STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175467	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kansas Christian Home	1035 SE 3rd Street Newton, KS 67114

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40689 The facility reported a census of 46 residents. The sample included three residents reviewed for neglect. Based on observation, interview, and record review, the facility failed to protect dependent Resident (R)1 from harm, when staff did not follow the resident's care plan, which instructed nursing staff to utilize a slide board (assist users and caregivers in the safe transfer from wheelchair to bed) to transfer the resident. On 10/18/24 at approximately 12:00 PM, Licensed Nurse (LN) G requested assistance from Certified Medication Aide (CMA) M when the resident requested to use the restroom. Certified Medication Aide (CMA) M entered the resident's room and observed the resident sitting in her wheelchair. CMA M offered to transfer R1 from her wheelchair to the bed to use the bed pan per her care plan, but the resident requested to use the toilet in the bathroom. CMA M propelled the resident to the bathroom, placed a gait belt around the resident's body, wrapped her arms around the resident, and completed a stand and pivot transfer from the resident's wheelchair to the toilet while LN G removed the resident's pants and brief. This failure resulted in broken bones in her right lower leg. Findings include: - R1's Physician Order Sheet (POS) dated 11/17/24, documented the resident was admitted on [DATE] with the following diagnoses: diabetes mellitus (the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with pathologic fracture (a break in a bone that is caused by an underlying disease), acute (condition characterized by a relatively sudden onset of symptoms that are usually severe), osteomyelitis (local or generalized infection of the bone and bone marrow) of the right ankle and foot, nondisplaced (a type of bone break where the bone cracks in one spot and stays aligned) trimalleolar (fracture of the ankle that involves the lateral malleolus, the medial malleolus, and the distal posterior aspect of the tibia) fracture (broken bone) of the right lower extremity, and above the knee amputation (AKA, surgical removal of a body part) of left extremity. The 09/04/24 Admission Minimum Data Set (MDS), revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required a manual wheelchair, propelled by staff, for mobility device due to above the knee amputation of the left extremity and non-bearing weight on right extremity. The resident was dependent on staff for transfers and toileting. The resident required a slide board for transfers. The resident was incontinent of bowel and bladder. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The ADL [Activities of Daily Living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 09/10/24, documented the resident had an above the knee amputation of the left extremity. The resident had a recent surgery on her right ankle due to a fracture prior to admission to the facility. She had a non-weight bearing status on admission and was working with therapy for transfers. She required assistance for all activities of daily living (ADLs). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 09/10/24, documented the resident required assistance from staff with toileting due to the resident's inability to transfer to the toilet and difficulty maintaining a sitting balance. The Fall Care Area assessment (CAA), dated 09/10/24, documented the resident had a fall score of ten that indicated the resident was at risk for falls. The resident had an above the knee amputation of left extremity and fracture of right ankle. The resident had non-weight bearing status and required the use of a mechanical lift for transfers on admission. R1's Care Plan, dated 09/16/24, instructed staff that the resident did not ambulate. The resident had an above the knee amputation of left extremity; she was non-weight bearing on right extremity due to surgical repair of right ankle related to a fracture. The resident was independent with meals and oral hygiene. The resident required moderate assistance by nursing staff with dressing her upper body. The resident required total assistance by nursing staff with dressing her lower body, bathing, transfers, and toileting. She required a mechanical lift for all transfers. On 10/16/24, the revised care plan instructed staff that the resident's transfer status was revised to include use of the slide board. R1's Morse Fall Scale, dated 08/28/24, documented a score of ten, which indicated the resident was a low risk for falls. R1's Morse Fall Scale, dated 10/03/24, documented a score of 35, which indicated the resident was a low risk for falls. R1's Xray report, dated 10/18/24, documented the resident had an oblique (slope) acute (condition characterized by a relatively sudden onset of symptoms that are usually severe), nondisplaced (a type of bone break where the bone cracks in one spot and stays aligned) fracture of midshaft (middle) tibial (shinbone is the larger, stronger, and anterior (frontal). The resident also obtained an acute (condition characterized by a relatively sudden onset of symptoms that are usually severe) fracture (broken bone) of the distal (end) fibular shaft (The fibular shaft lies distal to the neck and has three surfaces, lateral, medial, and posterior). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Investigation, dated 10/25/24 documented on 10/18/24 at approximately 12:00 PM, R1 turned on her call light. LN G answered the resident's call light. Upon LN G answering the resident's call light, the resident requested to use the restroom. LN G stepped out of the resident's room and asked CMA M for assistance toileting the resident. The resident advised the nursing staff that she did not want to use the bed pan, instead she wanted to use the bathroom. Staff offered the resident to use the bed pan and the resident declined. CMA M placed a gait belt on the resident and completed a stand and pivot transfer from the resident's wheelchair to the toilet. LN G assisted with pulling down the resident's pants and underpants before sitting on the toilet. The nursing staff heard a pop sound during the transfer. LN G completed an assessment while the resident was on the toilet and could not visualize any issue. The nursing staff transferred the resident from the toilet to her wheelchair with the stand and pivot maneuver. On 10/18/24 at approximately 01:30 PM, the resident was assisted back to bed. LN G assessed the residents' right leg and ankle. LN G observed a bump with bruising to right lower extremity. LN G obtained an order for a mobile Xray. On 10/18/24 at 06:00 PM during nursing shift change, mobile xray had not arrived to the facility. The facility received an order to transfer the resident to the Emergency Department (ED) for an evaluation. The resident returned to the facility on [DATE] at approximately 12:00 AM. The findings of the investigation included: the resident had a closed, comminuted (bone broken in at least two places), non-displaced tibial fracture and a distal fibular fracture of the right lower extremity. The residents returned with a posterior splint on right extremity. On 10/18/24 Emergency Department (ED) summary documented the resident with a closed, comminuted (bone broken in at least two places), non-displaced tibial fracture and a distal fibular fracture of the right lower extremity. On 10/18/24 while in the ED, they placed a posterior splint on the resident's right leg. The resident would need to follow-up closely with her orthopedist. Review of Witness Statement, dated 10/18/24, revealed Certified Medication Aide (CMA) M was asked to assist Licensed Nurse (LN) G to transfer R1 from the wheelchair to the toilet. CMA M documented R1 transferred the resident to her bed, however the resident wanted to use the bathroom. CMA M used a gait belt, completed the stand and pivot transfer to transfer the resident from her wheelchair to the toilet. During transfer, LN G, CMA M, and R1 heard a popping sound. The resident complained of pain. CMA M asked the LN G if pain medication should be given to the resident and LN G declined at that time. On 10/18/24 at approximately 01:30 PM, CMA M documented she assisted the resident to bed. At that time CMA M observed discoloration and a lump to her leg. CMA M reported her observation to LN G. Review of Witness Statement, dated 10/18/24, Licensed Nurse G documented she asked CMA M how R1 transferred and R1 placed her arms around CMA M's neck. CMA M then placed R1's foot on top of her foot to ensure resident did not bear any of her own weight during transfer. CMA M then picked up R1 from her wheelchair and transferred her to the toilet. While the CMA M had the resident in standing position, LN G removed the resident's pants and brief. When CMA M placed the resident onto the toilet seat, the heard a pop sound that sounded like a joint popped. After the resident finished using the restroom CMA M transferred the resident from the toilet to her wheelchair using a stand and pivot transfer. Several hours later, after the transfer, the resident complained of pain to her right anterior ankle. The right anterior ankle was warm to touch with mild swelling noted to right shin. The health care provider was notified to request a Xray of right lower extremity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 12/02/24 at 09:01 AM Administrative Nurse A verified the facility incident report reflected LN G and CMA M did not follow the resident's care plan regarding transfers. Administrative Nurse A stated she expected LN G to review all of the resident's care plan prior to transfers and before all cares. The facility's policy for Safe Lifting and Movement of Residents, dated 09/05/17, documented the facility shall protect the safety and well-being of the residents, promote quality of care, and use appropriate transfer devices. The facility failed to protect the resident from harm, when nursing staff did not utilize the appropriate transfer equipment to safely meet the needs of R1 that caused an oblique acute, nondisplaced fracture of mid tibial shaft. The resident also obtained an acute fracture of the distal fibular shaft.