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 _____	C 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #165260. This 2567 was electronically sent to the facility on 9/17/21.	F 000		
F 689 SS=D	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 reported a census of 80 residents with three selected for review. Based on observation, interview, and record review, the facility failed to implement an intervention following an incident of extensive bruising over a large area to the upper extremity caused from the assistive rail on her bed, to one of the three selected residents, Resident (R)1. Findings included: - The admission diagnoses, located in the electronic medical record (EMR), for Resident (R)1, included traumatic brain injury (an injury that affects how the brain works), aphasia (condition with disordered or absent language function), weakness, and other abnormalities of gait and mobility.	F 689		

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

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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The "Annual Minimum Data Set" (MDS), dated 12/20/20, revealed that R1 did not speak, she was rarely/never understood, had short/long term memory loss, and severely impaired decision making. She required extensive assistance of one staff for dressing and extensive assistance of two staff for bed mobility, transfers, and toilet use. She had range of motion impairment to both lower extremities and no impairment to her upper extremities.

The "Quarterly MDS," dated 06/10/21, revealed that R1 continued to have no speech, she was sometimes understood, and she had a "Brief Interview of Mental Status" (BIMS) score of five, indicating severe cognitive impairment. She required extensive assistance of one staff for bed mobility and extensive assistance of two staff for transfers, dressing, and toilet use. She did not have any impairment to her range of motion.

The "Care Plan," dated 12/29/20, indicated R1 needed limited and extensive assistance with bed mobility and that she was at risk for pressure ulcer and other skin related injuries due to incontinence and decreased mobility. The staff were to assist with repositioning as needed/indicated and to observe skin for redness and breakdown during routine care. The care plan lacked interventions to prevent the development of bruising.

The "Skin Condition" assessment, located in the EMR, dated 08/25/21 at 10:00 AM, revealed R1 had a bruise that started in the middle of the back of her hand extending to the base of her thumb and up her arm that measure 13 by 13 centimeters (cm). The edge of the bruise that

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was near the fifth finger was blue and the color changed in the bruise to light red to dark purple, especially on the palm side of the wrist and along the thumb side of the arm. R1 would draw back from the staff when the staff touched the area. The staff checked the area of bruising later in the day and where it was red was a deep purple color. The staff were to continue to monitor the area for resolution and signs and symptoms of infection twice daily until resolved.

The "Skin Condition" assessment, located in the EMR, dated 09/06/21 at 01:00 PM, revealed the discoloration to the right wrist area measured 22.5 cm by 10.5 cm.

The "Skin Condition" assessment, located in the EMR, dated 09/12/21 at 10:00 AM, revealed the area of discoloration to the right wrist area continued to fade and measured 19 cm by 15 cm.

The facility investigation, completed on 09/02/21, lacked any interventions planned or initiated to prevent R1 from developing further bruising.

On 09/13/21 at 09:17 AM, R1 was sitting in the dining room area in her wheelchair with a short sleeve shirt in place and faded bruising noted to her right hand extending to the right forearm that was yellow to light red in color, the edges of the bruising was darker red/purple in color.

On 09/13/21 at 09:20 AM, observation of R1's room revealed the left side of her bed against the wall and the right side of the bed had an assistive rail in the up position. The rail lacked padding and the center of the rail, on the mattress side,

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had an area approximately three inches in width, had a plastic area that was rounded and hollow in the center that was not flush with the rail. The gap between the rail and the mattress was approximately one inch.

On 09/13/21 at 10:44 AM, R1 continued to sit in her wheelchair with short sleeves in place, with right elbow resting on the arm of the wheelchair, watching television.

On 09/13/21 at 11:39 AM, Certified Nurse Aide (CNA) M assisted to transfer R1 from a recliner in the common area to her wheelchair using a gait belt and providing cues during the transfer to R1 to lean forward, stand, grab his arms, move her feet, and sit in the wheelchair. CNA M then placed his hand on R1's right arm gently, in the area of the bruising, and moved her arm from the outside of the wheelchair to her lap.

On 09/13/21 at 01:34 PM, CNA M stated that R1 required extensive assistance with transfers from one staff and the use of a gait belt. R1 could usually turn in the bed with cues and the staff would not have to touch her for assistance, and if not, then the staff would start the movement and she would take over. CNA M revealed that R1 would not grab the assistive rail on the bed unless you tell her to for bed mobility, but she did use it when moving from a lying to sitting position in the bed and when transferring from her wheelchair to her bed. CNA M stated that R1 can move her arms herself, he had never seen her arm be caught between or pressed against the rail or mattress, but had seen her propped up on her right arm before with one leg off of the edge of the bed. CNA M stated he was not aware of

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any new interventions to prevent R1 from developing any more bruises. He was told to really watch her arms to make sure they were not caught on anything, and that changes in a residents care plan would be communicated by the aide form the prior shift or the nurse would let the staff know.

On 09/13/21 at 01:55 PM, CNA M assisted R1 to transfer from her wheelchair to the toilet. R1 was able to stand using the grab bar and then sit on the toilet with cues from CNA M.

On 09/13/21 at 02:11 PM, Certified Medication Aide (CMA) R, revealed that she also helps provide resident care on her shifts, and that R1 required assist of one to two staff for transfers out of the chair and that she would always transfer R1 with two staff and the use of the gait belt and in the bathroom with assist of one and the gait belt as she would use the grab bar there to stand and turn. CNA R stated that for bed mobility R1 would try to help and cues could be given and if not, the staff used the bed pad to assist to turn her. CNA R stated she had not seen R1 use the assistive rail to turn when in bed, had not seen her arm caught between the rail and the mattress, and had seen her positioned sideways in the bed. CNA R reported she had not been informed of any new interventions to prevent further bruising developing to R1 and that information would come from the charge nurse of the staff that worked the shift before.

On 09/13/21 at 02:28 PM, Administrative Nurse D, stated that she assessed the bruising to R1 after LN G reported it to her on 08/25/21 and that she participated in the investigation in regarding

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the bruising. Administrative Nurse D indicated that the possible cause was that R1 bumped her arm on the wheelchair or may have caught it between the rail and the mattress as R1 can position herself. Administrative Nurse D stated that when bruising occurs, a new intervention is put into place and that R1 lacked a new intervention to prevent further bruising.

On 09/13/21 at 03:09 PM, CNA N stated she was not aware of any new interventions put into place to prevent further bruising and that would be communicated to her by the other employees.

09/13/21 at 03:20 PM, LN G stated that she had observed the bruising to R1's right arm and reported it to Administrative Nurse D after questioning staff if aware of the bruising present. LN G stated she was not aware of the cause of the bruising but had heard R1 leaned against or hit the bed rail and was not aware of any new interventions to prevent further bruising, but staff had informed her to keep an eye out on R1's positioning to ensure she was not leaning against the wall, as R1 will move around in the bed by herself. LN G was not aware if R1 used the assistive rail on the bed or if she was able to grab it.

On 09/13/21 at 03:36 PM, Administrative Staff A stated that she would expect an intervention to be put into place to prevent bruising from happening again and that the facility determined the cause of the bruising to be related to her bed positioning handle that she used when she turned side to side.

On 09/13/21 at 04:35 PM, CMA S, who also

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F 689	Continued From page 6 assisted to provide resident care, stated that he has not seen R1 use the bed positioning rail and that she can become "squirmy" when in the bed as one night shift several weeks ago when he worked she positioned herself down by the foot of the bed. The facility failed to implement an intervention following bruising to R1, following a large area of bruising to her upper extremity from the assistive rail on her bed, to prevent any further bruising injury.	F 689		