STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 10/06/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

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F 550	Continued From page 1	F 550		

interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure Resident (R) 22 was treated with dignity, when staff failed to provide a privacy bag for his indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag). This placed the resident at risk for an undignified experience.

Findings included:

- R22's Electronic Medical Record (EMR) documented he had diagnoses of retention of urine (lack of ability to urinate and empty the bladder) and urinary tract infection (UTI-an infection in any part of the urinary system).

R22's "Quarterly Minimum Data Set" (MDS), dated 08/08/23, documented R22 had a Brief Interview of Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS documented R22 required extensive staff assistance with dressing and toilet use, and limited staff assistance with bed mobility, transfers, and personal hygiene. The MDS documented R22 had an indwelling urinary catheter and was frequently incontinent of bowel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

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F 550	Continued From page 2	F 550		

R22's "Indwelling Catheter Care Plan," dated 08/30/23, documented R22 had a urinary catheter, and instructed staff to position the catheter collection bag and tubing below the level of R22's bladder and away from entrance room door; check tubing for kinks, and monitor for signs and symptoms of discomfort on urination and frequency. The care plan documented R22 required limited staff assistance with personal hygiene and toileting.

On 09/26/23 at 10:00 AM, observation revealed R22 in a resident council meeting, with other residents present, with an uncovered urine drainage bag hooked to the left side of his wheelchair.

On 09/26/23 at 11:30 AM, observation revealed R22 self-propelled in a wheelchair to the dining room with an uncovered urine drainage bag hooked on left side of the wheelchair.

On 09/26/23 at 01:51 PM, Licensed Nurse (LN) G verified the above observation and stated staff adjusted R22's catheter tubing but the resident pulled on it and took his catheter bag out of the privacy bag and hooked it on the front of his wheelchair. LN G stated the urinary drainage bag should be in the privacy bag.

On 09/27/23 at 03:01 PM, Administrative Nurse D stated staff should make sure R22's urinary drainage bag was in a privacy bag.

The facility's "Dignity Policy," revised February 2021, documented each resident should be cared for in a manner that promotes and enhances his or her sense of well-being , level of satisfaction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

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CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 550	Continued From page 3 with life, and feelings of self- worth and self-esteem. Resides would be treated wit dignity and respect at all times. The facility staff failed to ensure R22 was treated with dignity when staff failed to place his urinary catheter bag in a privacy cover. This placed the resident at risk for an undignified experience.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 656	Continued From page 4	F 656		

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan to include Resident (R)9's diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). This deficient practice placed the resident at risk for inappropriate care due to uncommunicated care needs.

Findings included:

- R9's Electronic Medical Record (EMR) documented she had a diagnosis of diabetes mellitus.

The "Quarterly Minimum Data Set" (MDS), dated 08/11/23, recorded the resident had severely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5	F 656		

impaired cognition, and required moderate assistance for bed mobility, transfers and locomotion. The MDS further recorded R9 received insulin (a hormone medication to control blood sugar) injections daily.

R9's EMR lacked a comprehensive care plan which addressed the use of insulin, signs of symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) and direction for the nursing staff to care for the resident with diabetes mellitus.

Review of R9's EMR revealed a "Physician Order," dated 07/27/23 for an Accucheck (a blood test for glucose levels) four times a day.

The "Nurses Notes" dated 08/23/23 at 04:30PM documented the charge nurse was called to the dining room to assess R9 who was unresponsive, and had an Accucheck reading of 35 milliliters (ml) per deciliter (dL). The note documented the charge nurse administered R9 orange juice with sugar by using a straw and encouraged R9 to swallow.

On 09/25/23 at 01:00PM, observation revealed R9 sat in a recliner chair in her room.

On 09/26/23 at 12:30PM, Administrative Nurse D verified the facility lacked a care plan for R9's diabetes mellitus and use of insulin.

The facility's "Care Planning" policy, dated 2023, stated each resident is to have a comprehensive care plan regarding individual needs and care provided for each resident.

The facility failed to develop a comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 656	Continued From page 6 care plan for R9, placing her at risk for inadequate care due to uncommunicated care needs.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to provide care which met professional standards for Resident (R) 9's treatment of hypoglycemia (low blood sugar) when staff adminstered liquids orally to R9 while R9 had decreased consciousness. This placed the resident at risk for further complications including choking. Findings included: - R9's Electronic Medical Record (EMR) recorded a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Quarterly Minimum Data Set" (MDS), dated 08/11/23, recorded the resident had severely impaired cognition, and required moderate assistance for bed mobility, transfers and locomotion. The MDS further recorded R9 received insulin (a hormone medication to control	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 658	Continued From page 7	F 658		

blood sugar) injections daily.

R9's EMR lacked a care plan for diabetes mellitus.

Review of R9's EMR revealed a "Physician Order," dated 07/27/23, for an Accucheck (a blood test for glucose levels) four times a day.

The "Nurses Notes" dated 08/23/23 at 04:30PM documented the charge nurse was called to the dining room to assess R9 who was unresponsive, and had an Accucheck reading of 35 milliliters (ml) per deciliter (dL). The note documented the charge nurse administered R9 orange juice with sugar by using a straw and encouraged R9 to swallow.

On 09/25/23 at 01:00PM, observation revealed R9 sat in a recliner chair in her room.

On 09/26/23 at 09:20AM, Licensed Nurse (LN) G verified R9's Accuchecks fluctuated. LN G was unsure of the care to provide R9 for hypoglycemia.

On 09/26/23 at 12:30PM, Administrative Nurse D verified the nurse should not have given R9 anything orally if R9 was unresponsive.

The facility's "Professional Standards" policy, dated 08/2022, states the licensed nurse will use skills, and abilities and make professional judgments based on the needs of each resident.

The facility failed to provide care which met professional standards in the treatment of R9's hypoglycemic episode. This placed the resident at risk for further complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 24 residents. The	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 9	F 690		

sample included 12 residents. Based on observation, record review and interview the facility failed to provide appropriate care for Resident (R) 20's suprapubic catheter (urinary bladder catheter inserted through the abdomen into bladder), placing R20 at risk for infection.

Findings included:

- R20's Electronic Medical Record (EMR) documented diagnosis of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections) urinary retention (lack of ability to urinate and empty the bladder), and suprapubic catheter.

The "Quarterly Minimum Data Set" (MDS) dated 07/14/23, documented R20 had short and long term memory problems, and moderately impaired cognition. The MDS further documented R20 was independent with bed mobility and transfers and required supervision with ambulation. R20 had a suprapubic catheter.

The "Urinary Incontinence/Catheter "Care Area Assessment Summary" (CAA), dated 11/14/22, stated R20 had a suprapubic catheter, and staff were required to provide appropriate care for the catheter.

R20's "Care Plan," dated 07/14/23, directed the staff to position the suprapubic catheter bag and tubing below the level of the bladder in order for urine to drain into the catheter bag.

On 09/25/23 at 01:30PM , observation revealed R20 ambulated with a front wheeled walker down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 690	Continued From page 10	F 690		

the south hallway. R20's catheter tubing stuck out over the front of his pants and was wrapped around the handles of the walker.

On 09/26/23 at 08:10AM, observation revealed R20 sat on a chair in his room. R20's urinary catheter bag laid on the floor.

On 09/26/26 at 11:20AM, observation revealed R20 ambulated down the south hallway with a front wheeled walker. R20 held onto the urinary catheter tubing with his right hand and the tubing was wrapped around the handle of the walker.

On 09/27/23 at 09:15AM, observation revealed R20 ambulated down the south hallway with his urinary catheter bag dragging on the floor behind him as he walked.

On 09/27/23 at 12:50PM, observation revealed R20 ambulated out of the dining room with his urinary catheter tubing wrapped around the handles of his walker.

On 09/27/23 at 02:50PM, Administrative Nurse D verified R20's suprapubic catheter tubing should not be wrapped around the walker and the urinary catheter bag should not drag on the floor.

The facility's "Suprapubic Catheter Care" policy, dated 10/2010, states the urinary drainage bag must be positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The resident with a suprapubic catheter is to be checked frequently to make sure the tubing is free of kinks and the urine is flowing freely in the tubing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 11 The facility failed to provide appropriate care for R20's suprapubic catheter tubing and catheter bag, placing the resident at risk for urinary infection.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 726	Continued From page 12	F 726		

by:
The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to ensure staff possessed the skill and knowledge required to conduct a thorough skin assessment in order to identify and treat R22's skin conditions. This placed R22 at risk for ongoing and worsening skin break down.

Findings included:

- R22's Electronic Medical Record (EMR) documented he had diagnoses of retention of urine (lack of ability to urinate and empty the bladder), urinary tract infection (UTI-an infection in any part of the urinary system) and skin picking disease.

R22's "Quarterly Minimum Data Set" (MDS), dated 08/08/23, documented R22 had a Brief Interview of Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS documented R22 required extensive staff assistance with dressing and toilet use, and limited staff assistance with bed mobility, transfers, and personal hygiene. The MDS documented R22 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel.

R22's "Activities of Daily Living (ADLs) Care Plan," revised 08/08/23, documented R22 required extensive staff assistance with bathing and his bath day was Wednesday afternoon, and as needed (PRN).

R22's "Pressure Ulcer Care Plan," revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 13	F 726		

08/08/23, instructed staff to follow facility policies and protocols for the prevention andtreatment of skin breakdown. The plan directed staff to monitor, document, and report any changes in skin status.

R22's "Bath Schedule" documented R22 was scheduled for a bath on Wednesday, 09/27/23 day shift, with skin assessment.

R22's "Bathing Task," in the EMR documented on 09/27/23 day shift bathing activity did not occur.

The "Skin Observation Tool," dated 09/27/23 at 02:42 PM, documented R22's right knee still had scabs which had been that way for a long time and no other skin problems.

On 09/27/23 at 02:03 PM, observation revealed Certified Nurse Aide (CNA) M provided R22 incontinent cares. R22's scrotum was red and tender to touch. R22 stated the area hurt. CNA M told R22 she would report the skin issue to the charge nurse.

On 09/27/23 at 02:52 PM, Licensed Nurse (LN) H stated the CNA had not told her R22 had any skin issues.

On 09/27/23 at 02:57 PM, LN H verified she had performed a skin assessment on R22 but did not notice any skin issues regarding R22's scrotum. LN H stated this she did not look at R22's scrotum during the skin assessment because R22 was sitting on toilet when she did the assessment.

On 09/27/23 at 03:01 PM, Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 14 stated she expected staff, to go in and physically assess resident from head to toe during weekly skin assessments and document what they find. Administrative Nurse D stated the assessments were usually performed at bath time. On 09/27/23 at 03:08 PM, LN H stated she usually conducted weekly skin assessments during the resident's bath but R22 had not received a bath that day. The facility did not provide a policy regarding skin assessments. The facility failed to ensure staff possessed the skill and knowledge required to conduct a thorough skin assessment in order to identify and treat R22's skin conditions. This placed R22 at risk for ongoing and worsening skin break down.	F 726		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

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F 812	Continued From page 15	F 812		

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The facility identified one main kitchen. Based on observation, record review, and interview the facility failed to prepare, store, and serve food in accordance with professional standards for food service safety for the 24 residents who resided in the facility and received their food from the facility kitchen, when facility failed to ensure clean and sanitary food prep areas. The facility kitchen staff failed to label and date food in the kitchen refrigerator and freezer. This placed the 24 residents, who resided at the facility and received food from the facility kitchen at risk for receiving foodborne illness.

Findings included:

- On 09/25/23 at 11:25 AM, observation in the kitchen revealed the following in the two-door silver refrigerator: unlabeled and undated plastic bags of lettuce aproximately three-quarters full, unlabeled and undated five pound (lb) bag of grated cheddar cheese, and unlabeled and undated plastic bags with four hard boiled eggs.

The white upright freezer had the following unlabeled and undated food items: a plastic bag with four pork fritter patties, a 22.75 ounce bag of country gravy mix one-quarter full, two (30 oz) bags of chicken breast nuggets, a plastic bag with nine sausage patties, two plastic bags of tator tots one bag of French fries all aproximately three-quarters full. The freezer also contained undated half full plastic bags of fried okra, sweet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16	F 812		

potato fries, and chicken strips as well as a bag with three breaded fish squares. Inside the freezer door compartment was an unsealed bag of chicken nuggets aproximately one-quarter full..

On 9/25/23 at 11:36 AM, Certified Dietary Manager (CDM) BB verified the above finding and stated staff should label and date all open food items before placing them in the refrigerator or freezer. CDM BB stated staff were bad about not labeling and dating food items due to the fact the food items were used up very quickly. CDM BB discarded the above food items in a trash can.

On 09/26/23 at 10:30 AM, observation revealed in the kitchen the following unlabeled, undated food items in the white upright freezer: a bag of smiley fries, a bag of meat balls one-quarter full, a bag of french fries one half full and an unsealed bag of breaded mushrooms aporximately half full.

On 09/26/23 at 10:30 AM observation revealed the flour and sugar bins were unlabeled and undated.

On 09/26/23 at 10:30 AM, observation revealed during the preparation of the pureed diets, Dietary Staff (DS) CC applied gloves then touched the oven, counter, and her blouse. DS CC then used the same contaminated gloved right hand to transfer the beef tips and noodles from one container to another, then picked up four rolls and placed them in a blender with same soiled gloves.

on 09/26/23 at 03:30 PM. CDM BB verified the above findings and stated staff should label and date food when opened and food items should be in a sealed bag. CDM BB stated staff should not use their gloved hands to transfer food items from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 one container to another or when picking up rolls, they should use utensils. The facility's Food Preparation and Service Policy," revised November 2022, documented food and nutrition services employees would prepare, distribute and serve food in a manner that complies with safe food handling practices. The facility's " Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices," revised November 2022, documented food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. The policy instructed staff to conduct hand washing/hand hygiene during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks The policy instructed staff to discard gloves after completing the task for which they are used. The facility failed to prepare, store, and serve food in accordance with professional standards for food service safety. This placed the 24 residents who resided at the facility and received food from the facility kitchen at risk for receiving foodborne illness.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 18	F 851		

staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 19	F 851		

staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) 2022 Quarter 4 and FY 2023 Quarters 1 and 2 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple (51) dates.

Review of the facility licensed nurse timeclock data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 20 On 09/25/23 at 10:00AM, observation revealed a registered nurse on duty in the facility. On 09/27/23 at 08:00AM, Administrative Staff A verified the facility did not send in the correct data to CMS for payroll-based data. The facility's "Reporting Payroll Based Data Journal" policy, dated 08/2022, states complete, and accurate direct care staffing information is to be reported electronically and, in the uniform, specified by CMS. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 21	F 868		

(e) of this section. The committee must:
(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The sample included 12 residents. Based on record review and interview, the facility lacked evidence the required committee members attended the Quality Assessment and Assurance (QAA) committee quarterly meetings. This placed the residents who resided in the facility at risk for decreased quality of care.

Findings included:

- On 09/28/23 at 10:00AM, review of the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets lacked signatures of attendees/committee members on the sheets. The sheets had just typed names of who was expected to attend the quarterly meetings.

On 09/28/23 at 10:15AM, Administrative Staff A stated the facility does not have members of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 22 QAPI team sign in when they have attended the meeting. The facility's "Quality Assurance& Performance Improvement Policy," dated 03/2022, documented it was the facility policy each resident and/or patient received the necessary care to attain or maintain the highest practicable physical, mental, psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. The QAPI program sets care protocols and implements mechanisms for evaluating compliance with those protocols in accordance with the guidance provided by the Centers of Medicare & Medicaid Services (CMS). the plan was data driven, proactive approach to improving the quality of life, care and services in the centers. The QAPI involved team members at all levels of the organization to identify opportunities for improvement, address gaps in system or processes, developed and implemented an improvement or corrective plan and continuously monitored the effectiveness of interventions. The facility failed to retain evidence the required QAA and QAPI members attended meetings at least quarterly which placed residents at risk of unidentified quality care services.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed follow acceptable standards of infection control when staff failed to provide adequate hand hygiene during personal cares for Resident (R)22 and R7. This placed the residents at increased risk for infection.

Findings included:

- On 09/27/23 at 08:30 AM, observation revealed Certified Nurse Aide (CNA) M knocked on R7's door and asked the resident if she was ready to get up then explained she was going to provide incontinent care. CNA M washed her hands, applied gloves, unfastened R7's incontinent brief, then provided catheter (tube inserted into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25	F 880		

bladder to drain urine) and front perineal (genital) care with a premoistened wipe. Wearing the same soiled gloves, CNA M applied an ace wrap to R7's left foot and lower leg, then placed a gripper sock over the wrap on the same foot. CNA M then touched R7's pillow, and blanket, and assisted CNA N to remove R7's gown. CNA M placed R7's bra, blouse and pants onto the resident wearing the same gloves. CNA M picked up a bottle of deodorant, sprayed under R7's arms, cued R7 to turn to her right side, then removed R7's incontinent brief. CNA M provided perineal care to R7's buttock area, then pulled up a new incontinent brief that CNA N had placed on R7. Continued observation revealed CNA M, with the same soiled gloves, adjusted R7's catheter bag in the resident left leg of pant, readjusted R7's blouse, placed the soiled gloved hands in the residents pant pockets to adjust the lining. CNA M assisted R7 to sit up in bed, touching R7's clothing with the soiled gloves. Further observation revealed CNA M, with the same soiled gloves, touched the curtain to open it, placed the full lift control into her hands, and used it to lift the resident. CNA M adjusted R7's feet on the wheelchair pedals, then removed the full lift jacket from behind R7. CNA M continued to wear the same pair of soiled gloves and readjusted R7's blouse, touched the bars of the wheelchair, propelled R7 to the bathroom, picked up R7's toothpaste and toothbrush, squeezed the toothpaste on the toothbrush, picked up a drinking glass, turned on water and filled the glass. Continued observation revealed CNA M, with the same soiled gloves, returned to R7's bed, and touched the sheets, top cover and pillow when making the bed.

On 09/27/23 at 02:03 PM, observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26	F 880		

CNA M washed her hands, then applied gloves. CNA M pulled down R22's pants, unfastened the incontinent brief, then provided incontinent care to R22's front perineal (private) area. Wearing the same soiled gloves, the CNA picked up a tube of wash creme, applied some on a premoistened wipe, then assisted R22 to turn on his right side. During this activity, CNA M touched R22's pants, shirt and back with the soiled gloves. Further observation revealed CNA M removed the incontinent brief from underneath the resident to reveal dried stool on the resident's back perineal area. CNA M placed a new incontinent brief underneath the resident, then assisted R22 in turning on his back touching his clothes again, then fastened the brief and removed and discarded the gloves. Further observation revealed CNA M failed to wash her hands after removing the gloves.

On 09/27/23 at 08:30 AM, CNA M verified she had not changed gloves during catheter care and said she should have. CNA M stated she usually does change her gloves.

On 09/27/23 at 02:03 PM, CNA M verifed she had not changed her gloves after providing perineal care and stated she was unaware she should.

On 09/27/23 at 03:01 PM, Administrative Nurse D stated when staff provided incontinent cares, staff should change gloves and wash hands between dirty and clean.

The facility's "Catheter Care, Urinary Policy," revised August 2022, documented steps in the procedure for routine perineal hygiene was to wash and dry hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE COUNTY VILLAGE INC	820 S DENISON STREET ST FRANCIS, KS 67756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 The facility staff failed to failed to follow acceptable standards of infection control when staff failed to change soiled gloves during personal cares and further failed to perform hand hygiene after removal of gloves. This placed the residents at risk for infection.	F 880		