STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175113	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy on 10th Avenue	2015 SE 10th Avenue Topeka, KS 66607

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 53 residents. The sample included five residents reviewed for accidents and falls. Based on observation, record review, and interview, the facility failed to ensure that staff placed and secured Resident (R) 1's wheelchair and the safety belt properly used in the facility's transportation van prior to engaging the vehicle to drive. This resulted in R1's wheelchair overturning, and R1 fell from his wheelchair. This placed R1 at risk of injury and likely harm.Findings included:- R1's Electronic Medical Record (EMR) recorded diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain), muscle wasting and atrophy (the decrease in muscle mass and strength), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R1's Annual Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 had functional limitation in range of motion with impairment on both sides of his lower extremities. R1 required the use of a wheelchair to assist with mobility. R1 required partial to moderate assistance from staff for his activities of daily living (ADL). R1 had not had any falls since the prior assessment.R1's Falls Care Area Assessment (CAA) dated 05/31/25 documented R1 had a history of falls due to unsteady gait and impaired mobility in his legs. R1 did frequently self-transfer without help but needed limited assistance. R1 used a wheelchair for mobility. R1 took an antidepressant (a class of medications used to treat mood disorders) and antianxiety (a class of medications that calm and relax people) medication, which placed him at risk for a fall.R1's Care Plan, last revised on 05/27/25, directed staff he was at high risk for falls, and he used a wheelchair for mobility independently. R1's Care Plan directed staff to provide limited to extensive assistance with transfers as he would often self-transfer without safety awareness. R1's Care Plan lacked staff direction regarding wheelchair safety during transportation in the facility van.R1's Fall Risk assessment dated [DATE] in the EMR documented he was a high risk for falls. R1's fall risk score was a 10.R1's Nursing Progress Note in the EMR dated 07/01/25 at 10:13 AM documented R1 reported to this nurse that he had a fall yesterday on the bus and was now having pain and swelling in his left hand. This nurse notified the provider, and an order was received for an X-ray.A Complaint Investigation Witness Statement of Facts Before the Kansas Department for Aging and Disability Services form completed by Activity Z on 07/01/25 documented she had R1 buckled in (in the transportation van) and when she turned a corner, R1's wheelchair fell over to the side. Activity Z then pulled the vehicle over to a different parking lot and stopped. Activity Z then got R1 out of his wheelchair and lifted him back up into the chair. Activity Z documented R1 was over on the left side of the bus, and she had to bring the seat belt from the right side of the bus over to buckle R1 in due to R1 being adamant about sitting on the left side of the bus. On 07/02/25 at 07:58 AM Nursing Progress Note in the EMR documented the X-ray result was received with no acute findings, and results sent to the provider for review.On 07/02/25 at 08:02 AM Nursing Progress Note in the EMR documented R1 was seen by his provider, and new orders were received. R1's electronic Medication Administration Record (MAR) was updated.On 07/02/25 at 10:29 AM Nursing Progress Note in the EMR documented a late entry note. The interdisciplinary team (IDT) reviewed the incident and the intervention at that time was education and training was provided to the transport drivers on securing wheelchair in van. R1 care plan was updated.A facility Off Boarding Form signed by Administrative Staff A and dated 07/01/25 documented an involuntary termination of Activity X for failure to notify the administrator or Director of Nursing of a resident fall.A Facility Self-Report form, dated 07/07/25, completed by Administrative Staff A documented an incident occurred on 06/30/25. Administrative Nurse D was informed by R1 that he had a fall in the facility van on 06/30/25, at approximately 12:50 PM during a transport to an appointment. Activity X stated that she was leaving the parking lot of the provider's office when a turn caused R1's wheelchair to overturn. Activity X stated that R1 was secured by the seatbelt, and all wheelchair tie downs were in place and functional at the time of the fall. Activity X has been terminated as the result of the completion of an internal investigation. The internal investigation discovered that R1's wheelchair was secured, but not in the appropriate placement in the van. Activity X stated she thought she was honoring the R1's resident's rights when he refused to move, and she did the best she could with securing R1's