, the facility failed to assess one Resident (R)44, for adverse effects of an antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions). Findings included: - Review of Resident (R)44's medical record revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear),and pseudobulbar affect (a neurological disorder that causes uncontrollable and inappropriate episodes of laughing or crying). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of one, which indicated severe cognitive impairment. The resident received antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions). The Delirium Care Area Assessment (CAA) assessed the resident received antipsychotic medication daily for violent behaviors and was stable. The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of one, and the resident received antipsychotic medications. The Care Plan reviewed 09/12/24, instructed staff the resident received antipsychotic medications with Black Box (a safety warning the FDA [Food and Drug Administration] issued for serious side effects of medication) and staff were to monitor for adverse effects due to medications. A Physician's order dated 03/12/24, instructed staff to continue Olanzapine (an antipsychotic) 5 milligrams, daily, for violent behaviors. Observation, on 10/14/24 at 08:57 AM, revealed the resident seated in her wheelchair in the common living area. The resident was tearful, and unable to respond verbally. Observation, on 10/15/24 at 08:10 AM, revealed the resident seated in her wheelchair, feeding herself breakfast. The resident had a flat affect and responded with mumbling nonsensically. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 10/17/24 at 12:30 PM, with Administrative Nurse E, revealed she would expect staff to assess the resident for antipsychotic side effects using the AIMS (Abnormal Involuntary Movement Scale) tool to determine if the resident was experiencing side effects of Olanzapine which included extra pyramidal (a group of side effects that include involuntary movements, tremors, involuntary movements of the tongue) adverse effects. Administrative Nurse E confirmed staff completed the last AIMS on 03/25/24 and staff should assess the resident with the AIMS every three months. The facility policy Behavioral Assessments, Intervention and Monitoring revise 10/2024, instructed staff to ensure he resident has minimal complications associated with the management of altered or impaired behaviors through nonpharmacological or pharmacological interventions. The Interdisciplinary Team will review and discuss interventions and AIMS or other findings. The facility failed to ensure this resident who received antipsychotic medication did not display adverse effects of the medication through assessment of extra pyramidal movements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 74 residents, with 20 sampled. Based on observation, interview and record review, the facility failed to use proper hand hygiene while completing wound care for one Resident (R)27. Findings included: - Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. She was at risk for the development of pressure ulcers (PU) and had no unhealed PU at the time of the assessment. The Pressure Ulcer/Injury Care Area Assessment (CAA), dated 01/18/24, documented the resident spent most of her time in her recliner and required assistance with positioning. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of one, indicating severe cognitive impairment. She was at risk for the development of PUs with no unhealed PU at the time of the assessment. The PU care plan, revised 10/14/24, instructed staff the resident utilized pressure reducing devices for her chair and bed. Review of the resident's EMR revealed a Braden assessment (used to determine the risk of a resident developing a PU), dated 09/24/24, which placed the resident at a high risk for the development of PUs. Review of the resident's skin assessments, included the following: On 10/04/24, the resident developed a stage II PU (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed), that measured 1.2 centimeters (cm) in length (L) by 0.5 cm width (W) by 0.1 cm depth (D), to her coccyx (area at the base of the spine). On 10/09/24, the stage II PU measured 0.8 L by 0.5 cm W by 0.1 cm D. Review of the resident's EMR revealed the following physician's order: Cleanse the wound with wound cleanser, pat dry and cover with a bordered foam dressing, ordered 10/06/24. On 10/16/24 at 09:33 AM, Administrative Nurse F entered the resident's room to change the dressing to her wound. Administrative Nurse F cleansed the wound with wound cleanser and patted the area dry. Administrative Nurse F then measured the wound without changing her gloves or performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 09:35 AM, Administrative Nurse F stated she had not changed her gloves after cleansing the resident's wound and before measuring the wound. She stated she should have changed gloves and performed hand hygiene but did not. On 10/21/24 at 09:15 AM, Administrative Nurse D stated it was the expectation for staff to change gloves and perform hand hygiene after cleansing a wound and before measuring the wound. The facility policy for Wound Care/Dressing Change, revised 05/2023, included: When changing the dressing to a resident's wound staff shall don gloves and cleanse the wound per orders. Staff shall then remove their gloves, perform hand hygiene, and don clean gloves. The facility failed to perform proper hand hygiene while completing this resident's wound care.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 34056 The facility reported a census of 74 residents. Based on observation, interview, and record review, the facility failed to ensure all resident equipment in one of the four neighborhoods were in clean, safe condition, regarding one toilet seat riser with legs and handles. Findings included: - During a brief environmental tour of C Court, on 10/14/24 at 09:25 AM, the following areas of concern were noted: A toilet seat riser had multiple rusty areas over all four legs. The plastic toilet seat had a crack where it met residents' buttocks area. On 10/21/24 at 09:49 AM, Housekeeping/Maintenance Staff U stated the toilet seat riser needed to be thrown away.Housekeeping/Maintenance Staff U stated the facility had extra toilet seat risers available for when one needed replaced. The facility lacked a policy for the maintenance and upkeep of resident equipment. The facility failed to ensure all resident equipment in the C Court neighborhood was clean and in safe condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Via Christi Village Pittsburg Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1502 E Centennial Pittsburg, KS 66762	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35721 The facility reported a census of 74 residents. Based on observation, interview, and record review, the facility failed to ensure a clean environment in one of the four neighborhoods regarding soiled, stained privacy curtains in a shower room in one of the four neighborhoods. Findings included: - During a brief environmental tour of C Court, on 10/14/24 at 09:25 AM, the following areas of concern noted: Two privacy curtains contained multiple areas which were dirty and stained. On 10/21/24 at 09:49 AM, Housekeeping/Maintenance Staff U stated housekeeping was responsible for ensuring the privacy curtains in the shower rooms were clean. The privacy curtains needed to be washed or replaced. The facility lacked a policy regarding the maintenance/cleaning of the shower curtains. The facility failed to ensure a clean environment in one of the four neighborhoods regarding soiled, stained privacy curtains in a shower room in one of the four neighborhoods.