STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 are the result of abbreviated survey and complaint investigation KS00179441 and KS00177516. The 2567 was sent electronically on 05/31/23.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility documented a census of 88 residents with three residents reviewed for falls. Based on record review, observation, and interview, the facility failed ensure staff provided the required level of assistance to prevent two falls for Resident (R) 1, who fell and sustained a non-displaced fracture (broken bone) of the right lateral (outside) malleolus (ankle bone) of the right fibula (outside bone of the lower leg). On 03/30/23, R1 fell in the bathroom during a one-staff assisted transfer of R1 from the toilet to the wheelchair, when R1 became weak, and staff lowered R1 to the floor. The 03/31/23 "Fall Documentation Note," included a fall intervention of two staff assistance with gait belt for transfers of R1. On 04/07/23, one staff assisted R1 with transfer from the commode to her wheelchair. R1 started to fall and Certified Nurse Aide (CNA) M	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 1	F 689		

lowered her to the ground, but R1's right foot was caught under the commode chair. R1 sustained a non-displaced fracture of the right lateral malleolus of the right fibula.

Findings included:

- The Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, difficulty in walking, unsteadiness on feet, and syncope (fainting or passing out).

The "Quarterly Minimum Data Set (MDS)," dated 03/10/23, documented R1 could not complete the Brief Interview for Mental Status (BIMS), had short- and long-term memory deficit, and R1's cognition was severely impaired. The MDS documented R1 required extensive assistance of one staff for bed mobility, transfer, locomotion off the unit, dressing, toilet use, personal hygiene, and bathing. The MDS documented R1 used a wheelchair, was not steady, and only able to stabilize with staff assistance when moving from a seated to a standing position, moving on and off of the toilet, and surface-to -surface transfer.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 10/28/22, documented R1 demonstrated altered level of cognitive function as evidenced by R1 forgetting to ask for help when transferring and/or R1 got up on her own without assistance.

The "Activities of Daily Living/Rehabilitation Potential CAA," dated 10/28/22 documented activities of daily living would be care planned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 2	F 689		

The "Fall CAA," dated 10/28/22, documented falls would be care planned.

The "Fall Care Plan," directed staff to use two people to assist the resident when R1 felt tired/weak dated 03/16/23; physical therapy and occupational therapy were to screen for bilateral lower extremity weakness dated 03/30/23, and staff were to be aware of R1's foot placement with transfers and ensure items are not in R1's way.

The "Faber Fall Risk Assessment," dated 03/29/23 documented R1 had a score of 49, which indicated R1 was a high risk for falls.

The "Fall Documentation Note," dated 03/30/23, documented R1 sat on the floor accompanied by a CNA at 03:30 PM. The CNA assisted R1 with a transfer from the toilet, but R1 was unable to stay standing, so the staff member safely lowered R1 to a seated position due to being mid-transfer from the commode to the wheelchair. R1 was incontinent of bowel and bladder prior to the fall. R1 was unable to restate what happened prior to the fall or what led up to the fall. R1 denied pain at the time and R1 was alert with no change from baseline. R1 had full range of motion to her upper extremities and lower extremities, with no difference noted between the sides of the body. Two staff assisted R1 up to her wheelchair using a gait belt. Safety measures in place included low bed and assist rail. Fall interventions in place included a low bed. R1's "Care Plan" was reviewed with interventions updated as indicated.

The "Fall Documentation Note," dated 04/01/23, documented staff were monitoring R1 due to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 3	F 689		

fall on 03/30/23. Fall interventions in place included two staff assistance with gait belt for transfers.

The "Progress Note," dated 04/07/23, documented at approximately 06:25 PM, CNA M alerted Licensed Nurse (LN) G she needed help because R1 was on the floor. LN G asked CNA M what she meant by R1 was on the floor, and CNA M explained she was assisting R1 up from the commode and R1 was not standing and started to go down, so CNA M assisted R1 to the floor. LN G went to R1's room and found R1 laying perpendicular to the commode with her head towards the sink on a pillow and her feet towards the opposite opening of the door to the bathroom. R1 complained about her right ankle which appeared to be resting in an awkward position. LN G asked R1 what happened and R1 stated she could not stand because she got caught by that, pointing at the leg of the toilet riser.

The "Progress Note," dated 04/08/23, documented LN H assessed R1's right ankle that morning. LN H noted R1's ankle was starting to bruise and was edematous (swollen). R1 was not bearing any weight on her right leg. R1's leg was tender to touch. LN H documented she did not feel comfortable with not knowing if R1's right ankle was fractured or not. LN H called the on-call physician and requested an x-ray of the right ankle that could be completed by mobile radiology. The on-call physician put an order in for the x-ray that would be completed later in the day.

The "Physician Communication Note," dated 04/08/23, documented a new order for an x-ray of R1's right ankle, three views.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 4	F 689		

The "Progress Note," dated 04/08/23, documented the x-ray was completed and the final report showed a possible irregularity along the inferior margin of the medial malleolus suggesting avulsion fracture (occurs when a small chunk of bone attached to a tendon or ligament gets pulled away from the main part of the bone). Correlate with point tenderness and consider right knee x-ray to evaluate for proximal fibular fracture. Soft tissue swelling over the lateral malleolus.

The "Progress Note," dated 04/09/23, documented R1 appeared to have good pain control with the use of Norco (pain medication).

The "Progress Note," dated 04/10/23, documented staff made an appointment for R1 to attend an orthopedic (bone specialist) appointment that day at 01:30 PM and R1's DPOA would meet her there.

The "Order Note," dated 04/10/23 documented a CAM (an orthopedic device prescribed for the treatment and stabilization of severe sprains, fractures, and tendon or ligament tears in the ankle or foot) to be on with all weight bearing activity, ice/elevate right ankle above the heart twenty minutes four times a day. R1 to be weight bearing as tolerated to right lower extremity in CAM boot, unless having pain, and then non-weight bearing and in wheelchair.

The "Witness Statement," dated 04/10/23, documented, CNA M started to get R1 ready for bed about 06:30 PM. CNA M helped R1 stand up and R1 was fine, but when it came time to pivot R1 said her legs were not working and R1 started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 5	F 689		

to fall. CNA M lowered R1 to the floor, gently. R1's right ankle got caught behind the toilet stool legs and got twisted. CNA M called LN G and they got R1 up on the toilet. LN G wrapped R1's ankle and LN G assisted CNA M placing R1 in bed, with R1's right leg elevated.

The "Witness Statement," dated 04/10/23, documented CNA M called LN G stating she needed help because R1 was on the floor. LN G asked CNA M what happened, and CNA M stated that she was trying to get R1 to the commode when R1 could not stand, and it looked like R1's foot got caught around the leg of the toilet riser as she was lowering R1 to the ground. R1 complained of right ankle pain and pain on the top of her right foot. There was swelling to the area but R1 was wearing hose.

The "Facility Incident Report," dated 04/14/23, documented on 04/07/23 at approximately 06:25 PM, CNA M assisted R1 to the toilet from R1's wheelchair. The wheelchair brakes were in the locked position. R1 did not have any reports of being tired or feeling weak. As CNA M pivoted, R1 legs gave out. As CNA M lowered R1 to the floor and noted R1's right foot got behind the toilet riser leg. Due to the positioning of the wheelchair, CNA M was unable to remove R1's right foot before lowering R1 to the floor. CNA M immediately notified LN G. Upon entering R1's bathroom, LN G found R1 laying perpendicular to the commode with her head toward the sink laying on a pillow and R1's feet were towards the opposite opening of the door to the bathroom. R1 complained about her right ankle which appeared to be resting inward around the right front toilet riser leg. LN G asked R1 what happened and R1 said that she could not stand because she got

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 6	F 689		

caught by that, pointing at the leg of the toilet riser. LN G assessed R1 and attempted to get R1 to her feet with assistance of CNA M. R1 was unable to stand so staff placed R1 back on the toilet riser. R1 was agreeable to remain on the toilet riser to allow CNA M to clean her up and get R1 ready for bed so that LN G could contact the doctor for further directions. The staff contacted R1's DPOA at 06:29 PM and the DPOA stated she would like to see how R1 did before sending her off to do x-rays. The staff paged the on-call doctor at 06:33 PM, who called the facility back, and was advised of R1's DPOA's wishes. The on-call doctor stated it would be better if radiology could wait until Monday and ordered LN G to utilize ACE wraps and ice to R1's right ankle and ordered one to two tablets of hydrocodone as needed, every four hours. LN G gave R1 two tablets of hydrocodone, applied ACE wrap to R1's right ankle, and elevated the extremity in bed immediately, per physician orders. On 04/08/23, LN H assess R1's right ankle and noted R1's right ankle was starting to bruise and was edematous. LN H also reported R1 continued to not bear any weight on her right lower extremity and it was very tender to touch. The staff updated the on-call doctor and received orders for an in house 3-view, x-ray. On 04/08/23, the x-ray report documented "Possible cortical irregularity along the inferior margin of the medial malleolus suggesting avulsion fracture. Soft tissue swelling over the lateral malleolus." The staff notified the on-call doctor of the x-ray results and suggested if R1's DPOA was okay with R1 staying at the facility through the weekend and her pain was controlled with as needed pain medication the best option would be to get R1 to an orthopedist on Monday, 04/10/23, to see what the options were. The staff received the orders to keep R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 7	F 689		

non-weight bearing until that time. R1's pain was well controlled throughout the weekend by as needed pain medication. On 04/10/23, R1 saw an orthopedist. The x-rays completed showed a non-displaced fracture of the lateral malleolus of the right fibula and ordered for R1 to wear a CAM boot with all weight bearing activity, ice/elevate R1's right ankle above her heart for twenty minutes four times a day, weight-bearing as tolerated to right lower extremity unless R1 was having pain, then non-weight bearing in her wheelchair. Corrective actions taken by the facility included: monitor R1's feet position while transferring to and from the toilet, CAM boot to be on with all weight bearing activity, ice/elevate R1's right ankle about her heart for twenty minutes four times a day, and weight bearing as tolerated to right lower extremity unless having pan then non-weight bearing in wheelchair.

The "Progress Note," dated 04/27/23, documented a progress note was received from R1's PCP stating R1 had a history of a right ankle fracture and would follow up with orthopedics. The progress note documented R1 was not very ambulatory anyway, so the PCP did not think this would make much of a difference. R1's pain seemed to be under control.

The "Progress Note," dated 04/29/23, documented R1 complained of pain to her leg. R1 rated her pain a 10 out of 10 on a pain scale as needed hydrocodone was given to R1.

The "Order Note," dated 05/10/23, documented R1 went to an orthopedics appointment and new orders were received to discontinue the CAM boot while R1 was seated/supine (laying on back) activity. R1 was able to wear the CAM boot with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 8	F 689		

transferring and weight bearing activity, then transition away from boot as tolerated. R1 was to begin physical therapy with active and passive range of motion and light strengthening of right ankle.

On 05/16/23 at 11:30 AM, observation revealed R1 self-propelled herself around the unit with a CAM boot in place. R1 appeared confused.

On 05/16/23 at 11:45 AM, CNA N stated R1 required two-person assistance when she was tired or weak, prior to her right ankle injury. CNA N stated R1 required two staff assistance with her CAM boot on for any transfers.

On 05/16/23 at 12:00 PM, Administrative Nurse E stated she thought the root cause of R1's fall was CNA M did not have R1's feet positioned correctly prior to the transfer, which allowed R1's foot to get caught behind the toilet riser leg.

On 05/16/23 at 12:15 PM, Administrative Nurse D stated she thought the root cause of R1's fall and right ankle fracture was the delay in therapy working with her from her previous fall. Administrative Nurse D stated therapy was supposed to start working with R1 on lower extremity strengthening after her fall on 03/30/23. Administrative Nurse D stated R1's feet positioning during the transfer contributed to R1's fall.

On 05/16/23 at 12:30 PM, Therapy Director GG, stated therapy did not receive the written orders to begin working with R1 on bilateral lower extremity strengthening until 04/10/23.

The facility's "Falls Prevention Policy," dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE MANHATTAN, INC	2800 WILLOW GROVE ROAD MANHATTAN, KS 66502

(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 689	Continued From page 9 January 2022, documented that facility would provide an environment that is free from accident hazards over which there is control and provide supervision and intervention to residents to prevent avoidable accidents. The facility failed ensure staff provided the required level of assistance to prevent accidents for R1, who sustained a non-displaced fracture of the right lateral ankle fracture when only one staff assisted with transfer.	F 689		