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	07/29/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 87 residents, with three residents reviewed for accidents and hazards. Based on record review, observation, and interview, the facility staff failed to ensure two staff safely transferred Resident (R)1 with a full mechanical lift as care planned. On [DATE] at 01:20 PM, CNA M was transferring R1 into her wheelchair with the full mechanical lift (Hoyer), without the assistance of the required second staff member. During the transfer, the bottom left sling loop came off the Hoyer lift, causing R1 to fall to the ground. Due to CNA M not following R1's care plan, R1 fell, broke her right distal femur, had extreme pain untreated by pain medication, and subsequently died. The facility further failed to ensure a safe environment free from preventable accidents for visually impaired Resident (R) 2, when facility staff did not ensure the ratchet harness was tightened to R2's wheelchair in the facility van before transport. On [DATE], Certified Nurse Aide (CNA) N attached the harness to R2 in the facility van for an out-of-town appointment, but due to a lack of training, did not ensure the ratchet straps were locked in order to prevent the ratchet harness from slipping/loosening. Approximately two miles from the facility, CNA N came to a stop, then accelerated for a right turn, heard the sound of the ratchet harness, and looked back to see R2 fall backwards in her wheelchair. R2 was bleeding from the back of her head and went to the hospital Emergency Room, where R2 received staples to close the scalp laceration to the back of her head. This deficient practice placed R1, and all residents driven to appointments at risk for injury, pain, and potential death.Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, major depressive disorder (major mood disorder which causes persistent feelings pf sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and falls.The Annual Minimum Data Set (MDS), dated [DATE], documented R1 had functional impairment on one side of her upper and lower extremities. The MDS documented R1 was dependent on staff for transfer.The Fall Care Area Assessment (CAA), dated [DATE], documented R1 utilized a Hoyer lift.R1's Care Plan directed staff R1 required two staff assistance with a Hoyer lift for transfers using a medium-sized sling. The care plan directed staff R1 was completely dependent on staff for all of her activities of daily living (ADL) ([DATE]). The Nurses Note, dated [DATE], documented upon entering R1's room, LN G saw CNA M and CNA N on the floor with the resident and the Hoyer lift nearby. CNA M sat with R1 with a towel against R1's head to decrease bleeding from a hematoma on the left side of R1's head. R1 was on the floor with an excessively bleeding hematoma on the left side (of her head). R1 was cold and clammy to the touch, alert and oriented, and able to respond to questions. LN G called 911. CNA M stated R1 fell from the Hoyer lift sling when one of the straps snapped off the hook. While doing a head-to-toe assessment, R1 could not bend or stretch her right leg without significant pain. Emergency Medical Services arrived and transferred R1 to the local hospital. Administrative Staff A's Notarized Witness Statement documented, on [DATE] at approximately 01:30 PM, Administrative Staff A passed R1's room, heard a scream and a thud sound, and saw R1 lying on the floor, with the sling still connected to the lift. Administrative Staff A documented, as he walked into the room, he saw blood on the floor and on CNA M's hand as she was holding R1's left side of her head/face. Administrative Staff A could not tell if R1 was speaking or groaning. CNA M's Notarized Witness Statement, dated [DATE], documented she got R1 in the lift sling and when CNA M pulled the lift and pushed R1 toward her chair, one strap fell out, and R1 slipped, falling on her left side to the floor. The emergency room (ER) Report, dated [DATE], documented R1 presented to the ER due to a three-foot fall from a Hoyer lift and hit her head and complained of right knee pain radiating to left hip pain. X-rays showed R1 sustained an acute, mildly impacted fracture (occurs when the broken ends of the bone are driven into each other) of her right femur (thigh bone) and an acute fracture of the distal femoral metadiaphysis (the area of the thigh bone located near the knee joint between the wider part just below the growth plate and the main shaft of the bone) with mild angulation (angular displacement of bone fragments). The report recommended to apply an immobilizer to leave on until seen by a bone specialist and an order for as needed narcotic pain medication (every 4-6 hours). The Nurses Note, dated [DATE], documented R1's body shook after she was transferred to bed. R1 rated her knee pain as a 10 out of 10. The Nurses Note, dated [DATE], documented R1 had severe pain with any type of movement, with transfers, and staff performing cares. R1 made statements of