STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175543	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living via Christi Village McLean	777 N McLean Blvd Wichita, KS 67203

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 32 residents, with 12 residents sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on observation, interview and record review, the facility failed to ensure one resident's advanced directives were thoroughly completed when Resident (R)34 had a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) which was only signed by two licensed nurses as a verbal order and lacked a physician signature rendering it invalid. This placed the resident at risk for an impaired right to have advance directives honored. Findings included:- R34 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R34's Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS recorded no behaviors. R34 was totally dependent with activities of daily living (ADL) including bathing, toileting, dressing, footwear, transfers, and personal hygiene. The MDS recorded R34 required maximal assistance with oral care and moderate with assistance with eating. The MDS recorded R34 received an antianxiety (a class of medications that calm and relax people), and an antidepressant (class of medications used to treat mood disorders) on a routine basis. R34's Psychotropic Drug Use Care Area Assessment (CAA) documented R34 had significant behaviors and remained on multiple medications to help manage. Staff would continue to monitor for behaviors and undesired effects related to her medication. She was on hospice services and was anticipated to have a decline in all care areas. R34's Quarterly Minimum Data Set, dated [DATE], documented the resident had a BIMS score of zero, which indicated severely impaired cognition. R34 was totally dependent with all ADLs. The MDS recorded R34 received antianxiety and antidepressant on a routine basis, and no behaviors. R34's Care Plan 10/16/24 documented R34 would have advance directives reviewed upon admission and at least annually. R34's Physician's Orders documented a DNR order, date ordered 10/16/24. R34's EHR, under the scanned document section, revealed a DNR, signed 09/15/22 by two nurses, that lacked a physician or provider signature. During an observation on 08/13/25 at 08:50 AM, R34 was sitting in her high-back wheelchair, and she had her right-hand splint on. During an interview on 08/13/25 at 10:00 AM, Licensed Nurse (LN) G reported that the Social Service Designee (SSD) X was responsible for obtaining the advanced directives for the residents. LN G reported that all DNRs required a physician's signature. During an interview on 08/13/25 at 04:00 PM, SSD X reported she was responsible for completing the advanced directives and stated that R34's current DNR, dated 09/15/22, in the EHR lacked a physician's signature. During an interview on 08/14/25 at 04:30 PM, Administrative Nurse D reported that she expected the DNRs to be signed by the physician. The facility's policy Advanced Directives dated 06/2025 documented it is the policy of Ascension Living to inform residents/resident representatives about Advance Directives, to assist those who wish to complete Advance Directives, honor choices identified in the Advance Directives, and to maintain records in accordance with federal, state law, and community policy.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility reported a census of 32 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure the correct and complete Beneficiary Protection Notification forms were issued to one of three residents reviewed, Resident (R) 27. This placed the resident at risk for uninformed decisions.Findings included:- On 08/13/25 a review of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-20052 (SNF ABN) revealed the facility lacked a completed form for R27. R27's Notification of Medicare Non-Coverage Form 10123(NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) was signed on 05/21/25. Last covered day of service was 05/23/25. R27 remained in the facility for long-term care.R27's 05/08/25 Progress Note at 01:48 PM documented R27 was admitted from hospital for skilled nursing care/rehab.R27's 05/23/25 Physical Therapy Discharge Summary documented R27 was discharged from physical therapy to reside in this long-term care facility. Goal partially met with level of assistance with the use of a front-wheeled walker, stand-stepping with cues for safety awareness to decrease risk for falls.During an interview on 08/13/25 12:45 PM, Administrative Staff A reported she could not locate the SNF ABN for R27 and would continue to try to locate the form. Administrative Staff A reported she expected to have required ABNs completed prior to discharge from therapy.The facility did not provide a policy on Beneficiary Protection Notifications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 32 residents. The sample included 12 residents, which included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 34's as-needed antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date, or a specified duration, and physician rationale for the extended duration. This deficient practice placed the affected resident at risk for adverse effects associated with the use of psychotropic (alters mood or thoughts) medications.Findings included:R34 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).The 11/05/24 Annual Minimum Data Set (MDS) documented resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS recorded no behaviors. R34 was totally dependent on staff with activities of daily living (ADL), including bathing, toileting, dressing, footwear, transfers, and personal hygiene. The MDS recorded R34 required maximal assistance with oral care and moderate assistance with eating. The MDS recorded R34 received an antianxiety and antidepressant (class of medications used to treat mood disorders) on a routine basis.The 11/07/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R34 had significant behaviors and remained on multiple medications to help manage. Staff would continue to monitor for behaviors and undesired effects related to her medication. The CAA noted R34 was on hospice services at that time, and she was anticipated to have a decline in all care areas. The 05/06/25 Quarterly Minimum Data Set documented the resident had a BIMS score of zero. R34 was dependent on staff assistance with all ADLs. The MDS recorded R34 received antianxiety and antidepressant on a routine basis, and no behaviors. R34's Care Plan documented interventions on 10/16/24, which directed staff to monitor behaviors and observe for patterns or triggers. Staff were instructed to redirect and remove R34 from overstimulation, offer snacks, or take her to the restroom. The plan instructed staff to monitor and document the effectiveness of mood enhancement medications. Staff were instructed to intervene as necessary to ensure the safety of the resident and others. The plan directed staff to administer medications as ordered and monitor for effectiveness and adverse side effects. Staff were instructed to talk with R34 in a calm voice when her behavior was disruptive and redirect the resident with the above interventions if the resident was crying and upset. The plan noted an intervention dated 06/11/25, which directed staff to continue as-needed (PRN) lorazepam (anti-anxiety medication). R34s Physician's Orders documented an order for Ativan (lorazepam) 0. 5 milligram (mg), give 0.5mg by mouth every four hours PRN for anxiety/restlessness, date ordered 11/04/24. The order lacked a stop date or specified duration. R34's Medication Regimen Review (MRR) reviewed from 01/30/25, documented R34 had an as-needed lorazepam order, and no rationale and duration was noted. The MRR recommended to discontinue the PRN lorazepam, as it was past the 14-day limit per Centers for Medicare & Medicaid Services (CMS). The MRR noted if the lorazepam was to continue, a face-to-face rationale for continued need and expected duration was required. A Physician Response to the MRR dated 02/17/25 during a face-to-face visit documented the PRN lorazepam was for an expected duration greater than six months for a rationale of anxiety and agitation: R34 yelled and had increased anxiety. The response lacked a specified duration. R34's Physician Progress Note dated 02/17/25 lacked documentation regarding the PRN lorazepam. R34's Behavior Progress Notes reviewed from 02/01/25 through 08/14/25, R34 had three documented episodes of uncontrolled crying and laughing episodes that required no PRN medications. During an observation on 08/13/25 08:50 AM, R34 sat in her high-back wheelchair. She wore a right-hand splint. During an interview on 08/14/25 at 07:39 AM, Certified Nurse Aide (CNA) M reported R34 had no behaviors and stated that R34 laughed and smiled quite often. During an interview on 08/13/25 at 10:00 AM, Licensed Nurse (LN) G reported that R34 was in hospice, and she did not require a stop date for her as-needed lorazepam.During an interview on 08/13/25 at 01:17 PM, Administrative Nurse D reported that R34 was a hospice resident and did not require a stop date for the lorazepam. She also reported that the consulting pharmacist would recommend a stop date and believed that R34's physician had completed a face-to-face in February 2025. The facility's policy Psychotropic Medication dated 06/2025 documented Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The need to

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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. The facility had a census of 32 residents. The sample included 12 residents, with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide a written bed hold policy and failed to issue a written notification as soon as practicable for transfers of Resident (R) 39. This placed the resident at risk for impaired rights related to returning to the facility. Findings included:Review of the Electronic Health Record (EHR), documented R39 had diagnoses acute hypoxia (a condition characterized by a relatively sudden onset inadequate supply of oxygen that are usually severe), and respiratory failure (a condition where the lungs can't adequately provide enough oxygen to the body or remove enough carbon dioxide, leading to potentially dangerous levels of oxygen and/or carbon dioxide in the blood).R39's 05/17/25 Entry Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R39 was totally dependent on staff for transfers, toileting, and lower-body dressing. The MDS documented R39 required oxygen and bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps breathing). R39's 05/17/25 Progress Note at 11:56 PM documented R39's family requested R39 be transferred to the hospital for an evaluation. R39's EHR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R39 and/or his representative.During an interview on 08/14/25 at 01:54 PM, Licensed Nurse (LN) H reported that she would complete a bed hold form and would have the family or resident sign the form if they could. LN H said if the transfer was emergent, the bed hold form would not be completed.During an interview on 08/14/25 at 01:57 PM, Social Service Designee (SSD) X reported Administrative Staff B, the Business Office Manager (BOM), would complete a bed hold form when a resident transferred to the hospital. During an interview on 08/14/25 at 02:02 PM, Administrative Staff B reported she would only do a verbal bed hold over the phone with the responsible party or the resident when they transferred to the hospital. Administrative Staff B said nursing would provide the bed hold form; however, the form did not state the cost of the room. Administrative Staff B reported she did not have a completed bed hold for R39. During an interview on 08/14/25 at 02:30 PM, Administrative Staff A stated the expectation was for staff to complete a bed hold for every transfer. Administrative Staff A said if the transfer was an emergency, staff would send it to the family the next business day or call them for a bed hold. Administrative Staff A said the nurse also sends a bed hold with the resident when they go to the hospital, but there is no rate on the form, and the resident or the responsible party could call the facility if they want to do a bed hold.The facility's policy Bed-Holds and Returns dated 01/2024, documented at the time of transfer for hospitalization or therapeutic leaves, the nursing facility must provide to the residents or resident representatives written notice which specifies the duration for the bed hold. The current bed-hold and return policy established by the state (if applicable) will apply to residents in the community. Prior to a transfer, written information will be given to the residents and the resident representatives that explains the duration of the bed-hold, the reserve bed payment policy as indicated by the state plan, and the details of the transfer.

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had a census of 32 residents. The sample included 12 residents. Based on observations, interviews, and record review, the facility failed to provide services to meet professional standards of care when staff signed a treatment order as completed but did not complete the treatment for Resident (R) 15. This placed the resident at risk for delayed healing and infection. Findings included:- R15 's Electronic Health Record (EHR) revealed diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R15's 05/27/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R15 required moderate assistance for bathing, toileting, lower body dressing, and footwear. The MDS documented R15 had one venous stasis ulcer (lesion of the lower leg due to poor circulation) and required a non-surgical dressing and application of ointment/medication. R15's 06/03/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R15 continued on multiple restorative programs to maintain the resident's level of function. R15's 06/03/25 Cognitive Loss/Dementia CAA documented R15 required prompting throughout the day for activities and when to complete activities of daily living (ADLs). R15's 10/01/24 Care Plan documented R15 was anticipated to have persistent and/or recurring wounds to both lower extremities related to diabetes and lymphedema (swelling caused by accumulation of lymph). R15's 06/16/25 Care Plan documented staff were to provide treatment as ordered. R15's Physician Orders ordered the wounds to anterior(front) left lower extremity, medical (towards the middle) right lower extremity, and right medial ankle were cleansed with wound cleanser and soaked gauze for 10 minutes, then apply Skin-prep (liquid skin protectant) to peri-wound (skin surrounding the wound), apply Opticell AG (antibacterial wound dressing) to wound bed, cover with pad dressing, secure with kerlix and tape, change daily and as needed until resolved, dated ordered 06/21/25. R15's 08/13/25 Treatment Administration Record documented that Licensed Nurse (LN) G signed off completed treatment at 01:36 PM in the EHR for both lower extremities' wound care. During an observation on 08/13/25 at 09:38 AM, R15 pulled down her dressing on her left leg. Observation revealed serosanguineous (semi-thick blood-tinged) drainage on the dressing as she pulled it towards her left foot from her knee. R15 then scratched at the area, removed the ace wrap, and placed the dressing and wraps on the dining room table. Certified Nurse Aide (CNA) M walked by R15 two times but did not intervene. During an observation on 08/13/25 at 10:10 AM, CNA N removed the ace wrap and dressing from the dining room table and took them to R15's room; the tablecloth remained on the table. CNA N reported that R15's dressing was still intact on R15's legs. During an observation on 08/13/25 at 01:55 PM, R15 sat in the dining room for lunch, then for an activity. Her left lower leg dressing remained off, and serosanguinous drainage remained on her left leg. During an interview on 08/13/2025 04:12 PM, CNA O reported that if a wound was missing a dressing, the staff would let the nurse know. During an interview on 08/13/225 at 04:51 PM LN G reported she signed off the order for R15's lower extremity treatment earlier that day, around 01:30 PM, and confirmed she had not completed the wound treatment even though she signed it as completed. LN G reported she was not aware that R15 had taken the dressing off her left leg earlier that day. LN G reported that the wound treatment was ordered for 08:00 AM daily and went on to say, that ship has not sailed yet and I don't know why they schedule treatments for that time as we cannot get those done at 08:00 AM LN G reported she was too busy administering medications and would get the treatment completed before she left today. During an interview on 08/13/25 at 05:00 PM, Administrative Nurse F said she expected the staff to sign off on an order only after it was completed. The facility's policy Guidelines for Charting and Documentation, dated 01/2024, documented that services provided to the resident, or changes in the resident's medical or mental condition, shall be documented in the resident's medical record. A legal record that protects the resident, care providers, and the community. Entries shall reflect the date, the time, and the signature and title of the person recording the data.

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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. The facility reported a census of 32 residents. The sample included 12 residents with one dependent resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to provide ADL care including grooming of facial hair for Resident (R) 9. This placed the resident at risk for impaired dignity and poor hygiene. Findings included:- R9's Electronic Health Record (EHR) revealed diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R9's 11/26/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS noted R9 required set-up assistance for personal hygiene and oral care. The MDS noted R9 required moderate assistance with toileting, standing, and transfers. The 12/05/24 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R9 continued occupational therapy and has been on and off therapy for a significant amount of time. With the progression of his Parkinson's, R9 was anticipated to continue to decline in function, which may be significant if he or his representative decide to discontinue therapy services; there may be a decline despite therapy interventions as well. The 05/27/25 Quarterly MDS documented a BIMS of 12, R9 required supervision with bathing and walking. R9 was independent in the remainder of ADLs. R9's Care Plan documented an intervention dated 06/06/24, which directed the resident required limited assistance from one of the staff with HYGIENE/ORAL CARE. The plan lacked direction related to having or removal of facial hair. R9's Point of Care documentation for tasks documented R9 had a shower completed on 08/02/25 and 08/06/25, and R9 required total assistance. A N, which indicated no, was documented under showers from 08/07/25 through 08/17/25. R9's Point of Care documentation for facial hair removal tasks from 08/01/25 through 08/14/25 was documented as Y, which indicated yes. The task directed staff to check and trim facial hair as necessary. R9's Point of Care documentation for refusal of care from 08/01/25 through 08/14/25 was documented as N. During an observation on 08/12/25 at 11:32 AM, R9 had prominent beard stubble on his face as he sat in the dining room for his lunch. During an observation on 08/14/25 at 07:30 AM, R9 was at the dining room table eating breakfast. R9 still had prominent beard stubble on his face. During an interview on 08/12/25 at 02:31 PM, R9 reported he wished he could shave himself and stated he would not do well because his hands shake. He stated he would need help from the staff. During an interview on 08/14/25 at 07:46 AM, CNA M reported residents were offered shaves on their bath days. During an interview on 08/14/25 at 10:50 AM, CNA N reported R9 could not shave himself; he would be shaved on shower days. CNA N said, R9 was showered and shaved on that day. CNA N stated staff should offer R9 a shave or shave him when requested. During an interview on 08/14/25 at 02:27 PM, Administrative Nurse F reported R9 would refuse a shower often. She expected staff to offer and complete facial hair on residents who required assistance. Administrative Nurse F reported that R9's personal hygiene for shaving was not addressed on his care plan. Administrative Nurse F reported that a Y charted in point of care documentation in HER would be a yes that the facial hair was completed when she reviewed the CNA documentation in EHR. The facility's policy Shaving the Resident dated 01/2024 documented the purpose of this procedure was to promote cleanliness and provide skincare. Review the resident's care plan to assess for any special needs of the resident. Document the date and time of the shave, and how the resident participated in the procedure.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 32 residents; the sample included 12 with five residents reviewed for unnecessary medications and related monitoring. Based on observation, interview, and record review revealed the facility failed to monitor and respond to Resident (R)14 and R36 for lack of bowel movements. This placed the residents at risk for complications including constipation and bowel obstruction. Findings included:- R14's Electronic Health Records (EHR), under the Physician Orders (POS), documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), hypovolemia (abnormally low circulating blood volume), and constipation (difficulty passing stools),R14's 4/15/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS noted R14 was frequently incontinent of bowel, without a toileting program, and/or constipation.The Urinary Continence and Indwelling Catheter Care Area Assessment (CAA), dated 04/20/25, documented the resident was incontinent of bowel and bladder. She did not usually know when she needed to be toileted. R14's Care Plan dated 7/13/25, directed staff to provide check and change for incontinent episodes. R14's POS listed in the EHR documented the resident had an order for MiraLAX Powder (laxative), 17grams (gm)/scoop, by mouth, daily, mixed in 8eight ounces of water or liquid for constipation ordered 10/29/24. Review of R14's bowel movement frequency in the EHR dated 07/16/25 through 8/14/25 revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 07/26/25 through 08/02/25 (seven consecutive days).On 08/12/25 at 01:48 PM, R14 sat at the dining room table adjacent to her room. She verbalized no concerns. On 08/14/25 at 08:30 AM, Licensed Nurse (LN) H administered R14's morning medication. She confirmed the resident was taking routine medications to treat constipation, but frequently refused her medications. LN H stated the administrative nursing staff generated a report daily to inform the nursing staff of residents that failed to have a bowel movement every three days. She stated when staff were made aware of the lack of a bowel movement within that timeframe, the nurses should initiate interventions to treat constipation, which included an assessment and Milk of Magnesium (laxative- a substance that eases the passage of stool). On 08/14/25 at 09:46 AM, Certified Nurse Aide (CNA) P reported sometimes R14 would refuse care. CNA P stated the CNAs should notify the nurse if the resident does not have a bowel movement during the shift, and document it in the EHR. She reported she was not aware R36 had issues with constipation. CNA P said the administrative nursing staff created a report for the nurses to monitor the frequency of bowel movements, and the nurses then initiated treatment if the resident did not have a bowel movement in three days. On 08/14/25 at 10:53 AM, Administrative Nurse D confirmed R14 lacked a bowel movement as noted above, which exceeded the three-day period where she would expect the nursing staff to intervene and initiate treatment in accordance with the standard of care. Administrative Nurse D stated staff should initiate interventions of assessment of bowel sounds and, if indicated, initiate prune juice followed by milk of magnesia, and if no results, staff should notify the physician to obtain orders for continued treatment as indicated. She stated the facility lacked a formal protocol with standing orders to follow up on residents without bowel movements for three consecutive days/72 hours. Administrative Nurse D confirmed R36 received a routine daily order to prevent constipation, which the facility should monitor for effectiveness.On 08/14/25 at 11:43 AM, Administrative Nurse F said she ran a daily report to determine when residents lacked a bowel movement for 72 hours/three days, which she reviewed with the nurses who then were expected to follow up with the provider and initiate treatment. Administrative Nurse F said there was not a system in place to ensure monitoring of bowel movement frequency when she was off two days a week, on vacation, or for our consecutive days off, as was the case on the dates noted above. Additionally, she confirmed R 36 received scheduled medications, which had adverse side effects of constipation the facility should monitor. The facility did not provide a policy to address the monitoring of residents to prevent constipation.- R36's Electronic Health Records (EHR), under Physician Orders (POS), dated 07/16/25, documented diagnoses which included pain, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and constipation (difficulty passing stools).R36's 04/01/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. The MDS noted she required supervision or touching assistance of staff with toilet transfers and partial/moderate assistance of staff for toileting hygiene. She was frequently incontinent of bowel, without a toileting program, and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175543	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living via Christi Village McLean	777 N McLean Blvd Wichita, KS 67203

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175543	A. Building B. Wing	08/14/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 32 residents. The sample included 12 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) when providing direct care to a Resident (R) 42 with a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart). The facility further failed to ensure adequate hand hygiene during personal care for R3 when staff failed to complete proper hand hygiene. The facility failed to store respiratory equipment in a sanitary manner for R6. These deficient practices had the potential to spread infections to the residents in the facility.Findings included:- Observation on 08/12/25 At 11:54 AM, R6 had oxygen tubing dated 08/03/25 stored in a plastic bag attached to an oxygen concentrator. The plastic bag had a large hole noted on the bottom and side of the bag and the plastic bag laid on R6's floor. Observation on 08/12/25 at 11:59 AM, Certified Nurse Aide (CNA) P provided peri-care to R3. CNA P removed her gloves and applied a clean pair of gloves, but did not perform hand hygiene prior to donning the clean gloves.Observation on 08/13/25 at 09:32 AM, Licensed Nurse (LN) H, applied gloves but no gown, then administered Cefazoline (antibiotic) 2 grams (gm), 100 milliliters (ml) normal saline, every 8 hours for sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) via intravenous (IV-administered directly into the bloodstream via a vein) to R42 through the PICC line. LN H stated she should have worn a gown when providing care to resident on EBP.Observation on 08/13/25 at 10:03 AM, CNA N provided peri-care to R15. CNA N removed her glove from her right hand in between the dirty and clean during peri-care provided and applied a new glove to her right hand without performing hand hygiene. CNA N stated she should have removed both gloves and performed hand hygiene between clean and dirty actions of the task.Observation on 08/13/25 at 10:19 AM, R6 had oxygen tubing dated 08/03/25 stored in a plastic bag attached to an oxygen concentrator. The plastic bag had a large hole noted on the bottom and side of the bag, and the plastic bag laid on R6's floor. Observation on 08/13/25 at 10:23 AM, LN H disconnected R42's IV. She removed her gown, but her gloves remained on as LN H exited R42's room. LN H closed R42's door with the handle, with gloved hands, and walked into the hallway. LN H stated she should have removed gloves and sanitized hands before leaving the resident's room.During an interview on 08/13/25 at 03:28 PM, Administrative Nurse E, the Infection Preventionist nurse, stated they expected staff to wear all required PPE for all residents that had EBP. Administrative Nurse E stated they expected staff to remove all PPE prior to exiting a resident's room and complete hand hygiene.During an interview on 08/14/25 at 10:55 AM, CNA N reported the oxygen tubing storage bag should not be placed on the floor and should not have several holes in the bag.During an interview on 08/14/25 at 11:30 AM, Administrative Nurse E expected staff to remove both gloves after peri-care was performed, perform hand hygiene before applying new gloves to complete peri-care. Administrative Nurse E expected respiratory supplies to be stored in a bag when not in use, placed off the floor with no holes in the bag.The facility's policy Standard and Transmission-Based Precautions dated 06/2025 documented that it is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's mode of transmission. Hand Hygiene should be performed immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the resident's immediate environment, and immediately after glove removal. Each community will fully implement Enhanced Barrier Precautions. Shall be implemented during high-contact resident care activities when caring for residents who have an increased risk for acquiring and/or transmitting multiple drug-resistant organisms (MDROs- common bacteria that have developed resistance to multiple types of antibiotics), such as a resident with wounds, indwelling medical devices, and residents with colonization with an MDRO.The facility did not provide a policy on the care of respiratory supplies.