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	175539	A. BUILDING _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE RIDGE	3636 NORTH RIDGE RD BLDG 400 WICHITA, KS 67205

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F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00188341, KS00188004, KS00187438 and KS00187371. The 2567 was sent electronically on 07/03/24.	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 56 residents with three residents reviewed for falls. Based on record review and interview, the facility failed to immediately implement interventions to prevent further falls for Resident (R) 1 after R1 had to be lowered to the floor when her left leg buckled underneath her. This failure led to another staff-assisted fall later the same day. As a result of this deficient practice, R1 sustained a severe fracture of the left ankle. This deficient practice also placed R1 at risk for pain, impaired mobility, and decreased independence. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of congestive	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and hypertension (high blood pressure).

R1's "Entry Tracking Record Minimum Data Set" (MDS) documented R1 admitted to the facility from the hospital on 05/16/24. No further MDS assessments were completed for this admission.

R1's "Care Plan" dated 05/20/24, documented R1 required extensive assistance from one staff for transfers and toileting. The care plan documented R1 had a history of falls in the past and the resident would not have any major injuries from falls. The care plan directed staff to keep pathways clear and provide adequate lighting, keep the bed at an appropriate height, keep personal belongings within reach, transfer the resident per intake information until R1 was seen by therapy, and then follow therapy recommendations/plan of treatment. On 05/22/24, R1's transfer status changed to note the resident required a full lift.

The undated "Resident at Risk Review" documented R1 had a fall risk score of 36 and was at risk for falls.

The "Nurse's Note," dated 05/17/24, documented R1 was alert and oriented.

The "Nurse's Note," dated 05/18/24, documented R1 was alert and oriented.

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The "Nurse's Note," dated 05/21/24 at 07:51 AM, documented therapy was walking R1 to the bathroom in R1's room when R1 lost strength in her left leg and staff lowered her to the floor. Staff notified R1's provider who planned to see R1 that day. The note indicated R1's family would also be in that day and staff would notify them then. The nurse manager was notified of the event.

The "Occupational Therapy Treatment Note," dated 05/21/24, documented upon arrival R1 sat up in a recliner stating she needed to go to the bathroom. R1 completed a transfer from the recliner with minimal assistance using a front-wheeled walker to complete mobility from the recliner to the bathroom. R1 stood outside of the bathroom door when her left lower extremity buckled beneath her Therapy Staff GG slowly lowered R1 to the floor using Therapy Staff GG's leg as a guide and support with R1 sitting on Therapy Staff GG's foot. Staff assisted R1 to the wheelchair with a two-person assist. The note documented the skilled interventions included to stand pivot transfer R1 from her wheelchair to the toilet with the use of bilateral grab bars with minimal assistance, lower extremity clothing management with maximum assistance, and peri care with maximum assistance. R1 required a brief change and lower extremity clothing application with maximum assistance while seated and standing. Staff left R1 in a wheelchair with bilateral lower extremities on leg rests, call light and table within reach, and covered with a blanket.

The "Physical Therapy Treatment Note," dated 05/21/24, documented they performed therapeutic activities for transfer training to decrease caregiver burden post skilled stay. R1

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presented in the recliner with a nasal cannula in place. R1 was very sleepy and required extra time to wake up. R1 was able to wake up and participate in mobility. R1 completed sit to stand activity from various surfaces with minimal assistance. R1 completed stand pivot transfers with cues for correct hand placement. R1 demonstrated a good ability to advance her feet during the stand pivot transfers. Note R1 had a non-injury fall when walking to the bathroom with Therapy Staff GG that morning. R1's legs gave out and she was assisted to the floor. R1's provider stated R1 had polypharmacy (multiple medications) and the provider planned to discontinue Haldol (antipsychotic medications used to treat major mental conditions that cause a break from reality), Baclofen (muscle relaxer), and Lyrica (a controlled substance used to treat muscle and nerve pain) in an effort to decrease tremors and improve alertness.

The "Nurse's Note," dated 05/21/24 at 09:30 AM, documented R1's daughter arrived and was informed of R1 being lowered to the ground. R1's daughter reported R1 was having pain in her left foot. The nursing staff reported the pain to the Physician's Assistant (PA).

The "Nurse's Note," dated 05/21/24 at 10:59 AM, documented R1's PA saw R1 and discontinued Lyrica, Baclofen, and Haldol due to R1 having decreased ability to communicate and twitching muscular movements. Staff notified R1's family of the new orders.

The "Nurse's Note," dated 05/21/24 at 01:29 PM, documented R1's PA ordered to hold R1's Lasix (diuretic used to promote formation and excretion of urine) for two doses, discontinue the lisinopril

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(medication used to lower blood pressure), place an intravenous (IV-directly into the vein) device and give R1 500 milliliters (ml) of normal saline at 75 ml's per hour. Staff notified R1's family of the order.

The "Nurse's Note," dated 05/21/24 at 08:00 PM, documented R1 received the ordered normal saline for dehydration. R1 was confused and pulled out her IV. R1 was unaware of what happened. Staff assessed the IV site and it was without bleeding or concern noted.

The "Nurse's Note," dated 05/21/24 at 11:00 PM, documented Certified Nurse Aide (CNA) M notified the nurse that R1 was unable to stand up for the bathroom and CNA M had assisted R1 to the floor. R1 stated her "knees had given up" and said she was unable to stand on her feet. R1 had no complaints of pain at that time. Staff performed a head-to-toe assessment, and no injury was noted. Staff assisted R1 up with a full lift, R1's brief was changed, and R1 was assisted to bed. R1 was talking to herself and pointing at stuff in her room.

The "Fall Scene Investigation Form," dated 05/21/24, documented Therapy Staff GG was walking R1 to the bathroom when R1's left leg gave out and PT lowered R1 to the floor with a gait belt on. R1 lost her strength while ambulating. R1 had gripper socks on. The fall intervention was for therapy to see R1 for strengthening.

Therapy Staff GG's "Witness Statement," dated 05/21/24, documented R1 was walking with therapy from the recliner to the bathroom. R1 was outside of the bathroom starting to turn in when

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R1's left lower extremity gave way and R1 was lowered to the floor with R1 ending up sitting on Therapy Staff GG's foot. R1 stated left ankle pain six out of ten.

CNA N's "Witness Statement," dated 05/21/24, documented R1 was working with therapy. Therapy came to get CNA N to help after R1's leg gave out on her. CNA N stated when she entered the room R1 was sitting on her bottom outside the bathroom door. The nurse was notified and assessed R1. CNA N and Therapy Staff GG helped R1 up from the floor and into her wheelchair.

The "Nurse's Note," dated 05/22/24 at 04:00 AM, documented R1 had purple bruising noted to her left ankle. R1 complained of pain and the note documented communication was placed for more evaluation.

The "Nurse's Note," dated 05/22/24 at 06:30 AM documented staff notified the on-call provider of R1's bruises and the provider ordered an x-ray of the left foot/ankle. The order was passed on to the on-coming nurse to notify the x-ray company.

R1's "Radiology Report," dated 05/22/24 at 05:14 PM, documented three views of the left ankle demonstrated a severe fracture dislocation of the left ankle. There was a transverse fracture (straight line fracture that runs in the opposite direction of the bone) at the medial (inner) malleolus (ankle bone). The distal (lower) fracture fragment as well as the talus (large bone of the ankle that connects with the tibia) were displaced laterally (to the outer side) by approximately 1.5 centimeters. Comminuted fractures (broken bones that have shattered into at least two

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pieces) were seen involving the distal fibula (lower leg bone) above the joint space. There was lateral angulation of the distal fracture fragment.

The "Nurse's Note," dated 05/22/24 at 06:15 PM, documented an order was received to send R1 to the hospital after the x-ray results came back. R1 exited the building at 06:15 PM.

The "Apparent Cause Analysis Report," documented R1 was admitted to the facility for skilled services on 05/16/24 with a primary diagnosis of CHF. On 05/21/24 at approximately 07:50 AM R1 was lowered to the floor by Therapy Staff GG during R1's therapy session. R1's left lower extremity buckled underneath her. Therapy Staff GG notified the charge nurse for assessment at the time of the fall. R1 complained of pain at a six on a scale of zero to ten, in her left ankle. R1 was seen by the PA and medication adjustments were made. The facility continued to manage R1's pain with routine pain medications. R1's weight-bearing status was not changed at that time by the PA or therapy. That evening at approximately 11:00 PM R1 was again lowered to the floor by clinical staff in her bathroom due to R1's legs giving out. R1 had no complaints of pain at the time of the second fall. On 05/22/24 at 04:00 AM, the nurse noted bruising on R1's left ankle and R1 complained of pain. R1's provider was notified via fax notification. At 06:30 AM, R1's PA was notified by phone of R1 having increased pain and bruising to the left ankle. The PA gave an order for an x-ray of the left ankle and foot. The x-ray results returned at 06:15 PM positive for lateral (to the side away from the center of the body) displacement relative to the tibia (lower leg bone). The facility received an order to send R1

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to the emergency room for evaluation and treatment and R1 left the building. The facility concluded and documented that the fracture to R1's left lateral ankle appeared to be the result of R1 rolling her ankle when she was lowered to the floor with therapy and immediately complained of pain of six out of ten in her left ankle.

The "Nurse's Note," dated 05/23/24, documented that R1's daughter did not want to hold her bed at the facility.

On 06/25/24 at 01:30 PM, Administrative Nurse D stated it was not up to nursing to determine R1's transfer status. Administrative Nurse D stated therapy determined R1 was a transfer with minimal assistance from one staff. Administrative Nurse D stated after R1's first fall, therapy did not change R1's transfer status so nursing continued to use a one-person assist.

On 06/25/24 at 03:30 PM, Therapy Staff GG stated after she lowered R1 slowly to the ground. there was no deformity or bruising to R1's ankle. Therapy Staff GG said after the nurse assessed R1, she and another staff assisted R1 to her feet and to the wheelchair and then took R1 to the bathroom. Therapy Staff GG stated R1 did not complain of any increased pain when she stood and was able to completely bear weight. Therapy Staff GG stated physical therapy worked with R1 later that morning and R1 was able to bear weight and complete all exercises and did not complain of pain. Therapy Staff GG stated therapy staff leave it up to nursing staff to increase the level of assistance required for a resident's transfer status with a change of condition.

The facility's "Fall Policy," revised July 2023,

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documented the purpose of the policy was to provide guidelines for the evaluation of a resident in the event a fall occurred and to assist associates in the identification of potential causes of the fall. The Faber Fall Risk Assessment form should be utilized to complete the evaluation of the residents' potential for falls during the admission process. The Faber Fall Risk Assessment should be completed quarterly or with significant change MDS Assessment and after every fall. If a resident sustains a fall or is found on the floor without a witness to the event, associates shall evaluate for possible injuries and provide first aid or treatment as necessary. Direct care associates shall evaluate the area where the fall occurred for possible contributors. A Licensed Nurse shall document the fall in the resident's Attending Physician and Resident Representative of the event. The Licensed Nurse shall document the fall in the resident's clinical record. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. A Licensed Nurse shall observe clinical status for 72 hours after an observed or suspected fall and document findings in the resident clinical record. The fall should be reviewed at the Daily Stand-Up meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. An incident report shall be completed for resident falls by a Licensed Nurse after the fall occurs.

The facility failed to initiate immediate interventions to prevent further falls for R1 after R1 was lowered to the floor when her left leg buckled underneath her. This led to another staff-assisted fall later the same day. As a result, R1 sustained a severe fracture of the left ankle.

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