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 12/13/2023

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 partial extended complaint survey KS00184597 and KS00184557. On 12/13/23 at 03:02 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R)1. On 12/07/23 R1 admitted to the facility with a physician's order for glimepiride (medication used to lower blood glucose [sugar] levels) 2 milligrams (mg) twice daily. Staff incorrectly transcribed the order as glimepiride 4 mg twice daily. R1 received a total of seven doses of glimepiride, at twice the prescribed dosage, before staff caught the error on 12/11/23 at 09:30 PM. Staff did not check R1's blood sugar but notified R1's representative and primary care physician (PCP) and stated there were no adverse effects from the error. A short while later, at 10:15 PM, staff found R1 face down on the floor of his room with his call light still hooked to his shirt. R1 was drowsy, with non-reactive pupils and then became non-verbal. Staff called Emergency Medical Services (EMS). EMS arrived and initiated transport to the Emergency Department (ED). EMS assessed R1's blood sugar in the ambulance as 36 milligrams (mg)/ per deciliter (dL) (normal range is 70-130 mm/dL). The facility failure to ensure R1 remained free from significant medication errors placed R1 in immediate jeopardy. On 12/13/23 the surveyor verified the following actions to remove the immediacy: An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary team on 12/13/23 and a plan of	F 000		

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

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 12/13/2023

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	Continued From page 1 correction was developed and implemented. All medication orders were audited on 12/13/23 to verify orders were entered accurately. All residents with diabetic medications were reviewed for blood sugar monitoring. The provider was notified for orders for any resident found without an order for blood sugar monitoring. Current nurse associates were re-educated by the Director of Nursing or designee by 12/13/23 or prior to working the next scheduled shift on order transcription and medication reconciliation. The Interdisciplinary team reviewed the "Admission Assessment and Follow Up" policy and procedure for compliance with the Centers for Medicare and Medicaid Services (CMS) regulation F760. After removal of the immediacy, the deficient practice existed at a scope and severity of a "G." The 2567 was sent electronically on 12/20/23.	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 identified a census of 80 residents with three residents reviewed for accidents and hazards. Based on record review, observation, and interview, the facility failed to ensure staff	F 689		

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 12/13/2023

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		

repositioned Resident (R)2 safely while in her Broda chair (specialized wheelchair with the ability to tilt and recline) and R2 sustained a right proximal (nearer to a point of reference or attachment) humerus (upper arm bone) fracture (broken bone). This deficient practice also placed R2 at risk for pain.

Finding included:

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set (MDS)," dated 06/16/23, documented R2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS documented R2 as dependent on staff for all her activities of daily living (ADL).

The "Activities of Daily Living/Rehabilitation Potential Care Area Assessment," dated 06/16/23, documented R2 was a 45 year old female admitted to the facility with multiple severe problems secondary to hypoxic (lack of supply of oxygen), ischemic (decreased supply of oxygenated blood to a body part) encephalopathy (inflammatory condition of the brain) with demyelinating (condition that causes damage to the protective covering that surrounds nerve fibers in the brain) process and history of a stroke (damage to the brain from interruption of its blood

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 12/13/2023

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		

supply).

R2's "Care Plan," dated 06/14/22, documented R2 needed assistance with ADL. The care plan directed staff R2 needed total assistance with the use of a Hoyer lift (total body mechanical lift) for transfers. R2 needed total assistance with mobility and extensive assistance with bed mobility.

The "Progress Note," date 12/05/23, documented Licensed Nurse (LN) G and Certified Nurse Aide (CNA) M repositioned R2 in her wheelchair and there was a pop in R2's back. R2 complained of mild discomfort at the time. Upon assessment, all of R2's extremities moved with passive range of motion at R2's baseline. R2 did not complain of any additional discomfort with range of motion.

The "Behavior Note," dated 12/06/23, documented R2 yelled out stating she was in pain even after receiving pain medication. R2 could not be redirected, and staff did not have any as needed anxiety medication to give R2.

The "Behavior Note," dated 12/06/23, documented R2 continued to yell out at times stating she hurt. R2 was not consistent reporting the location of the pain. Nursing attempted use of as needed medication, Voltaren gel (topical pain medication), and repositioned R2 when she allowed.

The "Progress Note," dated 12/07/23, documented LN J talked to the nurse at the medical clinic and was instructed to send R2 to the emergency room to be evaluated for the pop in her back on 12/05/23. Emergency Medical Service (EMS) called for a non-emergent transfer

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 12/13/2023

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		

to transport R2 to the emergency room. Staff called R2's responsible party and left a voicemail. R2's responsible party returned the call from LN J at 08:56 AM. EMS arrived at 09:07 AM and staff assisted transferring R2 from her bed to the cot.

The "Radiology Report," dated 12/07/23, documented R2 had sustained a closed fracture of the right proximal humerus.

The "Physician Communication Note," dated 12/07/23, documented R2 returned from the emergency room with a closed fracture to the proximal end of her right humerus. The emergency room doctor wanted R2 to follow up with her primary care physician to determine the need for an orthopedic (bone specialist) referral. The note directed nursing staff to use an ice pack and pain medications as needed. R2 was to wear a sling to her right arm.

The "Progress Note," dated 12/07/23, documented LN J spoke with the clinic doctor who returned day shift phone calls for R2's primary care physician. The clinic doctor agreed that she to send a referral to the orthopedic center first thing in the morning for possible need of a cast to R2's right upper extremity fracture. The clinic doctor stated she would order R2 oxycodone (opioid pain medication) 10 milligrams every six hours as needed and a new order for lidocaine (pain medication) patches for pain management until R2 was seen by the orthopedic clinic.

LN J's "Witness Statement," dated 12/07/23, documented LN J and CNA O went to reposition R2 in her Broda (special wheelchair with the ability to tilt and recline) chair because R2 slid off

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 12/13/2023

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		

of her sling, so staff were unable to use the mechanical lift. LN J and CNA O put one hand under each of R2's arms, and one hand under each one of R2's legs. The first attempt did not get R2 back far enough on the sling. LN J and CMA M lifted R2 a second time, and when they did, they heard a pop. R2 complained of pain in her back. At that point, R2 was far enough back on the sling to use the lift. LN J and CNA O put R2 in her bed and R2 started complaining of right shoulder pain. R2 then complained of back pain. LN J gave R2 an oxycodone for the pain. LN J was told by nurse management to monitor R2 and call the doctor's office on 12/06/23 if the pain persisted. LN J called the doctor's office on 12/06/23 and requested guidance. LN J received a call back on 12/07/23 and was instructed to send R2 to the emergency room for evaluation. R2's x-ray came back with a closed fracture to the right proximal humerus. LN J called the doctor's office on 12/07/23 and requested an office visit and an increase of pain medication but did not receive a call back.

CNA N's "Witness Statement," dated 12/08/23, documented CNA O was getting ready to transfer R2 for a check and change. CNA O noticed the sling was not properly under R2's bottom half of her body (bottom and thigh areas). CNA O got LN J to help adjust R2 as she had slid down in her Broda chair. CNA O and LN J used the sling, each on the opposite sides to lift R2 up higher in the Broda chair. Unfortunately, the sling was still not under R2 properly to safely do the transfer. Under LN J's instruction, CNA O and LN J stood on opposite sides of R2 in the chair. CNA O and LN J scooped with one hand under R2's shoulder on each side and one under her leg and attempted to move R2 up. CNA O and LN J heard

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 12/13/2023

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		

a pop and R2 seemed concerned. LN J informed R2 it was just her back. After a little time passed, R2 began expressing pain. CNA O informed LN J R2 expressed pain and LN J gave R2 medication.

The "Skin/Wound Note," dated 12/11/23, documented the nurse entered a treatment in the "Electronic Treatment Administration Record" (ETAR) R2 was not to remove the sling to her right forearm until cleared or further orders were received from the orthopedic clinic when R2 had her appointment. R2's sling should be checked throughout shifts to ensure proper fit.

The "Facility Incident Report," dated 12/12/23, documented R2 went to the emergency room on 12/07/23 for uncontrolled pain in her left shoulder after hearing a pop in her back during a transfer. R2 had a non-displaced surgical neck fracture of the proximal right humerus. On 12/05/23 at approximately 03:45 PM R2was in her Broda chair. Nursing staff noted R2 had slid down and was not properly positioned on her lift sling. LN J and CNA O reclined the chair then put their arms under each of R2's arms and under each leg. LN J reported the first lift did not get R2 back far enough on to the lift sling. A second lift was completed. During the second lift an audible pop was heard. R2 complained of pain in her back. After the second lift R2 was far enough back to use the lift sling to place R2 in bed. During the transfer to bed, R2 reported she was having right shoulder pain then also complained of back pain. R2 was administered oxycodone 5 mg by mouth for pain. R2 had the order as needed for pain management. LN J reported the event to the nurse manager and LN J was instructed to monitor R2 and call the provider's office on 12/06/23 if pain persisted. On 12/06/23 LN J

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 12/13/2023

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		

called the medical clinic for guidance. LN J called the medical clinic again on 12/07/23 and orders were received to send R2 to the emergency room for evaluation and treatment. R2 was sent to the hospital emergency room by non-emergency EMS.

On 12/13/23 at 01:00 PM, observation revealed R2 sat in her Broda chair in the day room. R2 had a sling to her right arm.

On 12/13/23 at 01:00 PM, R2 stated that her right arm was very painful, and she had not seen the orthopedic doctor yet. R2 stated her pain was at an "eight" (0-10 pain scale where zero represents no pain and 10 the worst pain imaginable) and the pain medication barely touched her pain. R2 stated that she heard the pop during the transfer and was concerned. LN J told her it was her back popping.

On 12/13/23 at 01:30 PM, LN J stated she could not remember if the pop occurred during the first transfer or the second transfer. LN J stated R2 constantly said she had pain, and the pain location was inconsistent. LN J stated she did not know of any other ways to get R2 back on the sling, so she could be safely transferred with the lift.

On 12/13/23 at 02:00 PM Administrative Nurse D stated all nurses were taught the arm and leg technique for moving residents. Administrative Nurse D stated LN J and CNA O should have laid the Broda chair completely back and rolled R2 to resituate the lift sling under her. Administrative Nurse D stated therapy placed a Dycem (anti-slide material) on R2's Broda chair between the chair and the lift sling to keep R2 from sliding

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 12/13/2023

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 down, and therapy worked with R2 for chair positioning. Administrative Nurse D stated therapy was going to re-educate staff on how to reposition the lift sling with a resident in a Broda chair. The facility "Safe Lifting and Moving Patients," revised December 2019, documented in order for the facility to protect the safety and well being of associates and resident and to promote quality care the facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. The facility failed to ensure staff repositioned R2 safely while in her Broda chair which resulted in a right proximal humerus fracture. This deficient practice also placed R2 at risk for increased pain.	F 689		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents with three residents reviewed for medication errors. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 remained free from significant medication errors. On 12/07/23 R1 admitted to the facility with a physician's order for glimepiride (medication used to lower blood glucose [sugar]	F 760		

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 12/13/2023

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 760	Continued From page 9	F 760		

levels) 2 milligrams (mg) twice daily. Staff incorrectly transcribed the order as glimepiride 4 mg twice daily. R1 received a total of seven doses of glimepiride, at twice the prescribed dosage, before staff caught the error on 12/11/23 at 09:30 PM. Staff did not check R1's blood sugar but notified R1's representative and primary care physician (PCP) and stated there were no adverse effects from the error. A short while later, at 10:15 PM, staff found R1 face down on the floor of his room with his call light still hooked to his shirt. R1 was drowsy, with non-reactive pupils and then became non-verbal. Staff called Emergency Medical Services (EMS). EMS arrived and initiated transport to the Emergency Department (ED). EMS assessed R1's blood sugar in the ambulance as 36 milligrams (mg)/ per deciliter (dL) (normal range is 70-130 mm/dL). The facility failure to ensure R1 remained free from significant medication errors placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), aspiration (inhaling liquid or food into the lungs), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues).

The "Admission Minimum Data Set" was not yet completed. Social services performed a Brief Interview for Mental Status (BIMS) and R1's BIMS was 10, which indicated moderate cognitive impairment.

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 12/13/2023

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 760	Continued From page 10	F 760		

The EMR lacked "Care Area Assessment" documentation.

R1's "Care Plan," date 12/07/23, documented R1's safety and psychosocial needs would be met. The care plan lacked any documentation regarding R1's diabetes mellitus needs.

The "Hospital Discharge Instructions," dated 12/07/23, directed nursing staff to administer glimepiride 2 mg by mouth twice daily.

R1's December 2023 "Electronic Medication Administration Record" (EMAR) documented an order entered by Licensed Nurse (LN) G for glimepiride 4 mg by mouth twice daily starting on 12/07/23. The EMAR documented R1 received 4 mg of glimepiride on seven occasions.

The "Progress Note," dated 12/07/23, documented R1 was admitted to the facility for skilled nursing, physical therapy, occupation therapy, and speech therapy with diagnoses of diabetes mellitus and dementia (progressive mental disorder characterized by failing memory, confusion). R1 was alert and oriented to who he was and where he was but was slow to process with communication. R1 was pleasant and cooperative.

The facility's "Physician's Order Sheet," dated 12/08/23, documented R1's PCP signed R1's admission orders with a signature stamp. The order's included the glimepiride 4 mg by mouth twice a day.

The "Progress Note," dated 12/11/23 at 09:30 PM, documented R1 had inadvertently received

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 12/13/2023

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 760	Continued From page 11	F 760		

Amaryl (glimepiride) 4 mg by mouth twice daily. R1's order actually stated Amaryl 2 mg by mouth twice daily. No adverse reaction was noted. R1's order was updated, R1's representative notified of the event, and R1's PCP was notified of the event.

The "Fall Documentation Note," dated 12/11/23 at 11:08 PM, documented Certified Nurse's Aide (CNA) M found R1 lying on the floor at 10:15 PM. R1 was face down with his feet toward the middle of the room and his head toward the wall of the room. R1's forehead rested on the metal bar of the rolling bedside table with his body horizontal to the bed and six to eight inches away from the bed. R1's call light was still clamped on his shirt. R1 was unable to state what happened but was able to answer pain questions and responded to requests to move his extremities. R1 was log rolled to his back with three staff assist. R1's forehead had a large, reddened area across his forehead and his left eye was starting to discolor. Neurological checks revealed R1's pupils were unequal and not reactive to light. Staff called EMS at 10:23 PM due to the results of the neurological exam. R1's level of consciousness was drowsy. Before EMS arrived R1 became non-verbal. R1 left the facility at 10:41 PM.

The "Progress Note," dated 12/12/23 at 03:09 AM documented LN G received a phone call from the emergency room with an update. The emergency room nurse stated the 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 showed no signs of a brain bleed. R1's blood sugars were under control and ordered the facility to check R1's blood sugars every two hours. Facility staff

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 12/13/2023

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 760	Continued From page 12	F 760		

picked R1 up from the emergency room.

The "Physician Communication Note," dated 12/12/23, documented R1's PCP called the facility with new orders to discontinue R1's order for glimepiride and to check R1's blood sugars twice a day and as needed.

The undated "Facility Incident Report" documented on 12/12/23 at 09:25 PM staff identified R1's glimepiride was inadvertently transcribed incorrectly and R1 received seven doses of glimepiride 4 mg by mouth twice a day. The order was entered by LN H on 12/07/23. R1's order per discharge instructions was for Amaryl 2 mg by mouth twice daily. The glimepiride order was corrected upon discovery on 12/11/23. R1's PCP was notified by fax on 12/12/23. At that time R1 had not had an adverse event. On 12/11/23 at 10:15 PM, LN G found R1 lying on the floor face down with his feet toward the middle of the room and his head toward the wall in his room. R1's call light was not initiated. R1 was not able to state what happened but was able to move his extremities when asked and report he had pain. R1 was drowsy at the time of assessment with a change from baseline noted. R1 was non-verbal when EMS arrived. When EMS checked R1's blood sugar his blood sugar was low at 36 mg/dL. EMS administered R1 Dextrose (sugar) 10% (D10). Upon R1's arrival to the emergency room, his blood sugar was in the 60's. A comprehensive metabolic panel (CMP-lab test) was obtained in the emergency room and R1's blood sugar was 76 mg/dL. The emergency room treated R1 with 25 milliliters (ml) of dextrose 50% (D50) and fed R1. R1 was monitored and returned to the facility at 03:45 AM. A CT of R1's head was negative. R1's PCP was notified of the event and orders

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 12/13/2023

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 760	Continued From page 13	F 760		

were received to discontinue the glimepiride and to complete blood sugars checks twice a day.

LN I's "Witness Statement," dated 11/12/23, documented LN I was called to the unit by LN H for assistance for a resident fall. Upon arriving to R1's room, LN I observed R1 lying supine (face up) on his room floor parallel to his bed. R1 was accompanied by two CNA's and LN H. R1 had a full body lift under him at that time. LN I observed LN H assessing R1, and advised LN I R1 was found with his head down and his forehead on the bottom bar of the bedside table. R1's fall was unwitnessed and due to R1's decline, LN H and LN I decided to contact EMS for patient transport to the hospital. R1 was minimally responsive and unable to answer staff appropriately. According to the CNAs, no vitals were obtained yet. LN I obtained R1's vital signs and noted his blood pressure was elevated. LN I checked R1's pupils and noted them to non-reactive to light. EMS arrived and R1 was transported to the hospital.

CNA N's "Witness Statement," dated 12/12/23, documented CNA N went to R1's room and R1 was laying on his stomach on the ground with his head on the metal part of his side table. R1 was saying his left arm hurt and he could barely move it. CNA N stated staff pulled R1 away from the table and then moved him on his side.

CNA M's "Witness Statement," dated 12/12/23, documented CNA M went to check on R1 and found R1 face first on the floor. CNA M told CNA N to get LN H while CNA M stayed with R1. CNA M, CNA N, and LN H turned R1 onto his back. LN I was called to assist, and EMS was called. EMS took R1 to the ER.

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 12/13/2023

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 760	Continued From page 14	F 760		

On 12/13/23 at 12:45 PM, observation revealed R1 sat at the dinner table with food in front of him. He was picking at his food and not eating. R1 was unable to hold a conversation.

On 12/13/23 at 02:00 PM, Administrative Nurse D stated the facility did not check blood sugars unless they were ordered by the physician. Administrative Nurse D stated even if a resident was showing signs of hypoglycemic (blood glucose reading less than 60 mg/dL) crisis the facility would have to obtain an order to check any residents blood sugar. Administrative Nurse D stated none of the residents who were just on oral anti-diabetic medication received blood sugar checks. Administrative Nurse D stated it was unfortunate the incident happened, and LN G felt horrible about transcribing the order incorrectly. Administrative Nurse D stated the facility was changing their order verification process so all orders were double checked by a second nurse and both nurses would have to sign that they verified the orders; if blood sugar checks were not ordered by the physician, the staff would query the physician. Administrative Nurse D stated LN G received coaching regarding the medication error.

The facility's "Admission Assessment and Follow Up: Role of the Nurse," revised March 2023, documented the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments. The nurse will reconcile the list of medications by reviewing the home medication history, the hospital discharge summary, and admitting orders. The nurse will

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 12/13/2023

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 760	Continued From page 15	F 760		

transcribe active orders into the electronic health record or community record to generate a physician's order list, a treatment administration record and a medication administration record.

The facility failure to ensure R1 remained free from significant medication errors placed R1 in immediate jeopardy.

On 12/13/23 the surveyor verified the following actions to remove the immediacy:
An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary team on 12/13/23 and a plan of correction was developed and implemented.

All medication orders were audited on 12/13/23 to verify orders were entered accurately.

All residents with diabetic medications were reviewed for blood sugar monitoring. The provider was notified for orders for any resident found without an order for blood sugar monitoring.

Current nurse associates were re-educated by the Director of Nursing or designee by 12/13/23 or prior to working the next scheduled shift on order transcription and medication reconciliation.

The Interdisciplinary team reviewed the "Admission Assessment and Follow Up" policy and procedure for compliance with the Centers for Medicare and Medicaid Services (CMS) regulation F760.

After removal of the immediacy, the deficient practice existed at a scope and severity of a "G."