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	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Ridge	3636 North Ridge Rd Bldg 400 Wichita, KS 67205

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 69 residents. The sample included 17 residents, with one resident reviewed for pain and activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to ensure Resident (R) 55 remained free from neglect when the facility failed to provide necessary care and services staff were aware R55 needed and had multiple failures, which resulted in delayed healing, physical discomfort, and decreased quality of life. Findings included:- R55's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), contact dermatitis (skin rash), and overactive bladder. R55's 01/07/26 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. R55's MDS documented no behaviors and minimal depression. R55 required total assistance with toileting hygiene, transfers, and bed mobility. R55 was always incontinent with bladder and had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). R55 had frequent pain and did not receive pain medications as needed in the five-day look-back period. R55 had moisture-associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous). R55's 05/12/25 Pressure Ulcer/Injury Care Area Assessment (CAA) documented R55 required assistance with toileting hygiene and transfers, and documented staff would monitor and assist R55 with peri-care to prevent infection. Staff would administer as-needed pain medications, and non-medication pain relief interventions were in place for her pain. Staff would encourage R55 to turn and reposition to avoid pressure injuries. R55's Care Plan, dated 11/22/24, revealed staff were instructed to provide perineal cleansing and apply a protective skin barrier after each incontinent episode, provide adult briefs, and report signs of impaired skin integrity or breakdown. Staff were to assist R55 to reposition every two to three hours using pillows to offload and for comfort. Staff were to provide treatments as indicated on the physician's orders. Staff were to provide medications for pain as ordered and report uncontrolled pain to the provider. R55's Care Plan, dated 09/29/25, directed staff to offer checks and change (of incontinence brief, if needed) upon getting R55 up for the day, before lunch, before supper, bedtime, and as needed during the night. R55's Care Plan, dated 11/21/25, instructed staff to follow the treatment orders for MASD from the wound care clinic. R55's Care Plan, dated 12/02/25, documented R55 received education on the importance of offloading her buttocks and allowing peri-care, as R55 often chose to spend long amounts of time seated in her wheelchair in urine incontinence. R55's 02/05/25 Physician's Orders documented an order for Tylenol 325 milligrams (mg), administer two tablets by mouth every 12 hours for pain. R55's 02/26/25 Physician's Orders documented an order for Tramadol (controlled narcotic pain medication) 50 mg, administer one tablet, by mouth three times a day as needed for pain. R55's 11/20/25 Physician's Orders documented an order to cleanse the bilateral buttocks, left and right posterior thighs twice a day with Vashe wound solution (wound cleanser containing pure hypochlorous acid to clean, irrigate, and debride acute and chronic wounds). Cleanse the perineal area with Baza cleanser (cleans and protects perineal area) and water with each (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 0600 Level of Harm - Actual harm Residents Affected - Few	incontinence episode, and apply Critic-aide clear or could substitute with A&D ointment for irritant contact dermatitis. R55's 01/27/26 Physician's Orders documented an order for Tramadol 50 mg, administer two tablets, by mouth, every eight hours for pain. R55's . Wound Healing Note (provided by the wound clinic), dated 09/16/25, documented the resident had irritant contact dermatitis to all skin areas. The left posterior thigh measured 6.8 centimeters (cm) by 3.1 cm by 0.1 cm with a moderate amount of serous (thin, clear) drainage. The left buttock measured 11 cm by 4.5 cm by 0.1cm with a low amount of serous drainage. The right buttock measured 10.8 cm by 5.9 cm by 0.1 cm with a low amount of serous drainage. The right posterior medial thigh measured 3.5 cm by 5.5 cm by 0.1 cm with a low amount of serous drainage. The areas appeared as chronic incontinence burn/incontinence dermatitis, with moisture and shearing contributing. The note documented goals which included a high-protein diet, vitamin supplementation, adequate hydration, and a return to the clinic in one week. R55's . Wound Healing Note, dated 09/23/25, documented no significant improvement to the buttocks. The resident and family were frustrated with the care at the facility. They were encouraged to discuss this with the facility. R55's . Wound Healing Note, dated 10/06/25, documented that the tissue remained red in appearance, but improvement was noted. The resident and family reported the facility had improved with more frequent incontinence care over the past week. R55's Skin Evaluation Form, dated 11/06/25, documented a MASD area on the resident's left groin with an original date for the skin area of concern on 08/21/25. The form documented left groin MASD, which was red in color and measured 10 cm by 15 cm. R55's Skin Evaluation Form, dated 12/10/25, documented a MASD area on the left posterior thigh with an original date of skin area of concern on 09/25/25. The form documented the left posterior thigh had MASD, which was red and irritated and measured 18 cm by 11 cm. R55's Skin Evaluation Form, dated 11/12/25, documented a MASD area on the right buttock with an original date of skin area of concern on 09/25/25. The form lacked a description of skin and recorded measurements of 11.5 cm by 5.5 cm. R55's . Wound Healing Note, dated 11/18/25, documented ulcers that were noted to be all similar in appearance that day. The writer conducted an examination for an ulcer that was resistant to healing despite numerous interventions. The plan was to examine any underlying conditions that impeded healing. The note documented R55 was incontinent of urine, was continuously dribbling, and a recommendation was made to the resident's family and resident, which included to talk to her provider about obtaining a Pure Wick (a non-invasive, external urine collection device designed to manage female urinary incontinence by using low-pressure suction to pull urine away from the body into a canister) or if unable to, consider placing a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). R55's . Wound Healing Physician's Orders, dated 12/05/25, noted the Advanced Practice Nurse Practitioner (APRN) ordered a Pure Wick for the use of diverting urine. The resident was incontinent of urine, and the Pure Wick was to be used when R55 was in bed. R55's EMR lacked evidence of the facility following up on the above recommendations and orders. R55's . Wound Healing Note, dated 12/09/25, documented the resident had severe pain from the irritant contact dermatitis at an eight on a scale of zero to 10. The pain was intermittent. The note documented that the APRN had ordered a Pure Wick system on 11/18/25, but the facility had not provided her with the Pure Wick system as of 12/09/25. The family would have a meeting with the facility's Director of Nursing. The note documented that it was unlikely for R55's skin to improve fully without diversion of urine. R55's Nurse Progress Note, dated 12/09/25 at 09:48 AM, documented staff received orders from the wound clinic that included an order for a Pure Wick. Administrative Nurse D called the wound clinic and spoke to the staff at the clinic. Administrative Nurse D informed the clinic that the facility was unable to complete the order as the facility did not have Pure Wick devices, and the resident did not have a diagnosis that was appropriate for a Pure Wick or a Foley catheter. A fax sent on 12/22/25 from the wound clinic to the facility included a medical letter of necessity for a Pure Wick system and documented the ongoing moisture exposure, which placed the resident at risk for worsening dermatitis and skin maceration, secondary skin infections, pain, and impaired quality of life. R55's Via [NAME] Wound Healing Note, dated 01/13/26, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	documented the left posterior thigh MASD on the resident measured 16.5 cm by 24 cm. The left buttock area measured 10 cm by 4.5 cm, and the right buttock measured 13 cm by 7.5 cm. The right posterior thigh area measured 6 cm by 9 cm. R55's .Urology Note, dated 01/28/26, documented the resident had chronic urine leakage worsening over three years and complicated skin wound healing due to constant moisture. The wounds located on her legs and bottom were managed by the wound clinic. The wound clinic emphasized the necessity of maintaining dry skin to facilitate healing, yet the nursing facility faced obstacles in implementing long-term solutions like a Pure Wick device. The treatment plan recommended Pure Wick for three months to support wound healing by keeping skin dry and listed an alternative plan, if Pure Wick was declined by the facility, was to consider an indwelling Foley catheter. R55's Nurse Progress Note, dated 1/28/26 at 11:53 AM, the resident returned from a urology consult with an order from the physician for a Pure Wick external catheter for 3-6 months on continuous suction. Staff called the physician at the urology office and left a message with the nurse that the facility was unable to complete the order at that time. The note indicated the order was reviewed with Physician Provider HH, who instructed staff not to complete the order for the Pure Wick at that time, and R55's family member was updated; R55's family member reported to the facility to watch for an order from the urologist for an internal (indwelling) catheter. R55's Skin Evaluation Form, dated 01/28/26, documented the right buttock MASD had redness and measured 11cm by 5 cm. R55's Skin Evaluation Form, dated 02/04/26, documented that the left groin MASD was red in color and measured 9 cm by 13 cm. R55's Skin Evaluation Form, dated 02/04/26, documented the left posterior thigh MASD was red with intact skin and measured 16 cm by 9 cm. During an observation on 02/09/2026 at 10:22 AM, R55 sat in her wheelchair and played the piano. R55 reported she had a sore on her left leg from her hip to her knee. That caused her a lot of pain, and the urologist and wound clinic she had been to recently ordered a catheter to heal the wounds. R55 reported that Physician Provider HH would not allow R55 to have a catheter. R55 was very teary-eyed when she spoke. During an interview on 02/09/26 at 10:30 AM, R55's family member reported R55 had been dealing with her wounds for the past six months and reported R55 went to the wound clinic and a urologist, who both recommended a Pure Wick system or an internal catheter. R55's family member reported the provider at the facility would not follow the recommendations. R55 and the family member were both crying when they spoke. They stated R55 was supposed to be in bed by 10:00 AM to offload. During an observation on 02/09/26 at 10:35 AM, Certified Nurse Aide (CNA) N answered the resident's call-light and told R55 it would be 30 minutes before staff could assist her back to bed because the lift was not available. During an observation on 02/09/26 at 11:05 AM, CNA N and CNA O assisted R55 into bed and began incontinence care. CNA N and CNA O provided incontinent care to R55. Observation revealed large, very bright red, shiny skin areas that covered the back of both thighs, inner thighs, buttocks, and coccyx area. R55 winced in pain and cried when CNA N cleansed and applied the A & D ointment to all the red areas. R55 asked CNA N to let the nurse know she was hurting badly and needed a pain pill. CNA N nodded her head yes. R55 asked CNA N to turn on the television to help her keep her mind off the pain. During an interview on 12/09/26 at 01:29 PM, CNA N reported she told Licensed Nurse (LN) H around 11:15 AM that R55 requested pain medication. CNA N reported that R55 would complain of pain every time she received incontinent care. During an interview on 12/09/26 at 01:34 PM, LN H reported the CNA N did not notify her that R55 requested pain medication around 11:00 AM and reported she had just administered R55 the scheduled pain medication about 20 minutes prior. During an interview on 12/09/26 at 01:42 PM, R55 reported she received pain medication about 20 minutes prior and reported it took the nurse a long time to get her pain medication. R55 was tearful when she spoke. During an interview on 02/10/26 at 10:22 AM, CNA N reported R55 never refused to go back to bed and always allowed the staff to complete incontinent care. CNA N reported sometimes R55 would not allow the CNAs to apply the A&D ointment after she was cleansed, but never refused to have incontinent care. During an interview on 02/10/26 at 10:30 AM, LN H reported R55's skin was the same for about six months. LN H reported R55 went to the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	wound clinic for about four months, had several different treatments ordered, and her skin had not healed. LN H stated any discussion about a Pure Wick or a Foley catheter would have to be with Administrative Nurse D. During an interview on 02/10/26 at 10:52 AM, Physician Provider HH reported the discussion about the Pure Wick and Foley catheter would have to be with Administrative Nurse D. Physician Provider HH reported she was told by Administrative Nurse D that she could not order a Foley catheter for R55 because R55 did not have an appropriate diagnosis. Physician Provider HH nodded her head yes when asked if she thought R55 would benefit from a Foley catheter. Physician Provider HH reported she expected the staff to administer pain medication as ordered and reported it was unacceptable that R55 had to wait two hours for a pain pill. During an interview on 02/10/26 at 04:30 PM, Administrative Nurse D reported R55 could not have a Pure Wick system at the facility because it would be unsafe for her to have one. Administrative Nurse D reported R55 did not have an appropriate medical diagnosis or a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) or higher wound to justify the Foley per her understanding of the state regulations. Administrative Staff A reported R55 would not be able to have the Pure Wick system at the facility, as they did not use those devices at the facility and had no way to have continuous suction. Administrative Staff A reported the Pure Wick and Foley orders, and the discussion was all coming from R55's family member, who just wanted things for R55 that she really did not need, and reported that the facility had several interdisciplinary meetings weekly with R55's family member about his concerns. Administrative Staff A reported R55 would refuse to have incontinent care provided and refused to offload the areas, and that R55 liked to be up in her wheelchair. Administrative Nurse D reported that she did not know if R55 had increased pain, but said she expected the nurse to administer pain medication as needed per orders. Administrative Nurse D reported that R55's skin had not improved with all the treatment changes ordered from the wound clinic. During an interview on 02/11/26 at 10:11 AM, Administrative Nurse D reported she had not spoken to the urologist who gave an order for a Foley catheter; she spoke to the nurse at the urology office, and a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) was discussed. Administrative Nurse D reported the supra-pubic catheter would be too invasive for R55 and that R55 did not qualify for a catheter. During an interview on 02/11/26 at 11:27 AM, Consultant Staff JJ (Wound Clinic LN) reported the provider at the wound clinic recommended and sent an order to the facility for a Pure Wick system, and the facility refused to allow the Pure Wick. Consultant Staff JJ reported R55 had a consultation with a urologist and thought R55 would have a Foley catheter placed and that the urologist would handle the urine diversion device to assist in healing R55's wounds. Consultant Staff JJ reported that a high-protein diet, vitamins, and supplements were a goal on R55's first visit, 09/16/25, and thought the facility would have ordered them. During an interview on 02/11/26 at 11:56 AM, Physician Provider II reported R55 could not use a Pure Wick system at the facility as it would not be beneficial for her and would cause more skin breakdown. Physician Provider JJ reported R55 was assessed by Physician Provider HH and was seen often and had adjusted R55's pain medication. Physician Provider II reported that the facility reported to her that R55 would refuse incontinent care and refuse to offload, and that was a concern. Physician Provider II reported R55 did not really qualify for a Foley catheter. Physician Provider JJ also reported that a catheter would cause more concerns, such as urinary tract infection (UTI- an infection in any part of the urinary system). Physician Provider JJ expected staff to administer as-needed pain medication if available, and was concerned that R55 waited two hours for pain medication. During an interview on 02/11/26 at 01:15 PM, Consultant Staff KK (Registered Dietitian) reported that he did not know that R55 had wound notes from the wound clinic that recommended a high protein diet. Consultant Staff KK reported that R55 was not on a high-protein diet and did not require a high-protein diet related to contact dermatitis. During an interview on 02/11/26 at 01:40 PM, Administrative Nurse D reported a resident who had unhealing wounds should receive high protein per provider orders/recommendations. Additionally, they should receive supplements and vitamins. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Administrative Nurse D reported that the facility would normally not provide a high-protein diet and vitamins for residents with MASD, and she reported that R55 was not healing and did not know that the wound clinic notes had goals for high protein and vitamins. Administrative Nurse D reported she had not read the wound clinic notes and that the floor nurses would read the wound notes. The facility's Abuse Prevention Policy documented that the residents have the right to be free from abuse, neglect, and to be protected from abuse and neglect from community associates. The facility's policy Pain, dated 12/2025, documented that the physician and associates would identify individuals who have pain or who are at risk for pain. Administer pain drugs on a regular basis to maintain therapeutic levels and use as-needed medications for breakthrough pain.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility reported a census of 69 residents. The sample included 17 residents. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and failed to follow appropriate infection control practices related to hand hygiene, sanitization of shared equipment, and sanitary storage of respiratory equipment. Findings included:1. On 02/09/26 at 11:05 AM, Certified Nurse Aide (CNA) N and CNA O assisted R55 to bed using the mechanical lift. R55 had a colostomy (a surgical creation of an artificial opening on the stomach wall to excrete feces from the body). CNA N and CNA O did not apply a gown during this care. CNA N used her gloved hands to open R55's drawer to retrieve the hygiene wipes. She wiped the red areas of R55's inner thighs several times using that same wipe. Staff assisted R55 to her side, and CNA N washed the resident's buttocks. Wearing the same gloves, she sprayed perineal lotion into her gloved hand and then mixed A&D ointment on the same gloved hands and applied the mixture to R55's buttocks. Wearing the same gloves, CNA N grabbed the bottle of perineal lotion and the A&D ointment tube, mixed more up in her gloved hands, and applied it to the resident's coccyx (the area of the buttocks at the end of the spine). CNA N removed her gloves and reapplied new gloves without performing hand hygiene and proceeded with cleansing R55's front perineal area. CNA N and CNA O pushed the mechanical lift out of the resident's room into the hallway without sanitizing the lift or sanitizing their hands after removing their gloves. On 02/09/2026 at 01:29 PM, CNA N and CNA O agreed they should have worn a gown while providing care for a resident who required EBP. CNA N stated she did not realize she had used her gloved hand to touch the resident's dresser. Both CNA N and CNA O confirmed they should sanitize the mechanical lift after each use to prevent cross-contamination and the spread of infection. On 02/10/26 at 10:30 AM, Licensed Nurse (LN) H reported that she expected the staff to sanitize their hands when they remove gloves and expected staff to wear the required PPE for EBP, which includes gowns when providing direct care, such as incontinence care; additionally, staff should sanitize the mechanical lift between residents' use. 2. On 02/09/26 at 10:14 AM, R6 was in bed with his oxygen tubing wrapped around the concentrator and hanging without a cover. Her nebulizer mask mouthpiece lay directly on the table, uncovered, with clear liquid in it. On 02/09/26 at 01:54 PM, R6 reported she received breathing treatments last evening, but she did not know if the staff rinsed the equipment. Observation revealed the nebulizer mouthpiece remained touching the nightstand and still had clear liquid in the chamber. Her continuous positive airway pressure (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask lay directly on the nightstand. Her oxygen tubing was wrapped around the oxygen tank on the back of her wheelchair, with the nasal cannula touching the tank. On 02/10/26 at 04:13 PM, CNA P reported that a nasal cannula and CPAP mask should be placed in a bag, though sometimes the CPAP masks were placed in a sanitizer box if the resident had one. CNA P stated the nurse took care of the nebulizer equipment. On 02/10/26 at 04:18 PM, CNA P reported that R6 did not have a sanitizer box in her room for her CPAP mask and said the nasal cannula with oxygen tubing should be placed in a bag.On 02/10/26 at 09:17 AM, LN J reported that once a nebulizer treatment was administered by the nurse, the equipment should be taken apart, rinsed, and air dried; it usually would then be placed in a bag or a pencil box. She reported she had not yet given R6 breathing treatment that day. LN J reported that when a nasal cannula was not in use, it should be placed in a bag, and the same for a CPAP mask. On 02/11/26 at 04:25 PM, Administrative Nurse D reported she expected staff to wipe off the mechanical lift with a sanitizer wipe after each use. She expected the staff to wash their hands after they removed their gloves before applying new gloves, and not use gloves for personal care after touching drawers and handles on the resident's furniture. She expected the respiratory equipment to be stored in the correct way, which was in a bag or box, to prevent contamination and the spread of infection. Administrative Nurse (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D stated the staff should use EBP when giving direct care to residents who have an artificial opening in their body, such as a colostomy, including a gown. The infection Control Policy titled Personal Protective Equipment, dated 02/2025, included that personal protective equipment appropriate to specific task requirements should be used when indicated for isolation precautions to prevent the spread of infection, to protect wounds from contamination, and to protect hands from potential infectious material. The staff is to perform hand hygiene when removing gloves, and when the use of gowns is indicated, all personnel must put on gowns before treating a resident. The policy lacked addressing the storage of respiratory equipment and tubing when not in use and/or the sanitation of mechanical lifts between resident use.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 69 residents. The sample included 17 residents with five reviewed for discharge and two for hospitalization. Based on interviews and record review, the facility failed to provide a written bed hold policy at the time of transfer for Resident (R)75 and R3. Findings included: 1. R75's Electronic Medical Record (EMR) recorded an admission Minimum Data Set (MDS) dated [DATE], which documented, per staff interview, that the resident had short-term and long-term memory problems. The resident admitted on [DATE]. R75's Nursing Progress Notes, dated 01/05/26 at 05:37 PM, documented the nurse called emergency services based on a physician order to send the resident to the hospital. The resident was transferred to the hospital on [DATE] at 05:15 PM. The Transfer Form, dated 01/05/26 at 04:03 PM, documented the facility would provide the resident and/or representative with a bed hold that included the daily room rate and duration of the bed hold prior to transfer. However, the documentation lacked evidence that a written bed hold was provided for the transfer. 2. R3's admission MDS, dated 07/19/25, documented a Brief Interview for Mental Status (BIMS) score of 13, indicating cognition intact. On 08/11/25 at 07:31 pm, the resident was sent to the hospital short of air/breath (SOA). On 02/10/26 at 08:13 AM, R3 was in bed. She stated she had transferred to the hospital on multiple occasions and went on to say she was not made aware of a bed hold policy. She reported she did not recall being provided with a written bed hold when she transferred to the hospital. On 02/10/26 at 03:56 PM, Licensed Nurse (LN) H reported that when a resident was transferred to the hospital, the nurse would send the Transform Form. She would not give the residents a written bed hold form, which included the room rate and duration of bed hold prior to transfer. LN H said Social Service X did that. On 02/10/26 at 05:04 PM, Social Service X reported that she would send the bed hold, which included duration and room rate, via certified mail, when a resident was sent to the hospital. She could not provide the documented evidence of a written bed hold sent to the residents and/or their representative. On 02/11/26 at 09:55 AM, Social Service X reported that she did not provide the bed hold when residents were transferred to the hospital; she stated the nurses would provide that prior to transfer to the hospital. On 02/11/2026 at 01:51 PM, Administrative Nurse D verified the lack of a written bed hold in the resident's EMR, which included the daily room rate and/or the duration of the bed hold. Administrative Nurse D stated she did not know who was responsible for providing the residents and/or representatives with a written bed hold policy. On 02/11/26 at 02:06 PM, Administrative Staff A reported that Social Service X did not provide the written information when residents transferred to the hospital because they were unaware that it was required for Medicaid residents. The undated facility Bed-Holds and Returns Policy documentation included that prior to transfer, written information will be given to the resident and the representatives, which explains in detail the duration of the bed hold, the reserve bed payment policy as indicated by the state plan.

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	175539	A. Building B. Wing	02/11/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 69 residents. The sample included 17 residents. Based on interview, observation, and record review, the facility failed to provide services to meet professional standards of care when staff failed to ensure Resident (R) 7's Electronic Medical Record (EMR) contained appropriate documentation for the schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) diagnosis. Findings included:- R7 's EMR revealed diagnoses of schizophrenia, and dementia (a progressive mental disorder characterized by failing memory and confusion). R7's Annual [NAME] Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R7's MDS revealed a diagnosis of schizophrenia. R7's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 09/30/25, documented R7 was at the facility for long term care. R7 had dementia and required staff to assist with activities of daily living. R7's Quarterly MDS, dated 07/28/25, documented a BIMS score of 12 and revealed a diagnosis of schizophrenia. R7's Care Plan, dated 09/22/21, documented R7 documented had a diagnosis of schizophrenia and would remain stable. Staff provided education to monitor behaviors, provide support as needed. R7's Care Plan, dated 09/22/21, documented R7 had a potential for drug related complications associated with use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use for schizophrenia. R7's Physician Orders ordered Zyprexa (antipsychotic medication), 5 milligrams (mg) by mouth every day, for schizophrenia, date ordered 11/23/21. R7's Psychological Evaluation, dated 09/10/1979, lacked schizophrenia as a diagnosis. R7's Basic Psychological Evaluation, dated 06/17/1982, lacked schizophrenia as a diagnosis. R7's Psychological Evaluation dated 09/29/2003, lacked schizophrenia as a diagnosis. R7's History and Physical dated 04/07/2017, lacked schizophrenia as a diagnosis. R7's Client, Assessment, Referral, and Evaluation, dated 04/18/2017, indicated R7 had not been diagnosed with a serious mental disorder. R7's Physician Orders ordered Zyprexa, (antipsychotic medication) 5 milligrams (mg) by mouth every day, for schizophrenia, date ordered 11/23/21. R7's Psychotropic Medications Risk, Benefit and Consent, dated 12/08/22, documented reason for use of medications diagnosis of schizophrenia. During an observation on 02/10/26 at 07:58 AM, R7 ambulated to the dining room with staff. He had a smile, and he was very friendly. During an interview on 02/11/26 at 08:36 AM, Administrative Nurse E reported that R7 did have a diagnosis of schizophrenia when he was admitted to the facility on [DATE]. Administrative Nurse E revealed an admission document Basic Psychological Evaluation, dated 06/17/1982, with a documented diagnosis of schizoid personality traits (personality disorder marked by a lack of desire for relationships and emotional coldness). Administrative Nurse F reported she thought it was a diagnosis for schizophrenia and had updated R7's diagnoses list in EMR on 09/03/21 with the diagnosis of schizophrenia. During an interview on 02/11/26 at 03:30 PM, Consultant Staff GG reported she thought R7 had the required documentation in his EMR for the diagnosis of schizophrenia. During an interview on 02/11/26 at 04:45 PM, Administrative Nurse D reported she expected the residents EMR to reflect their accurate diagnoses. The facility did not provide a policy for professional standards of care in diagnosing schizophrenia for use with antipsychotics.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** The facility identified a census of 69 residents. The sample included 17 residents with two residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to ensure staff provided ADL assistance with personal hygiene for Resident (R) 55 and R63, who did not receive fingernail care and facial hair removal, and R8 who did not receive staff assistance to get dressed. Findings included:1. R55's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), contact dermatitis (skin rash), and overactive bladder. R55's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. R55's MDS documented that she had no rejection of care during the observation period and minimal depression. R55's MDS documented that she required total assistance with personal hygiene. R55's Care Plan, dated 11/22/24, documented R55 had neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) to her hands. Staff were instructed to provide assistance with her ADL. During an observation on 02/09/26 at 10:31 AM, R55 had several long white facial hairs approximately half inch on her face. She reported she was unable to remove them and would like the staff to remove them but went on to say the staff would not do that for her. During an observation on 02/10/26 3:50 PM, R55 lay in her bed as she watched television. Several long white facial hairs remained on her face. During an observation on 02/11/26 at 09:20 AM, R55 sat in her wheelchair in the beauty shop. Her facial hairs were unchanged from previous observations. 2. R63's EMR recorded diagnoses of hemiplegia (paralysis of one side of the body) following a 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) which affected her right side, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and need for assistance with ADLs. R63's Annual MDS, dated [DATE], documented a BIMS of 14, which indicated moderately impaired cognition. R63's MDS documented that he had no rejection of care during the observation period and minimal depression. R63's MDS documented that he required maximal assistance with personal hygiene and had impairment of one upper extremity. R63's Care Plan, dated 09/23/25, documented staff instructed that R63 required extensive assistance with one person staff support for hygiene. During an observation on 02/09/26 at 10:47 AM, R63 was lying on his bed observed a right hand contracture (abnormal permanent fixation of a joint or muscle). R63 turned his arm and revealed long fingernails that were cutting into the right palm of his hand causing red marks. He reported that he could not cut his nails. A right arm/hand splint lay on his windowsill. During an observation on 02/10/2026 at 10:40 AM, R63 was seated upright in his bed with his right-hand splint on. He reported that staff had not cut his nails yet, and observation revealed long fingernails on his right hand. During an observation on 02/10/2026 at 12:30 PM, R63 was seated was seated in his wheelchair at the dining room table eating his lunch. R63's splint was off his right hand, Certified Nurse Aide (CNA) S asked R63 where his right-hand splint was. R63 pointed at CNA Q. CNA Q reported she had removed the splint to transfer R63. R63's right-hand fingernails remained long, and observation revealed red lines on the palm of his right hand. 3. R8's EMR revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), acoustic neuroma (typically slow-growing tumor that develops on the main nerve connecting the inner ear to the brain) with hearing loss, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R8's Significant Change MDS, dated 06/05/25, documented the resident had a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented R8 required moderate assistance with dressing. The MDS documented R8 had no rejection of cares during the observation period. R8's ADL Functional/Rehabilitation CAA, dated 06/10/25, documented R8 required moderate assistance with dressing related to cognition and fall (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk. R8's Care Plan, dated 02/28/25, directed staff R8 required limited assist of one staff member for dressing. During an observation on 02/09/26 at 10:56 AM, R8 sat in his wheelchair in his room. He wore a blue long sleeve shirt and an incontinence brief. R8 reported he was sitting half naked. During an observation on 02/10/26 at 08:06 AM, R8 sat on the side of his bed with gripper socks on. He leaned towards his right side, propped up by his elbow. R8 wore the same blue long sleeve shirt from previous observation. During an interview on 02/10/2026 at 10:22 AM, CNA N reported that R55 did not refuse care and required assistance with all her ADLs. During an interview on 02/11/26 at 09:23 AM, CNA Q reported R55 would allow staff to remove her facial hair and would be provided on her shower days. CNA Q reported that fingernails were trimmed or filed on shower days too. During an interview on 02/11/26 at 09:30 AM, Licensed Nurse (LN) I reported that R8 could not dress himself but said the resident would allow staff to dress him. LN I reported that the residents would have their fingernails cleaned and cut when they have a shower, and they would have their facial hair removed on shower days and as needed. During an interview on 02/11/2026 at 04:10 PM, CNA P reported that R63 did not refuse care and required staff to assist with his personal hygiene. During an interview on 02/11/26 at 04:30 PM, Administrative Nurse F said she expected that staff to assist residents with removal for facial hair and filing/trim fingernails as resident/family preferred. The facility did not provide a policy for ADLs for dependent residents.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 69 residents. The sample included 17 residents with one reviewed for hearing aid use. Based on interview and record review, the facility failed to ensure Resident (R) 8 received the necessary services, including staff assistance, with his hearing devices. Findings included: - R8's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), acoustic neuroma (typically slow-growing tumor that develops on the main nerve connecting the inner ear to the brain) with hearing loss, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R8's Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R8 required moderate assistance with personal hygiene. The MDS noted R8 had minimal difficulty with hearing and R8 used hearing aids. R8's Communication Care Area Assessment (CAA), dated 06/10/25, documented R8 had acoustic neuroma with hearing loss of his right ear and used a hearing aid for his right ear; R8 was deaf in the left ear. R8's Care Plan, dated 02/14/25, directed staff R8 wore a right ear hearing aid; staff were to place important items within his reach. During an observation on 02/09/26 at 10:56 AM, R8 sat in his wheelchair wearing only a brief and a blue long sleeve shirt. His hearing aid was in a dish on the table to the left of R8, outside of his reach. R8 reported he had a hearing aid and did not know where it was. R8 said he needed staff to put it in his ear. During an observation on 02/10/26 at 10:37 AM, R8 sat in his wheelchair. His eyes were closed and there was no hearing aid in his right ear. R8 reported he did not know where his hearing aid was. During an observation on 02/11/26 at 09:21 AM, R8 sat in his wheelchair eating breakfast as he watched television. He did not have a hearing aid in his right ear. His hearing aid was in the dish on the table to the left of R8 and outside of his reach. During an interview on 02/11/26 at 09:23 AM, Certified Nurse Aide (CNA) Q reported that R8 would play with his hearing aid, and the staff should apply it to his ear. CNA Q reported that R8 would usually lose the hearing aide in bed. CNA Q reported that the hearing aid was kept in the dish on R8's nightstand to keep track of it. CNA Q verified that R8 could not apply his hearing aid by himself. During an interview on 02/11/26 09:30 AM, Licensed Nurse (LN) I reported she expected the CNAs to follow R8's Care Plan and apply his hearing aid when they first got him up in the morning. LN I reported the residents kept their hearing aids in their rooms. During an interview on 02/11/26 at 04:10 PM, CNA P reported that R8 required assistance with his hearing aid and reported that she placed his right hearing aid in his right ear that afternoon. CNA P reported that R8 would not refuse his hearing aid. During an interview on 02/11/26 at 04:30 PM, Administrative Nurse F said she expected staff to assist residents with their hearing aids. The facility's policy Care of the Hearing-Impaired Residents, dated 01/2026, documented the purpose of this procedure was to provide guidelines when providing care to the residents with hearing impairment, motivate residents to use hearing aid if ordered, and assist residents to adjust the different sounds of a hearing aid.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 69 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to ensure Resident (R) 31 remained free from significant medications errors when staff held metoprolol without a physician's order and did not contact the physician regarding the held medication. Findings included: - R31's Electronic Medical record (EMR) revealed the following diagnosis: hypertension (elevated blood pressure). R31's admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The medication section did not indicate hypertension. R31's Quarterly MDS, dated 02/02/26, indicated no changes to R31's BIMS or medications. R31's Care Plan, dated 11/06/25, noted R31 had hypertension and documented it would remain stable. Staff were to monitor R31's blood pressure and monitor and report side effects of medication. The plan directed staff to inform the physician of any concerns. R31's Physicians Orders, dated 11/06/25, noted an order for metoprolol (medication used to lower blood pressure), tab 25 milligrams (mg) by mouth twice a day for hypertension. R31's Nurses Notes, dated 01/03/26 at 10:01 AM, documented that metoprolol 25 mg was held for a blood pressure of 107/60 millimeters (mm) of Mercury (Hg). The notes lacked an indication that the physician was notified to obtain a hold order or to alert of the blood pressure reading. R31's Progress Notes, dated 01/21/26 at 09:01 AM, documented that R31's metoprolol 25 mg was held for a blood pressure reading of 98/63 mmHg. The notes lacked an indication that the physician was notified to obtain a hold order or to alert of the blood pressure reading. R31's Nurses Notes, dated 01/30/26 at 08:17 AM, documented that metoprolol 25 mg was held for a blood pressure reading of 94/78 mmHg. The notes lacked an indication that the physician was notified to obtain a hold order or to alert of the blood pressure reading. On 02/11/26 at 10:20 AM, Licensed Nurse (LN) G said that nurses should notify the physician if the metoprolol was held. LN G confirmed there was no order and no ordered parameters to hold the medication. On 02/11/26 at 10:50 AM, Administrative Nurse D said she expected the nursing staff to contact the physician and obtain orders for holding medications or for parameters if needed. On 02/11/26 at 03:46 PM, Consultant Staff GG said she reviewed the EMR for trends and to see if medications were being held. She said if medications were being held, the medications may need to be readjusted. She said staff should be contacting the physician with any medication that was held, and the facility should have a policy on this. The facility's policy Clinical Protocol: Guidelines for Notifying Health Care Providers (physicians) of Clinical Problems documented the guidelines are to help ensure that medical care problems are communicated to the health care provider efficiently and effectively, and all significant changes in resident status are assessed and documented in the medical record, immediate notification should occur as soon as possible, and the health care provider should be informed at the time of the event.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 69 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment for residents and staff in the facility laundry. Findings included:- On 02/11/2026 at 12:30 PM, the tour of the facility laundry with Laundry/Housekeeping Staff U and Maintenance Staff V revealed the following concern. Three linen bins had soiled laundry, but were not covered. A 10-foot by four-inch area on the wall had peeling, unsealed, and unsanitary sheetrock. Two clean linen storage bins used for the delivery of clothes throughout the facility had frayed, unsanitary fabric around the top of the bins in an area that would have direct contact with clothes. On 02/11/26 at 12:53 PM, Laundry Staff U and Maintenance Staff V confirmed the above findings. They reported they were unaware that the soiled linen should be covered and were unaware of the inability to sanitize the clean clothes bins due to the frayed fabric. The staff verified that the sheetrock along the wall was unsealed and needed repair. Laundry Staff U reported the damaged sheet rock was due to the staff running the laundry carts into the wall. The facility did not provide a policy to address the above concerns.