STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via Christi Village Pittsburg Inc	1502 E Centennial Pittsburg, KS 66762

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40689 The facility reported a census of 81 residents. The sample included three residents reviewed for neglect. Based on observations, record review, and interview, the facility failed to prevent the staff neglect of Resident (R) 1. On 11/27/23 at 08:45 AM Certified Medication Aide (CMA) R entered cognitively impaired R1's room and observed R1 on the floor with her legs extended in the doorway of the closet. CMA R administered medications to R1 while she remained on the floor, and then left the resident's room. CMA R failed to report to any staff member that R1 was on the floor. At 12:45 PM, four hours later, CNA M heard noises coming from R1's room and when she entered the residents' room, she observed R1 sitting on the floor next to her bed. CNA M asked Housekeeping Staff U, who was also in the room, to immediately get Licensed Nurse (LN) G. The nurse assessed R1 and noted the resident had pain in her left hip, her left leg was rotated outward and appeared to be shorter than her right leg. R1 was transported to the Emergency Department (ED) by Emergency Medical Services (EMS) and was diagnosed with a left hip fracture which required surgical repair. This deficient practice placed R1 in immediate jeopardy. Findings included: - Resident (R)1's "Physician Order Sheet" (POS) dated 04/23/24, documented diagnoses which included: vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), seizure (violent involuntary series of contractions of a group of muscles), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), narcolepsy (excessive sleepiness in the daytime and may also suddenly fall asleep during any activity), bilateral (both) hearing loss (keeps sound from passing through your ear canal and/or middle of ear), and mixed receptive-expressive language disorder (a condition that affects how people express themselves and understand what others say). R1's 03/02/23 "Significant Change of Condition Minimum Data Set" (MDS), documented the resident was admitted from acute care on 06/15/21. She had a "Brief Interview of Mental Status" (BIMS) score of three, which indicated severely impaired cognition. She had inattention, disorganized thinking, and she was vigilant (startled easily to any sound or touch). The resident required extensive assistance with bed mobility, transfers, toileting, and limited assistance with ambulating. She was frequently incontinent of bowel and bladder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Via Christi Village Pittsburg Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1502 E Centennial Pittsburg, KS 66762	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 03/08/23, documented the resident had confusion and forgetfulness. The resident's BIMS interview documented the resident had long and short-term memory deficits. The "Falls Care Area Assessment (CAA), dated 12/08/23, documented the resident was at risk for falls due to an unsteady gait and poor safety awareness. The resident ambulated independently with verbal cues and redirection for safety. R1's 11/02/23 "Quarterly MDS", documented the resident had a BIMS score of three, which indicated severely impaired cognition. She had inattention, disorganized thinking, and she was vigilant (startled easily to any sound or touch.) The resident required extensive assist with bed mobility, transfers, toileting, and limited assist ambulating. She was frequently incontinent of bowel and bladder. R1's 10/30/23 "Fall Risk", evaluation documented a score of three. The score of zero to 15 indicated minimal risk for falls. The Altered level of cognitive function related to vascular dementia Care Plan", dated 11/03/23, instructed staff to call the resident by her name, and to keep routine consistent to decrease confusion. R1's Fall Care Plan, dated 11/03/23, instructed staff to keep pathways clear and provide adequate lighting, keep the resident's bed at the appropriate height, encourage the resident to wear non-slip socks, assist the resident with using her wheelchair for mobility when the resident was unsteady, and offer to assist her to a couch or easy chair after meals. R1's ADL Care Plan dated 11/03/23, instructed staff the resident required extensive assist with one staff for bed mobility, transfers, and toileting. Review of a Nurses Note on 11/27/23 at 05:17 PM, revealed Housekeeping Staff U notified Licensed Nurse (LN) G that the resident was on the floor in her room. CNA M also notified LN G. N G entered the resident's room and observed the resident sitting on her bedroom floor beside her bed. The resident was non-verbal and unable to answer staff questions. Upon further assessment, the resident guarded her left leg and hip during a range of motion (ROM) assessment. The resident's left leg was rotated outward with some length difference from her right leg. LN G contacted Administrative Nurse D and Administrative Staff A of the incident. LN G called the resident healthcare provider for an order to transfer the resident to the Emergency Department (ED) by Emergency Medical Service (EMS). Review of the facility's investigation revealed CMA R observed the resident on the floor on 11/27/23 at 08:45 AM with her legs extended in the doorway to the closet. CMA R waved and said Hi, [R1]. CMA R reported that the resident smiled and laughed after being greeted. CMA R then administered medications while the resident remained on the floor and CMA R left the resident's room. CMA R did not advise anyone that the resident was on the floor. Review of the hospital records revealed R1's diagnostic images of her pelvis and two views of the left hip, dated 11/27/23, demonstrated a displaced (bones moved enough to create a gap) comminuted (broken in at least two places) intertrochanteric (top part of the thigh bone) femur (thigh bone) fracture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's hospital discharge summary, dated 12/01/23, documented the resident resided in a long-term facility and sustained a left intertrochanteric fracture (hip fracture). Review of a Nurses Note dated 12/01/23 at 01:00 PM documented the resident readmitted to the facility from acute care hospital. R1 sustained a left intertrochanteric fracture (hip fracture). Observation on 05/06/24 at 06:00 AM, revealed the resident was in bed resting with her eyes closed. Observation on 05/06/24 at 08:45 AM, revealed the resident ambulated with her walker to the dining room table with staff providing stand-by assistance. Review of CMA R's witness statement dated 11/27/23 at 08:45 AM, revealed CMA R entered the resident's room to administer her medications. She observed the resident sitting on the floor near the closet. CMA R said, Hi [R1] and waved at the resident. The closet door was opened, and it seemed as if she was messing around in her closet. CMA R administered the resident her medications and left the resident sitting on the floor and left the room. CMA R reported in her statement I didn't think anything of it because I have known the resident to do her own thing while still needing help. Review of Certified Nurse Aide (CNA) M's witness statement revealed on 11/27/23 at 12:45 PM, CNA M was assisting another resident when she heard R1's squealing. She entered R1's room to discover R1 was on the floor next to her bed. LN G was immediately notified. On 05/06/24 at 10:00 AM, Housekeeping U reported she was at the door of the resident's room and CNA M asked her to notify LN G that the resident was on the floor. On 05/07/24 at 12:23 PM, LN G reported that on 11/27/23 at approximately 12:45 PM, CNA M notified her that she found R1 sitting in her room on the floor next to her bed. LN G reported the resident required assistance with bed mobility, transfers, toileting, and ambulating. The resident was non-verbal and unable to verbalize her needs and would not be able to tell staff how she fell . LN G notified Administrative Nurse D of the fall. The resident guarded her left hip and left leg. Her left leg appeared to be shorter than her right leg. Staff had R1 transferred to the ED by EMS. LN G reported that she asked CMA R to assist her with R1. While CMA R was assisting LN G with R1, CMA R notified LN G that she observed R1 on the floor in her room with her legs extended in the doorway of her closet and administered R1 her medications and left R1 on the floor without alerting any other staff. The facility's Abuse Prevention Policy, dated 06/2022, documented the residents have the right to be free from abuse, neglect and to be protected from abuse and neglect from community associates. On 05/06/24 at 03:38 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified the facility failed to protect R1 from neglect on 11/27/23, when CMA R found cognitively impaired R1 on the floor in her room, with her legs extended in the doorway of her closet and CMA R administered R1 her medications and left R1 on the floor without alerting any other staff. R1 remained on the floor for four hours, until another CNA (CNA M) heard R1 squealing from R1's room and alerted the LN. R1 had pain in her left hip, leg length difference and rotation and required emergent transport to the hospital and for surgical repair of a left hip fracture. This failure placed R1 in immediate jeopardy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy was determined to first exist on 11/27/23 at 12:45 PM. The facility identified and implemented corrective actions on 11/27/23 to include the following: 1. The facility educated all staff on the topics of Falls, Abuse, Neglect and Exploitation, and Timely Reporting. 2. R1 was assessed by Administrative Nurse D on 11/27/23 and no adverse effects noted. 3. R1's care plan related for falls reviewed by the Interdisciplinary Team and fall interventions were appropriate. 4. Staff education provided for all clinical staff on 11/27/23 at 02:00 PM and completed prior to the onsite survey. Due to the corrective actions completed prior to the onsite survey the deficient practice was deemed past non-compliance and existed at a J scope and severity.