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	175347	A. BUILDING _____ B. WING _____	06/18/2025

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 07/01/25.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 21 residents. The	F 657		

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

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sample included one resident reviewed for Hospice care. Based on record review and interview, the facility failed to review or revise the care plan for Resident (R) 74 when he was admitted to Hospice care and chose not to have cardiopulmonary resuscitation (CPR- emergency lifesaving procedure performed when the heart stops beating). This deficient practice placed him at risk for staff not honoring his wishes regarding his care.

Findings included:

- R74's "Electronic Medical Record" documented diagnoses of thrombocytopenia (abnormally low number of platelets, the parts of the blood that help blood to clot, sometimes associated with abnormal bleeding), liver cirrhosis (chronic degenerative disease of the liver), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), pain, anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), and atrial fibrillation (rapid, irregular heart beat).

R74's "Significant Change Minimum Data Set" assessment was closed due to R74's passing.

R74's "Care Plan," dated 06/11/25, documented (Specify) Hospice, (Specify) phone number. The plan of care directed staff to contact Hospice with any concerns or changes in conditions that might warrant the need to modify the coordinated care plan, initiated 06/06/25. R74's plan of care stated the Hospice care plan and all documentation would be scanned into the facility's computer documentation system, initiated 06/06/25. When

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or if the resident is transferred to the hospital, the resident's choices will be communicated by using advance directives, initiated: 06/06/25. R74's plan of care documented CPR would be initiated if the resident's heart or breathing ceases, and resuscitation orders would be part of the medical record, initiated 02/20/25.

The "Provider Note" dated 06/09/25, documented R74 was re-admitted to the facility from the hospital with Hospice or comfort care ordered.

On 06/16/25 at 12:24 PM, Administrative Nurse D stated the resident was given last rites this morning with family present.

On 06/17/25 at 09:36 AM, Certified Nurse Aide (CNA) M stated that staff can check DNR or CPR status in the Kardex for aides, which is right at the top of the page. CNA M was unsure what services Hospice provided.

On 06/17/25 at 03:30 PM, Administrative Nurse D stated she was not sure if Hospice had sent the facility their care plan, and the facility did not have one onsite currently. She stated she had put in the Hospice information on the facility care plan, but the information had disappeared. Administrative Nurse D verified staff should have updated the care plan for DNR.

The facility's "Hospice Program" policy, dated July 2017, stated Hospice would determine the appropriate hospice plan of care as it related to the terminal illness and related conditions. The facility would meet the resident's personal care and nursing needs in coordination with the hospice representative. The facility staff would obtain the most recent hospice plan of care

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F 657	Continued From page 3 specific to the resident, physician certification and recertification of the terminal illness of the resident, names and contact numbers for hospice personnel involved in the resident's care, the Hospice physician and attending physician orders for the resident. Coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility. The coordinated care plan would reflect the resident's goals and wishes as stated in his/her advance directives and would be revised and updated as necessary to reflect the resident's current status.	F 657		
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;	F 690		

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F 690	Continued From page 4	F 690		

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 21 residents. The sample included 12 residents, with three reviewed for bowel and bladder. Based on observation, interview, and record review, the facility failed to care for Resident (R) 3's catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) in a manner to prevent infection.

Findings included:

- R3's "Electronic Medical Record" documented a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).

R3's "Quarterly Minimum Data Set" (MDS), dated 06/06/25, documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. The MDS documented R3 had a urinary catheter and was dependent on staff for toileting, dressing, and mobility.

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R3's "Care Plan," dated 06/08/25, stated R3 had a 16 FR (size) indwelling urinary catheter. The care plan directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort on urination and frequency. Initiated 01/26/23.

R3'S "Care Plan," update of 04/01/24, directed staff to utilize personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) gloves and gown before performing any high-contact care activities such as: changing briefs or assisting with toileting, caring for or using an indwelling medical device or urinary catheter, bathing, transferring residents from one position to another, providing hygiene, or changing bed linens. The care plan directed staff to change PPE before caring for another resident to prevent cross-contamination.

The "Physician Order," dated 07/04/24, directed staff to provide a 16-French (fr) with a 5-10 cc (cubic centimeter) balloon and change the catheter only when clinically necessary.

The "Physician Order," dated 09/09/24, directed staff to administer Keflex (antibiotic medication) 250 milligrams (mg) every day for urinary tract infection prevention.

On 06/17/25 at 09:15 AM, R3 self-propelled her wheelchair to the living room with her catheter bag in a privacy bag under the wheelchair. A section of the catheter tubing was dragged along the floor.

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F 690	Continued From page 6 On 06/17/25 at 11:33 AM, Certified Nurse Aide (CNA) M wheeled R3 in her wheelchair to the dining room with the catheter tubing sliding on the floor. At 11:35 AM, another CNA wheeled the resident out of the dining room to the weight scale with the tubing dragging on the floor. On 06/17/25 at 01:17 PM, R3 was in her wheelchair in her room, with two to four inches of the catheter tubing on the floor. At 01:30 PM, CNA M washed hands and gloved, but did not don PPE. CNA M set a measuring container on a paper towel on the floor, used an alcohol wipe on the spigot, emptied the catheter bag, wiped the spigot with alcohol again, and placed the catheter bag back into the privacy bag. CNA M measured the urine, emptied it into the toilet. She bagged the container, took it to the soiled utility room, and rinsed it. She placed the container in a bag in the resident's bathroom. At this time, the tubing was not on the floor. CNA M verified that she should have worn PPE. On 06/17/25 at 02:46 PM, Administrative Nurse D verified staff were supposed to wear PPE while providing catheter care and ensure the tubing was off the floor. The facility's "Urinary Catheter Care" policy, dated August 2022, directed staff to be sure the catheter tubing and drainage bag are kept off the floor.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		

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labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 21 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store and label biologicals as required in the treatment cart, when staff failed to place an open date on Resident (R) 7 Humalog insulin vial (a small, glass container that holds a liquid solution of insulin lispro, a fast-acting insulin used to manage blood sugar levels in people with diabetes) and Lantus pen (a prefilled, disposable injection device containing insulin a long-acting insulin used to manage blood sugar levels in people with diabetes). This placed the resident at risk for receiving an expired and ineffective dose

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F 761	Continued From page 8 of insulin. Findings included: - On 06/16/25 at 09:00 AM, observation revealed in the treatment cart R7's undated to when opened Humalog insulin vial and Lantus pen. On 06/16/25 at 09:00 AM, Licensed Nurse (LN) G verified the above finding and stated staff should date the insulin pen and vial when they open it. On 06/18/25 at 11:34 AM, Administrative Nurse D stated staff should label and date an insulin pen and vial when they open them. The facility's Insulin Administration Policy," revised March 2025, documented staff were to check the expiration date if drawing from an opened multi-dose vial. If opening a new vial, record the expiration date and time on the vial.	F 761		
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	F 812		

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F 812	Continued From page 9	F 812		

from consuming foods not procured by the facility.

§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 21 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store food by professional standards for food service safety in one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness.

Findings included:

- On 06/16/25 at 08:48 AM, observation in the kitchen revealed the following:
In the walk-in refrigerator two pans of uncovered Jello.
The two-door silver artic refrigerator had an unzipped bag of yellow square cheese and an unzipped bag with five hamburger patties, which left them open to the air.

On 06/16/25 at 08:50 AM, Certified Dietary Manager (CDM) BB verified the above findings and stated everyone has problems zipping the ziplock bags, but staff should make sure the bags are sealed when they are placed in the refrigerator. CDM BB stated that staff should cover food items before placing them in the refrigerator. CDM discarded the above food items in the trash.

On 06/17/25 at 10:30 AM, observation during follow-up to the kitchen revealed the following:

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Both outer sides of the two ovens had numerous different-sized yellow sticky streaks of a sticky substance.
The movable island located next to the oven had numerous different-sized streaks of a sticky substance on the back and side.

The dish machine log for June 2025 lacked documentation of temperatures on the following days and meals:
06/03/25 - dinner
06/04/25 - breakfast, lunch, and dinner
06/06/25 - breakfast, lunch, and dinner
06/09/25 - dinner
06/10/25 - breakfast and lunch
06/12/25 - lunch and dinner
06/13/25 - breakfast, lunch, and dinner
06/15/25 - breakfast, lunch, and dinner
06/16/25 - dinner

A fluorescent ceiling light, approximately 18 inches (in) by 3 feet, located above the right end of the stove, above the prep islander, had a crack in the outer cover at the end, approximately 5 in by 1/4 in wide.

On 06/17/25 at 01:15 PM, CDM BB verified the facility kitchen dishwasher was a low-temp dishwasher, verified the lack of temps in the findings above, and stated she expected staff to check dishwasher temperatures every meal. CDM stated she had noticed the crack in the light fixture cover today and would report it to maintenance.

The facility's "Kitchen Daily, Weekly, and Monthly Cleaning Schedule" documents tasks for dietary staff to complete.

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F 812	Continued From page 11 The facility's "Food Receiving and Storage Policy", undated, documented food services or other designated staff would maintain clean and temperature/humidity appropriate food storage areas at all times. All foods stored in the refrigerator or freezer would be covered, labeled, and dated. ("use by" date). The facility's "Sanitization Policy," revised November 2022, documented all utensils, counters, shelves, and equipment would be kept clean, maintained in good repair, and are free from breaks, corrosion, open seams, cracks, and chipped areas that may affect their use or proper cleaning. The policy documented the dishwashing machines would be operated according to the manufacturer's instructions.	F 812		
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 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	F 880		

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 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.

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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 21 residents. Based on observation, interview, and record review, the facility failed to use proper infection control practices when they failed to don personal protective equipment (PPE- gloves and gowns) when providing catheter care for Resident (R) 3 and failed to change gloves between soiled and clean areas during incontinent cares for R5.

Findings included:

- On 06/17/25 at 01:17 PM, R3 was in her wheelchair in her room, with two to four inches of the catheter tubing on the floor. At 01:30 PM, CNA M washed hands and gloved, but did not don PPE. CNA M set a measuring container on a paper towel on the floor, used an alcohol wipe on the spigot, emptied the catheter bag, wiped the spigot with alcohol again, and placed the catheter bag back into the privacy bag. CNA M measured the urine and emptied it into the toilet. She bagged the container, took it to the soiled utility room, and rinsed it. She placed the container in a bag in the resident's bathroom. At this time, the tubing was not on the floor. CNA M verified that she should have worn PPE.

On 06/17/25 at 02:46 PM, Administrative Nurse D verified that staff were supposed to wear PPE while providing catheter care and ensure 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 _____	06/18/2025

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 14	F 880		

tubing was off the floor.

The facility's "Enhanced Barrier Precautions" policy, dated December 2024, stated Enhanced Barrier Precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multidrug-resistant organisms (MDROs) during high-contact resident care activities. Enhanced barrier precautions apply when caring for an indwelling device (catheter).
- R5's Electronic Medical Record (EMR) documented that R5 had a diagnosis of overactive bladder (a condition characterized by frequent, sudden urges to urinate that can be difficult to control and may lead to involuntary urine leakage).

R5's " Quarterly Minimum Data Set" (MDS), dated 05/09/25, documented that R5 had a Brief Interview of Mental Status (BIMS) score of two, which indicated severe cognitive impairment. The MDS documented R5 was dependent with toileting and was frequently incontinent of urine and bowel.

R5's "Care Plan," revised 05/03/25 care plan-, documented R5 required one staff assistance with toileting. The plan instructed staff to provide R5 perineal (private area) with each incontinent episode.

On 06/16/25 at 12:42 PM, observation revealed the resident sat on the toilet, Certified Nurse Aide (CNA) N applied gloves, removed a wet incontinent brief, then with the same soiled placed a new incontinent brief on R5. Continued observation revealed CNA N with the same soiled gloves placed R5's house slippers on, cue and

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F 880	Continued From page 15 assisted R5 with a gait belt to stand, provided perineal care. CNA N with the same soiled gloves, pulled up the resident's incontinent brief, pants, pulled her shirt bottom over her pants, then removed and discarded gloves. On 06/16/25 at 02:14 PM, CNA N verified she had not changed her gloves after providing perineal care for R5 and stated she should have. On 06/18/25 11:36 AM, Administrative Nurse D stated staff should change gloves whenever they touch something dirty during incontinent care. Upon request, the facility failed to provide a change of gloves during the incontinent care policy.	F 880		