STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(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 represent the findings of complaint investigations #KS00188199 and KS00182704. On 06/10/24 at 02:49 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R) 1. On 05/29/24 at 12:15 PM, Transportation FF strapped R1's wheelchair into the facility's transportation van but did not place the seatbelt around R1. When Transportation FF braked before making a turn, R1 slid out of her wheelchair onto the van floor. R1 was taken to the hospital for evaluation where she was found to have left tibia (bone in the lower leg) and fibula (bone in the lower leg) fractures as a result of the accident. This failure placed R1 in immediate jeopardy. The facility completed the following corrective actions by 05/30/24: An OT evaluation for R1 was ordered on 05/29/24. All facility transportation was suspended on 05/29/24 until training and competencies were completed by transportation staff. R1's "Care Plan" was updated on 05/30/24. Transportation EE and Transportation FF completed transportation competencies on 05/30/24. Due to the corrective measures implemented and completed prior to the onsite survey, this deficient practice was cited as past noncompliance. The scope and severity remained at a "J".	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/18/2024

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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F 000	Continued From page 1 The 2567 was sent on 06/18/24.	F 000		
F 689 SS=J	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 identified a census of 60 residents. The sample included three residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to provide a safe environment, free from preventable accidents for Resident (R) 1. On 05/29/24 at 12:15 PM, Transportation FF strapped R1's wheelchair into the facility's transportation van but did not place the seatbelt around R1. When Transportation FF braked before making a turn, R1 slid out of her wheelchair onto the van floor. R1 was taken to the hospital for evaluation where she was found to have left tibia (bone in the lower leg) and fibula (bone in the lower leg) fractures as a result of the accident. This failure placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of pain, fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), and weakness.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

The "Admission Minimum Data Set (MDS)" dated 04/17/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15. R1 had impairment on both sides in upper and lower extremities and she used a wheelchair. R1 did not have any falls since admission.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 04/22/24, documented R1 had chronic pain and needed assistance with most ADLs.

The "Falls CAA" dated 04/22/24, documented R1 used a sit-to-stand (mechanical lift) lift for transfers as she was not strong enough to bear weight while transferring with staff.

R1's "Care Plan" dated 04/10/24 and discontinued 05/29/24, documented R1 could not complete her care on her own because she had physical challenges and required two helpers providing more than half the effort to transfer with the stand-up lift.

R1's "Care Plan" dated 05/30/24, documented R1 had the potential to fall down and hurt herself and directed an Occupational Therapy (OT) evaluation was ordered for a Broda (specialized wheelchair with the ability to tilt and recline) chair for all transports outside of the facility as of 05/29/24.

R1's "Care Plan" dated 06/03/24, documented R1 could not complete care on her own because of physical challenges; she transferred with two helpers providing more than half the effort with a full body lift.

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F 689	Continued From page 3	F 689		

The facility's investigative report, dated 06/04/24, documented on 05/29/24 at 01:10 PM, Administrative Nurse E, and Administrative Nurse F notified Administrative Nurse D that there had been an accident with a possible injury in the facility's van involving R1. Transportation FF was driving the facility's van when he pushed the van brake to turn into a parking lot. Upon pushing on the brake, R1 slid out of her wheelchair. Transportation FF pulled over to assist R1 and R1's friend called 911. The ambulance arrived and transported R1 to the Emergency Room (ER) for evaluation. At 02:45 PM, Administrative Nurse E received a call from R1's representative stating that R1 had tibia and fibula fractures.

In a notarized "Witness Statement" on 05/29/24, Transportation FF stated he took R1 to the hospital on 05/29/24. He tied the front and rear straps to R1's wheelchair which he always did. He stated he was asked to stop at a fast-food restaurant and when they approached the business, he had to stop quickly. Transportation FF stated the next thing he knew, R1 was sliding out of the wheelchair onto the floor. He stated he stopped and assisted R1 but R1's friend was sure there were broken bones. He stated the ambulance came and took R1 out of the van and to the hospital.

In a notarized "Witness Statement" on 05/29/24, Transportation EE stated on 05/29/24 at 12:15 PM, Administrative Nurse E went to her office and asked if she had heard from Transportation FF. She stated that R1's representative had called the facility regarding an accident. Transportation EE stated she called Transportation FF, but he did not answer so she called R1's friend. She stated

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F 689	Continued From page 4	F 689		

that R1's friend reported that R1 slipped out of her wheelchair when Transportation FF put on the brakes and the ambulance was called.

The "Computed Tomography (CT- scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) Ankle Left without Intravenous (into a vein) Contrast" report, dated 05/29/24, documented R1 had comminuted (fracture that occurs in at least two places) fractures in the distal (away from the farthest point of origin or attachment) fibula, comminuted fractures in the posterior (back) distal tibia, comminuted fractures in the anterior (front) distal tibia, and comminuted fractures in the central and superior (toward the head end of the body) medial malleolus (bony projection that extends downward from the medial surface of the lower end of the tibia).

On 06/10/24 at 01:17 PM, R1 lay in her bed and watched television. She stated on 05/29/24, her wheelchair was strapped to the floor, but a strap was not placed across her lap or body. R1 stated the driver hit the brakes of the van fast and she slid clear out of her wheelchair and her left ankle was twisted underneath her. She stated it was very painful and she could feel something was wrong immediately.

On 06/10/24 at 12:38 PM, Transportation FF stated on 05/29/24, he took R1 and her friend to an appointment and afterward, they asked to go through a drive-through for food. He stated he had to stop quickly and the next thing he knew, R1 was out of her wheelchair and onto the floor. Transportation FF stated he stopped the van and was going to lift her up but could not lift her then her friend called for an ambulance. He stated that

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F 689	Continued From page 5	F 689		

day, he had strapped R1's wheelchair down on the front and the back and locked the wheelchair brakes but he did not use a seatbelt because she was large, and he did not know if he could get the seatbelt around her. Transportation FF stated they were not going very far so he did not think too much about a seatbelt. He stated there should be a seatbelt on if in a wheelchair or in a van seat.

On 06/10/24 at 12:51 PM, Transportation EE stated on 05/29/24, she called R1's friend who told her the facility van was turning into the fast-food restaurant when R1 was suddenly on the floor. She stated the four hooks under the wheelchair were fastened and the resident should have been buckled in. She stated residents were expected to be buckled in if they were not in a wheelchair. Transportation EE stated she had not received training that it was necessary to buckle the resident in if they were in a wheelchair before the incident but said she had received this training since the incident. She stated residents in wheelchairs were buckled in with four straps on the wheelchair and a lap belt across the resident.

On 06/10/24 at 01:00 PM, Administrative Nurse D stated on 05/29/24, she was informed the seatbelt was not on R1, but the wheelchair was buckled in. She stated when a resident in a wheelchair was loaded onto the facility's van, the wheelchair's wheels were locked and the wheelchair was locked into the van then a seatbelt went across the resident. Administrative Nurse D stated she expected the seatbelt to be buckled.

On 06/10/24 at 01:44 PM, Administrative Staff A stated he expected laws and regulations to be

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followed and seatbelts to be worn and properly secured. He further stated he expected the wheelchairs to be properly secured and the seat belt used.

The facility's "Transportation Van or Bus Policy," dated April 2024, directed the facility to complete transportation van/bus competency training for all employees or volunteers who transport or secure the elder's mobility device in the facility van or bus. The "policy" directed the driver to obey all laws, rules, and regulations.

On 06/10/24 at 02:49 PM Administrative Staff A received a copy of the "Immediate Jeopardy Template" and was informed the facility's failure to provide a safe environment, free from preventable accidents for R1 placed R1 in immediate jeopardy.

The facility completed the following corrective actions by 05/30/24:
An OT evaluation for R1 was ordered on 05/29/24.
All facility transportation was suspended on 05/29/24 until training and competencies were completed by transportation staff.
R1's "Care Plan" was updated on 05/30/24.
Transportation EE and Transportation FF completed transportation competencies on 05/30/24.

Due to the corrective measures implemented and completed prior to the onsite survey, this deficient practice was cited as past noncompliance. The scope and severity remained at a "J".