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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00183601 and KS00183470. On 10/26/23 at 04:31 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template and was informed of the IJ for Resident (R) 1 and R2. On 10/14/23 Certified Medication Aide (CMA) R picked R1 up from the Emergency Room (ER) using the facility transportation van. CMA R assisted R1, who used a wheelchair, into the van. CMA R failed to secure the two front straps as well as the lap strap. As CMA R made the first left hand turn after leaving the hospital, R1's wheelchair tipped backward, and R1 fell from the chair and hit his head. R1 returned to the ER where he was diagnosed with a fracture of the cervical vertebrae (neck spine). The facility further failed to ensure R2 remained free from preventable accident hazards when staff allowed cognitively impaired R2 outside without staff supervision. Staff failed to recognize R2, who was at risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) and wore a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort), as a resident and failed to respond appropriately to Wander Guard alarms. This allowed R2 to exit the facility through the Assisted Living (AL) wing and remain outside without staff supervision for eight minutes, until the resident went back to the door to be allowed in. These failures placed both R1 and R2 in Immediate Jeopardy.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/03/2023

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F 000	Continued From page 1 The facility put the following corrections in place by 10/20/23: A Quality Assurance and Performance Improvement (QAPI) meeting was held on 10/18/23. All associates were retrained on vehicle competency during the skills fair on 10/19/23. CMA R was fired from the facility on 10/20/23. The facility put the following corrections in place by 10/24/23: R2 was placed on 15-minute checks immediately on 10/20/23 and continued until his discharge to home. Administrative Nurse E reviewed other residents at risk for elopement on 10/20/23. Mass text alerts were sent out to staff regarding elopement risk residents on 10/20/23 at 10:45 PM A Quality Assurance and Performance Improvement meeting was held on 10/24/23. All corrections were completed prior to the onsite survey therefore the deficient practice was cited at past noncompliance and remained at a scope and severity of "J." The 2567 was sent electronically on 11/03/23.	F 000		
F 689 SS=J	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.	F 689		

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F 689	Continued From page 2 This REQUIREMENT is not met as evidenced by: The facility identified a census of 85 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to provide a safe environment free from preventable accidents for Resident (R) 1 and R2. On 10/14/23 Certified Medication Aide (CMA) R picked R1 up from the Emergency Room (ER) using the facility transportation van. CMA R assisted R1, who used a wheelchair, into the van. CMA R failed to secure the two front straps as well as the lap strap. As CMA R made the first left hand turn after leaving the hospital, R1's wheelchair tipped backward, and R1 fell from the chair and hit his head. R1 returned to the ER where he was diagnosed with a fracture of the cervical vertebrae (neck spine). The facility further failed to ensure R2 remained free from preventable accident hazards when staff allowed cognitively impaired R2 outside without staff supervision. Staff failed to recognize R2, who was at risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) and wore a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort), as a resident and failed to respond appropriately to Wander Guard alarms. This allowed R2 to exit the facility through the Assisted Living (AL) wing and remain outside without staff supervision for eight minutes, until the resident went back to the door to be allowed in. These failures placed both R1 and R2 in Immediate Jeopardy. Findings included: - R1 admitted to the facility on 10/13/23. He	F 689	Past noncompliance: no plan of correction required.	

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transferred to the ER on 10/14/23 related to hyperglycemia (high blood sugar).

R1's Electronic Medical Record (EMR) documented a diagnosis of diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

R1's "Care Plan" dated 10/13/23, directed R1 needed assistance with daily activity of daily living (ADL) care and directed R1 needed limited assistance with two staff support for mobility and used a wheelchair.

The facility's investigative report dated 10/20/23 documented, on 10/14/23 at approximately 04:00 PM, R1 was returning to the facility from the ER in a facility van, accompanied by CMA R. R1 sat in the wheelchair with the bilateral brakes applied as well as the wheelchair securement straps in the facility van. CMA R reported R1's wheelchair fell backward when she made the first left turn after leaving the hospital and R1 hit the back of his head and reported having pain in his neck and chest. CMA R immediately pulled over to the nearest parking place and called for assistance. Licensed Nurse (LN) G and Social Services X arrived and assisted R1 off of the van floor and back to his wheelchair using the gait belt. LN G assessed R1 and felt he should return to the ER for evaluation and treatment and escorted R1 back to the ER with CMA R. The report documented Social Services X reported when LN G and she arrived to where CMA R was parked, R1 was sitting in front of his wheelchair. Social Services X climbed through the side of the van, opposite side of CMA R, and LN G went through the back of the van to assess R1. After LN G assessed R1, he was assisted with three staff to

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his wheelchair. Once R1 was back in his wheelchair, Social Services X asked CMA R if R1 was strapped in properly and CMA R stated yes. The report documented R1 then spoke up and told Social Services X he did not have a seatbelt on, and he flew backward then hit his head on the back door. In the ER, R1 was diagnosed with a C5 (cervical vertebra level five) fracture with no further intervention needed per neurology. R1 returned to the facility at approximately 07:10 PM by facility van in his wheelchair and was escorted back with two staff present.

In a "Witness Statement," dated 10/16/23, CMA R documented on 10/14/23, after R1 discharged from the ER, she loaded R1 into the van and applied the wheelchair locks and the locks secured to the van. CMA R documented that as she left the hospital parking lot and turned left, R1 fell back; CMA R rushed to the nearest parking lot. CMA R stated she tried to get R1 off the floor but could not get him up, so she called LN G for help. Upon Social Services X and LN G's arrival, they got R1 into his wheelchair and his head was bleeding.

In a "Witness Statement," dated 10/16/23, LN G documented on 10/14/23 she received a call from CMA R saying R1's wheelchair tipped back on the way back from the hospital in the van and R1 was bleeding. She and Social Services X left the facility to assess R1. LN G stated when they arrived, R1 was sitting on the floor of the van.

In a "Witness Statement," dated 10/16/23, Social Services X documented on 10/14/23, LN G was in the office when her phone rang; it was CMA R who was picking a resident up from the hospital. Social Services X told LN G she could run over to

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where CMA R was but needed a nurse to assess the resident. Upon arriving to the area where CMA R was parked, R1 was not in his wheelchair but sat in front of it on the floor. Social Services X stated she climbed through the side of the van, the opposite side of CMA R, and LN G climbed through the back. It took two tries to get R1 back in his wheelchair and once he was back in his wheelchair, Social Services X asked CMA R if the resident was strapped in properly and CMA R stated yes. Social Services X stated R1 spoke up and told her "No," he did not have a seat belt on, and he flew backward then hit his head on the backdoor.

An "Emergency Room Note" on 10/14/23 documented R1 was just dismissed from the ER and was in the van going back to the nursing home when he became loose and fell backwards hitting his head. R1 did not lose consciousness and complained of some head pain and neck pain. A computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) scan revealed a fracture of the C5 (5th cervical vertebrae).

On 10/26/23 at 04:14 PM, R1 sat in his wheelchair in his room. He had a neck pillow wrapped around his neck from the front and he was unable to look up. He stated he had constant pain in his neck and was unable to lift it up when sitting in the wheelchair to watch television. R1 stated on 10/14/23, the wheelchair was not fastened down and he tipped backward but he did not remember if he wore a seatbelt.

On 10/26/23 at 12:09 PM, CMA R stated on 10/14/23 when she picked R1 up for

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transportation, she failed to strap him in properly and he fell. She stated she failed to utilize the two front straps from the van and the lap belt. CMA R stated she was really busy that day and just did not think about fastening the straps at the time.

On 10/16/23 at 01:21 PM, Administrative Nurse D stated R1 was admitted on 10/13/23 and on the morning shift on 10/14/23, he was transferred to the ER for high blood sugar. R1 was stabilized and the facility picked him back up. She stated staff had been trained on the van and on the weekends, floor staff provided transportation usually. Administrative Nurse D stated she expected staff providing transportation to wheel the resident up to the square area behind the front seat, secure the two buckles to the back of the wheelchair, secure the two buckles to the front of the wheelchair, and put the seatbelt on. She stated from her understanding, the seatbelt and two front straps were not secured and that was why R1 tipped backward.

On 10/26/23 at 04:26 PM, Administrative Staff A stated he expected transportation staff to go over safety checks to make sure the resident was strapped in properly which included a traditional seatbelt and retention hooks attached to four non-moveable parts of the wheelchair.

The facility's "Fleet Safety Guidelines" policy, not dated, directed all drivers had a responsibility to themselves, their ministry, and to their community to adhere to safe driving practices. Drivers were required to wear safety belts and require other occupants to do so.

The facility failed to ensure CMA R properly secured R1 in the transportation van. During

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transportation, CMA R turned left and R1 fell backward in his wheelchair, hitting his head on the backdoor. This deficient practice resulted in a C5 fracture for R1 and placed him in immediate jeopardy.

The facility put the following corrections in place by 10/20/23:
A Quality Assurance and Performance Improvement (QAPI) meeting was held on 10/18/23.
All associates were retrained on vehicle competency during the skills fair on 10/19/23.
CMA R was fired from the facility on 10/20/23.

All corrections were completed prior to the onsite survey therefore the deficient practice was cited at past noncompliance and remained at a scope and severity of "J.".

- R2 was admitted on 10/19/23 for respite care (short term health services to the dependent adult) and discharged home on 10/23/23.

R2's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and abnormalities of gait and mobility.

R2's "Care Plan" dated 10/19/23, documented R2 was at risk for increased behavioral expressions, altered mood, elopement, and impaired adjustment ability to new environment. The care plan documented interventions for staff to follow community elopement evaluation and monitoring process, identify current mood and behavioral expressions and monitor for changes; and orient R2 to the community layout, routines, and

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schedules.

An "Elopement Risk Screening and Evaluation" on 10/19/23, documented R2 had a score of 16 which indicated staff were to assume R2 was at risk for elopement.

A "Faber Fall Risk Assessment" on 10/19/23, documented R2 had a score of 17 which indicated R2 was a moderate risk for falls.

The facility's investigative report, dated 10/27/23, documented on 10/20/23 at approximately 07:20 PM, R2 went downstairs and asked CMA S and Certified Nurse Aide (CNA) M how to get out. CMA S asked CNA M to show R2 due to inadvertently thinking R2 was a visitor. At 07:28 PM, CNA M assisted R2 to the front door where they both exited the building. At this time, the door alarm was sounding through the double doors and CNA M was unable to turn the alarm off from the side of the door he was on, due to the Wander Guard system. R2 was with CNA M between the double doors in the foyer. The report documented CNA M left R2 at the front entrance to go around the building to let R2 back in the building at the same time another resident's family member came from inside the building after seeing R2 and let him inside the building using the 15 second delayed egress. R2 followed the family member to AL, setting off the door alarm there. CNA M returned to the front doors to let R2 back in the building but R2 was not there, he then reset the front door alarm and the AL door alarm then returned to long term care (LTC) at 07:32 PM. The report documented while R2 was in the AL, AL staff A let another resident's family member out of the building at 07:33 PM and R2 followed the family member out of the AL

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dining room door. AL staff A thought R2 was a family member's husband. At 07:41 PM, AL staff B head the alarm of the AL dining room door and went to investigate it when she noted a man trying to get in the building. When AL staff B tried to let R2 back in the building, she first entered the door code which did not release the door, she then entered the Wander Guard code and realized that R2 was wearing a Wander Guard bracelet. The report documented AL staff B asked R2 his name and where he lived. AL staff B assisted R2 back to LTC. Upon returning to his unit, LN H assessed R2, and no injuries were noted. R2's Wander Guard was checked and verified to be working appropriately and the Wander Guard system and door system were functioning correctly.

In a "Witness Statement," dated 10/23/23, CMA S documented on 10/20/23, R2 asked her where the door was to get out and she was passing medications. She asked she asked the CNA to help R2 out.

In a "Witness Statement," dated 10/23/23, CNA M documented on 10/20/23, R2 seemed to be lost and he did not know R2 was a resident because he did not have his walker and was asking how he could leave. CNA M stated he walked R2 through the doors and the Wanderguard did not work as the door alarm did not go off. He and R2 were stuck in the front doors so CNA M went back around the facility to open the doors for R2 but he was not there when CNA M returned.

In a "Witness Statement," dated 10/21/23, AL staff A documented at approximately 08:00 PM on 10/20/23, she exited a resident's room and saw a lady standing by the AL door. The lady stated she

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was an AL resident's family member and was told she could move the resident's stuff into her AL apartment. AL staff A stated she opened the door for the lady and a gentleman who she thought was the lady's husband was with her. As they began moving furniture through the door, the alarm sounded, and AL staff A assumed the door had timed out and alarmed so she reset the door.

In a "Witness Statement," dated 10/23/23, AL staff B documented on 10/20/23 the alarm on the South AL door went off, she went to investigate, and saw a man trying to get in. She directed him to the doors in the dining room and finally assisted him into the building. She stated that was when she noticed the Wanderguard on his left wrist, but she did not recognize him, so she asked him his name and where he lived. AL staff B stated she walked R2 back to LTC.

According to the "Kansas State University Historical Weather" website, the temperature on 10/20/23 at 07:00 PM was 65.5 degrees Fahrenheit (F) and at 08:00 PM it was 61.8 degrees F.

On 10/26/23 at 01:28 PM, observation of the door and area R2 eloped from revealed the AL dining room door exited onto a well-maintained sidewalk that wrapped around the building. There was parking available in front of the sidewalk and there were streets in front and to the side of the building. The streets in front and to the side of the building had a speed limit of 30 miles per hour (mph).

On 10/26/23 at 01:28 PM, Maintenance U stated on 10/20/23 R2 exited LTC with staff that let him through the double doors and was left between

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the double doors while staff went around the building. He stated a family member let R2 back in and he followed the family member into AL where he sat in a chair. Maintenance U stated the AL resident's family member was with an AL staff member and when they walked by R2, he followed the family member out of the door. He stated the AL staff member was able to put the code in at that point and R2 exited the building. R2 walked around the sidewalk to the other door then came back around to the AL dining room door. He stated R2 tried to get in and that was when AL staff realized they had to put the Wanderguard code in to let R2 back inside and that he was a resident.

On 10/26/23 at 02:57 PM, Administrative Nurse D stated she expected if a resident was exit seeking, staff attempted to redirect the resident. She stated if a door alarm sounded, she expected staff to respond timely, search the surroundings before shutting off the alarm, and call each court to do a headcount. Administrative Nurse D stated R2's elopement was different because staff had let him outside and she had talked to CNA M on 10/20/23 but he was unaware that R2 was a resident there.

On 10/26/23 at 03:57 PM, CMA S stated she knew what residents were at risk of elopement by looking in the CNA/CMA book for the elopement risk photos. She stated if a resident was wandering or exit seeking, she looked to see if they had a Wanderguard, and called the court the resident lived on to ask for assistance. CMA S stated if a door alarmed, she ran to the door to make sure a resident did not go out and called all of the courts to alarm them to check rooms to make sure all residents were there. She stated

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staff went outside to look for the resident as well.

On 10/26/23 at 04:04 PM, LN H stated elopement was prevented by responding to door alarms and calling all courts to make sure the Wanderguard residents were where they needed to be. She stated there was an elopement risk list in the CNA binders, at the nurse's stations, and at the front desk. She stated staff verified if someone was a resident before they put the door code in.

On 10/26/23 at 04:26 PM, Administrative Staff A stated he expected staff to know which residents were at high risk for elopement based on the elopement precautions, where those residents were located in the building, and where residents were regardless of cognition if they were outside the building with staff present if they were not cognitively intact.

The facility's "Elopement Response" policy, last revised July 2022, directed if an associate observed a resident leaving the premises, he/she attempted to prevent departure in a courteous manner, got help from other associate members in the immediate vicinity if necessary, and instructed another associate member to inform the charge nurse that a resident left the premises.

The facility failed to ensure staff recognized R2 as a resident and responded to door alarms when R2 exited the building after staff let him out. He was outside the facility for eight minutes. This deficient practice placed R2 in immediate jeopardy.

The facility put the following corrections in place by 10/24/23:
R2 was placed on 15-minute checks immediately

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 10/26/2023

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 13 on 10/20/23 and continued until his discharge to home. Administrative Nurse E reviewed other residents at risk for elopement on 10/20/23. Mass text alerts were sent out to staff regarding elopement risk residents on 10/20/23 at 10:45 PM A Quality Assurance and Performance Improvement meeting was held on 10/24/23. All corrections were completed prior to the onsite survey therefore the deficient practice was cited at past noncompliance and remained at a scope and severity of "J.".	F 689		