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	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Manhattan, Inc	2800 Willow Grove Road Manhattan, KS 66502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 91 residents, with 3 residents sampled for medication errors. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 received treatments and care in accordance with professional standards of practice. On 03/22/25 at 10:30 AM, Certified Medication Aide (CMA) R assisted R1 in undressing in the bath spa and noted extensive purple/black bruising to R1's bilateral (both sides) axilla (armpit), bilateral arms, torso, and back. CMA R reported her findings to Licensed Nurse (LN) G, who assessed R1 and documented the extensive bruising. LN G then reported the findings to the nurse manager on duty, LN H. Neither LN G nor LN H reported R1's extensive bruising to her primary care physician even though R1 was on Coumadin (medication for anticoagulation (a treatment that prevents blood from clotting too quickly or excessively) and per facility protocol, staff were to notify the primary care physician of any resident who was on an anticoagulant (medications that prevent blood from clotting) of signs of excessive bruising before the next scheduled dose of Coumadin would be given. Facility staff gave R1 three more doses of Coumadin 5 milligrams (mg) on 03/22/25 at 05:00 PM, 03/23/25 at 05:00 PM, and 03/24/25 at 05:00 PM. This deficient practice placed R1 at risk for complications for bleeding, falls with injury, and possible death. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of long-term/current use of anticoagulants, nonrheumatic aortic valve stenosis (narrowing of the valve in the large blood vessel branching off from the heart), and obstructive hypertrophic cardiomyopathy (a condition in which the heart muscle becomes abnormally thick making it hard for the heart to pump blood). The Admission Minimum Data Set (MDS), dated [DATE], documented R1 admitted to the facility on [DATE]. The MDS documented R1 was unable to complete the Brief Interview for Mental Status (BIMS) interview. The MDS documented R1 had short and long-term memory loss, could not recall the current season, could not recall the location of her room, could not recall staff names and faces, and could not recall that she was in a nursing facility. The MDS documented R1's cognition was severely impaired. The MDS documented R1 required substantial assistance from staff for toileting, bathing, dressing, transfers, and personal hygiene. The MDS documented R1 was dependent on staff for assistance with sitting to lying and lying to sitting. The MDS documented R1 had falls within the last month before her admission and had falls the last two to six months before her admission. The MDS documented R1 was taking anticoagulants. (continued on next page)

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.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 03/02/25, documented R1 had memory problems, impaired decision-making, and impaired ability to comprehend. The Fall CAA, dated 03/02/25, documented R1 was at risk for falling and had fallen previously before entering the facility. R1's Care Plan directed staff R1 required two staff assistance for transfer from the chair or the bed (02/24/25). The care plan documented R1 was at risk for falls and directed staff to keep pathways clear, provide adequate lighting, keep personal items within reach, and orient to room and call light (02/24/25). The care plan documented R1 was at risk from complications from blood thinning agents and would not develop complications from blood thinning agents. The care plan directed staff to monitor R1 for the presence of bone, abdominal, joint, or other pain (02/26/25). The care plan directed staff to monitor R1 for the presence of hemorrhage (loss of a large amount of blood in a short period of time) under the skin, oral mucosa (a membrane that lines various body cavities), and/or conjunctiva (a thin, transparent membrane that covers the white of the eye) at least daily (02/26/25). The care plan directed staff to monitor for the presence of active bleeding such as hematuria (blood in the urine), petechiae (tiny brown/purplish spots due to bleeding under the skin), bruising, bloody stools, or nose bleeds at least daily (02/26/25). The care plan directed staff to prevent falls which could potentially cause a high risk of bleeding. The care plan directed staff if R1 had side effects from the blood thinning agent a nurse would reflect this issue with an immediate follow-up notification to the physician via a phone call (02/26/25). The [NAME] Fall Scale, dated 03/25/25, documented R1 had a fall risk score of 37 which indicated R1 was a high fall risk. The Progress Note, dated 03/22/25 at 10:31 AM, documented staff were called to the spa room to check on R1 for large areas of purple/black skin noted under both armpits, upper lateral (pertaining to the side, away from the middle) back/torso (truck or central part of the body). R1 had no skin break. The March 2025 Electronic Medication Administration Record (EMAR), documented R1 received Coumadin 5 mg at 05:00 PM on 03/22/25 (after the extensive bruising was found), 03/23/25 at 05:00 PM, and 03/24/25 at 05:00 PM. The March EMAR documented R1's Coumadin 5mg was held on 03/25/25 and then was discontinued. The Progress Note, dated 03/24/25 at 10:30 PM, documented R1 was noted to have increased bruising due to being on Coumadin. A fingerstick International Normalized Ratio (INR - a blood test that measures the time it takes for blood to clot. Therapeutic values for people taking Coumadin are 2.0 to 3.0) was checked and the result was greater than 8.0. The on-call doctor was notified regarding the results of the fingerstick INR and R1's bruising to her axilla (armpits) and arms. The on-call doctor ordered to monitor R1, hold Coumadin, PT (Prothrombin Time - a blood test that measures how long it takes for blood to clot.)/INR on Tuesday and Wednesday, and send to the emergency room if R1's vital signs became unstable, or bleeding was noted from R1's orifices (an opening of the body). R1 was placed on frequent checks and vital signs every eight hours. The Progress Note, dated 03/25/25, documented the nurse obtained lab for PT/INR and Complete Blood Count (CBC - a blood test that measures various components of the blood). R1 tolerated the procedure well. Specimen sent with transportation to the clinic. Awaiting results. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Progress Note, dated 03/25/25, documented R1's primary care physician's office called with the INR results. R1's INR was 9.55 (the normal INR for people on Coumadin is 2.0 to 3.0). A new order was received to hold Coumadin until the results of the next INR, give Vitamin K (antidote (a medicine given to counteract another medicine or poison) to Coumadin) 2.5 mg one time, and have R1 to avoid falls. The order was faxed to R1's pharmacy. The Progress Note, dated 03/25/25, documented R1's primary care physician called and rescheduled the INR lab draw for tomorrow, 03/26/25, and to give the Vitamin K 2.5 mg that evening. According to R1's Treatment Administration Record (TAR) Vitamin K 2.5 mg was given to R1 by mouth. The Progress Note, dated 03/26/25 at 12:49 AM, documented R1's INR was 9.5 and Pro Time was 108.7. The Progress Note, dated 03/26/25 at 07:30 AM, documented the nurse obtained lab work this morning of PT/INR. R1 tolerated the procedure well. The blood specimen was sent with transportation to the clinic. Awaiting results. The Progress Note, dated 03/26/25 at 03:30 PM, documented R1's INR was 2.73 and PT was 31.9. The Progress Note, dated 03/26/25 at 04:30 PM, documented R1's primary care physician ordered to continue to hold R1's coumadin as the INR was 2.73. The facility does not have to do another INR unless further notified. CMA R's Notarized Witness Statement, dated 03/24/25, documented CMA R was working as a Certified Nurse Aide (CNA) on 03/22/25 and assisted R1 with a shower. CMA R stated when she assisted R1 with the removal of her shirt she noticed dark bruising under R1's arms by her armpits. CMA R documented she called LN H of what she had found and then called LN G into the spa room to look at the bruising. LN G's Notarized Witness Statement, dated 03/24/25, documented CMA R called LN G into the spa room to show LN G the bruises on R1. R1 had purplish/black bruises under her armpit, the upper arm, the upper torso, and on both upper extremities. LN G stated she had not been informed of R1's skin condition. LN H's Notarized Witness Statement, dated 03/27/25, documented LN H had been informed of R'1 bruising to her bilateral arms and axilla. Upon assessment, deep purple bruising to the left arm from the elbow to the axilla, and the right arm with spotty dark bruises and deep dark bruises to the right axilla. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Facility Incident Report, dated 03/31/25, documented on 03/22/25 it was noted by CMA R while assisting R1 with the removal of her clothing for her shower R1 had dark bruising under her arms by her armpits. CMA R then notified LN G and LN H of the finding. LN G went and assessed R1 noting purplish/black under the armpits, upper arm, upper torso, and both upper extremities. No skin breakdown. The bruising measured: right lateral upper arm three centimeters (cm) by 2.5 cm, lateral lower right arm five cm by 2.5 cm, right medial axilla three cm by two cm, left lateral axilla down the entire left arm 40 cm by seven cm and the left lateral axilla 10 cm by five cm. On 03/24/25 upon investigation, it was found R1 had been recently treated with antibiotics for a respiratory infection. R1's fingerstick INR was obtained and the results were noted to be greater than eight. The on-call physician was notified of the results. Orders received to continue to monitor R1, hold Coumadin, draw PT/INR on Tuesday and Wednesday, follow up with R1's primary care physician tomorrow, send to the emergency room if R1's vital signs were unstable, bleeding from orifices, or if R1 falls. On 03/25/25 R1's INR was 9.5. New orders were received to give Vitamin K 2.5 mg, recheck INR on 03/26/25, and continue to hold Coumadin. On 03/26/25, R1's INR was 2.73, and continued to hold Coumadin. The facility increased R1's vital signs, frequent monitoring for fall prevention, and noted R1 now required two staff extensive assistance with a gait belt for transfers. On 04/01/25 at 11:30 AM, Administrative Nurse D stated a couple of days after the bruising was noted and the facility was investigating the origin of the bruising it was noted R1 had been on antibiotics so a fingerstick INR was done and it was greater than 8. Administrative Nurse D stated she did not know why the APRN did not order an INR to check if the antibiotics would increase the effect of the coumadin. Administrative Nurse D stated the facility put R1 on VS's every 8 hours and 30-minute checks for her safety. Administrative Nurse D stated she would expect staff to follow the anticoagulant protocol. On 04/01/25 at 12:30 PM, observation revealed R1 had diffuse light purple bruising to her upper bilateral arms. On 04/01/25 at 12:45 PM, LN I stated she first saw the bruising to R1's arms last week and it was purple under her arms and down her upper arms. LN I stated she had been told the bruising was because R1's INR had been too high. LN I stated she would have called the nurse manager and the doctor right away because residents on Coumadin and antibiotics need to be monitored closely because the two medicines counteract each other. On 04/01/25 at 01:00 PM, CNA M stated she saw R1's bruising last week and it was pretty bad under her arms. CNA M stated she was not the first one to see the bruising and if she had been she would have reported it to the nurse right away. On 04/01/25 at 01:30 PM, LN G stated he had seen the bruising on R1's arms when CMA R had called him into the spa room. CMA R had already notified LN I who was the nurse manager on shift that day. LN G stated it did not enter his mind to call and notify R1'a primary care physician of the bruising and the nurse manager did not tell him to, so he did not. LN G stated he did realize R1 was on Coumadin and going forward if any bruising happened to a resident, he would notify the doctor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's Anticoagulant Procedure, revised in December 2017, documented the physician will prescribe anticoagulant therapy appropriately in accordance with recognized guidelines. The physician will identify potentially serious medication interactions with coumadin for example: digoxin, Dilantin, amiodarone, and many antibiotics. The associates will identify and address potential complications in individuals receiving anticoagulants. The physician will be notified of anticoagulant therapy if an antibiotic is prescribed. The associates and the physician will monitor for possible complications in individuals being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis (spitting or coughing up blood) or other evidence of bleeding the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The facility failed to ensure R1 received treatments and care in accordance with professional standards of practice. This deficient practice placed R1 at risk for complications for bleeding, falls with injury, and possible death.