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 02/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS the following citations represent the findings of complaint investigation #150063. This 2567 was electronically sent to the facility on 2/25/2020.	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 71 residents, with three r esidents selected for review of accidents. Based on observation, interview, and record review the facility failed to ensure the safety of one (R)1 of the three sampled residents, when being transported in the facility van and her wheelchair became loose, rolled forward, hitting her shin into the back of the seat in front of her, causing a large hematoma with open area and bruising. Findings included: - Review of R1's significant change in status "Minimum Data Set" (MDS,) dated 11/21/19 revealed a Brief Interview for Mental Status (BIMS) score was 15, indicating no cognitive impairment. The resident was independent with walking in her room and required supervision out	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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of her room, using a walker and a wheelchair for mobility.

Nurses' Notes, dated 02/04/2020 at 04:14 PM, revealed completion of a general skin check of the resident's skin. The resident had a new issue identified. The resident reported that during transport back from the doctor's office this afternoon that the wheelchair rolled forward in the van and she hit her left shin on the seat in front of her. She complained of the site burning. The staff cleaned the area with wound cleaner, triple antibiotic ointment (TAO), applied a border gauze dressing placed, and put an ice pack on the hematoma. The area was not actively bleeding and the staff planned to continue to monitor the area.

The 02/04/2020, skin evaluation form, documented a description of the resident's left shin area as a swollen hematoma (a solid swelling of blood under the skin, discolored) 10 centimeters (cm.) by 13 cm. , with an open area in the center of the hematoma which measured 2 cm. by 3 cm., without any drainage or active bleeding. The surrounding skin contained a bruised area.

The Nurses' Notes, dated 02/04/2020 at 04:45 PM, documented the staff notified the physician and received no new orders at the time for the resident's shin wound.

The 01/06/20 care plan, instructed staff R1 was independent to and from the bathroom with a front wheeled walker, initiated 09/24/2019. Additional update, dated 02/07/2020, included the resident required extensive assistance of one to two staff with transfers, to use a wheelchair and

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transfers to the toilet.

On 02/20/20 at 09:15 AM, the resident sat in a recliner in her room and just completed her breakfast. The resident reported she was going to the doctor this afternoon. R1 further explained that not long ago she was in the facility van going to the doctor and heard a noise and she guessed that something came loose because her wheelchair started moving and she ended up right behind the driver. R1 hit her leg on the seat in front of her. She further explained that the driver did secure the wheelchair to the bottom of the van but she did not remember him putting the seatbelt from the wall of the van around her.

On 02/20/20 at 10:00 AM, Certified Nurse Aid (CNA) O, reported the resident needed one to two staff assistance now. The resident recently took care of herself, but fell recently in her room. CNA O knew of the resident's fall in the van and that the resident received a bruise to the shin around the first week of February 2020. CNA O further explained that the CNA/van driver MM, following the accident, brought the resident back to the court, and left her in her wheelchair just outside the nurse office. Certified Medication Aide (CMA) P asked her look at R1's leg and there was a swollen knot on her leg. The CMA then reported it to the nurse. CNA O reported the resident was able to get around with the walker until she fell a couple days later. R1 now required one to two staff to assist her with transfers.

On 02/20/20 at 11:10 AM, Administrative Nurse D reported the facility suspended Transportation staff MM, staff completed an investigation, and then terminated Transportation staff MM on 02/07/20. Transportation staff MM wrote a

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statement reporting he picked R1 up and put her wheelchair brakes on, but forgot to put the straps on the wheelchair and she rolled to the front and hit her leg.

On 02/20 /20 at 02:46 PM, observation of Transportation staff LL, left the facility to pick up the resident. At 2:50 PM, staff LL, arrived at hospital, went inside, and brought the resident out in her wheelchair. He opened the door to the lift on the van and wheeled the wheelchair onto the lift. He closed the gate and engaged the lift. When in the van, the driver positioned the resident's wheelchair, secured the hooks on both wheels, then pulled the seatbelt from the side wall across the resident in the wheelchair and fastened it into a receptacle on the floor. The resident pointed to the seat behind the driver's seat and stated, "That is where I wound up when I hurt my leg, I don't know how it happened really, I told you I heard a noise, and then I was up there."

On 02/20/20 at 03:30 PM, social services staff X , reported she interviewed R1 and she said Transportation staff MM, turned the van, she heard something come undone and her wheelchair flew up to the front of the van. She told me if the seat was not there, she feared she would hit the windshield and said the seatbelt was not around her at the time. The resident further explained that she did not fall out of her wheelchair.

On 02/20/20 at 03:45 PM, Administrative Nurse E reported she and Maintenance staff U evaluated the straps in the van after R1 reported what happened. They noted the straps were tightened all the way to the floor with no slack in

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them. Usually after a transfer the staff would loosen the straps on the floor. The seatbelt was assessed and found to lock up with any quick movements. We pulled the seat as if to secure around a wheelchair and the strap locked up frequently and required slow steady movement to pull it out.

On 02/20/20 at 04:30 PM, Maintenance staff U reported on the afternoon of 02/04/20, he inspected the straps and seatbelt. He reported it was evident the straps and seatbelt were either used incorrectly or most likely not at all. All the equipment following the incident functioned properly when used correctly. Each strap has a locking mechanism which prevents the strap from retracting unless the button is pushed.

On 02/20/20 at 6:00 PM, Administrative staff A reported the facility lacked a policy for securing residents in the van when transferring.

The facility failed to ensure this resident received adequate assistive devices to prevent the resident's wheelchair from coming loose in the transportation van, causing the wheelchair to go forward and hit the resident's leg into the back of a seat, causing a large hematoma, open area and bruising to the leg.