STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175145	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Retirement Community	700 W 7th Street Overbrook, KS 66524

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 - Immediate jeopardy to resident health or safety 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** The facility identified a census of 47 residents. The sample included three residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free from accidents when Activity Staff Z did not utilize the seatbelt to secure R1 in the facility transportation van before transporting. On 02/02/26 at approximately 03:25 PM, Activity Staff Z pressed on the brakes quickly upon seeing a stopped school bus and cars in their lane of the highway. The sudden braking, with no seatbelt applied, caused R1 to fall forward onto the floor of the facility van. Activity Staff Z stated there was no place to pull over, so Activity Staff Z continued to drive R1 back to the facility, about a mile and half away, with R1 on the floor of the vehicle. Once they arrived at the facility, the staff called for Emergency Medical Services (EMS) and an ambulance took R1 to the hospital. As a result of the fall, R1 suffered an abrasion to forehead, skin tear to left lower leg, and a right humerus (upper arm) fracture. The staff failure to secure R1 in the transportation van prior to transporting R1, placed R1 in immediate jeopardy. Findings Included:- R1's Electronic Medical Record (EMR) documented diagnoses of unspecified fracture of upper end of right humerus, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), obesity (excessive body fat), chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dependence on wheelchair, long term use of anticoagulants (medications that prevent or reduce the blood's ability to form clots), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction affecting right dominant side, and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 used a wheelchair. The MDS further documented R1 was dependent on staff for toileting hygiene, bathing, lower body dressing, bed mobility, and changing from a seated to standing position. The MDS documented R1 required substantial to maximal assistance for upper body dressing, putting on or taking off footwear, personal hygiene, toileting transfers and shower transfers.The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 01/18/26, documented R1 had a history of cerebrovascular accident (CVA- stroke) with right side flaccid hemiplegia; osteoarthritis (disease, where the protective cartilage cushioning the ends of bones breaks down over time. It causes joint pain, stiffness, and reduced mobility) of both knees, occasional but improved dyspnea (difficulty breathing), and osteoporosis. The CAA further documented R1 continued with dyspnea and shortness of breath (SOB) when flat in bed.R1's 04/17/23 Care Plan documented R1 required assistance with ADLs due to weakness, mobility impairment, and right-side hemiparesis associated with an old CVA. The Care Plan documented (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the following interventions:08/11/24 - Wheelchair was primary transport and generally R1 was independent throughout facility in a wheelchair.04/17/23 - As of 01/29/25 R1 needed two staff for transfers, toileting and use of gait belt. As of 06/20/25 R1 used a sit to stand lift (powered or manual lift designed to safely raise a person with limited mobility from a sitting position to a standing position) for transfers but may still use on staff gait belt transfers if able in bathroom only. As of 08/6/25 R1 used a sit to stand with all transfers.04/17/23 - Approach directed staff to encourage and assist R1 as needed to reposition or transfer in the morning, before meals, after meals, at activities, at bedtime, during the night, and as needed.R1's 04/17/23 Care Plan documented R1 was at risk for falls due to weakness and was at greater risk of injury and fractures due to osteoporosis.An investigation document provided by the facility, dated 02/06/26 with a CP number of 2734007, documented on 02/02/26 at approximately 03:15 PM, R1 was being transported back to the facility after a physician's office visit at a hospital in Topeka. R1 was being transported in a facility transport van and was in a wheelchair in the van. Activity Staff Z drove the van at the time. The investigation document recorded per Activity Staff Z's witness statement, they were traveling eastbound on a highway toward the facility. The documented recorded as they neared an intersection, they crested the hill, and on the east side of the hill, a school bus was stopped in the west bound lane. In front of them, in the eastbound lane, five or six cars were stopped because of the school bus. Per the investigation document, Activity Staff Z had to apply the brakes quickly, and as a result, R1 slid out of her wheelchair onto the floor. Per the investigation document, Activity Staff Z realized he did not have a gait belt holding R1 in the wheelchair and R1 was on the floor of the van, behind the front seats. The investigation documented further recorded they were in traffic, and the highway no shoulder in which to pull over. R1 and Activity Staff Z discussed what to do and since they were only a couple of minutes from the facility, they decided to drive on to the facility for help. The investigation documented that once they arrived at the facility, Activity Staff Z immediately went inside for help and nursing staff quickly came out to assess and provide first aid to R1. Nursing assessment documented staff found R1 lying on her back, alert and oriented, with a small abrasion on her forehead. Per the investigation document, R1 expressed significant pain in her right forearm, particularly when she attempted to move it. The investigation documented staff observed a skin tear on R1's left lower extremity, and staff promptly applied first-aid. Per investigation staff contacted EMS and R1 went to a hospital. Per the investigation document, R1's X-Ray indicated her right humerus was fractured, and she had sustained a small abrasion on her forehead.A Nursing note dated 02/02/26, documented at approximately 03:30 PM, a Certified Nurse Aide (CNA) alerted the nurse that R1 had recently returned from an appointment and experienced a fall in the van. The note documented the nurse, accompanied by another nurse, proceeded to assess R1 in the van. Staff found R1 lying on her back, alert and oriented, with a small abrasion on her forehead. She denied any associated pain and exhibited no visual concerns or speech difficulties. The note documented R1 expressed significant pain in her right forearm, particularly when R1 attempted to move it. The staff observed a skin tear on R1's left lower extremity and promptly applied first-aid. The staff obtained vital signs and due to the persistent pain in R1's right forearm and the presence of a skin tear, the staff called for an ambulance. The note documented the staff carefully transferred R1 directly from the van to the ambulance for transport to a hospital.An Emergency Department (ED) Provider Note dated 02/02/26 at 10:27 PM, documented R1 had a fall from a wheelchair while in a moving transport vehicle. The note further documented R1 had multiple injuries after falling, including proximal humerus fracture and a large skin tear of her lower leg. The note documented R1 had significant generalized weakness and was a frail elderly woman. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The note documented the large skin tear and noted the laceration was pulled together and looked better. R1 admitted for observation and further evaluation.On 02/11/26 at 11:17 AM observation revealed the facility had two transport vans. Both transport vans had a have you fastened your seat belt sign placed in the vehicle. The Van R1 was transported in had large metal floor with straps to secure wheelchairs for transport.On 02/11/26 at 12:51 PM R1 sat in her wheelchair in an office room. R1 had a bruised area around the top of her right eye. R1 had a black sling on her right arm. R1's right arm rested across her abdomen, and she used her left hand to hold her right arm in place. R1 stated Activity Staff Z was taking her back to the facility in the transport van. She stated when they went over a hill, they could see a bus stopped and there were cars in front of them. R1 stated Activity Staff Z put on his brake, and she was propelled forward out of her wheelchair. R1 stated she did not have a seatbelt on at the time. R1 stated she was normally not able to use her right arm as it was paralyzed, but she stated she kept saying her arm was broken after she fell out of her wheelchair. She stated she normally moves her right arm with her left hand and was not able to move it due to the pain. R1 stated the amount of pain she had, and not being able to move it, was why she knew it had to have been broken. R1 stated she must have hit her head because she ended up with a bruise over her eye. R1 further stated she had a skin tear on her left skin and it was bleeding. She stated she did not notice her skin tear until she arrived at the hospital. R1 stated once she arrived at the hospital, they performed x-rays and found she had a fracture to her right arm. R1 stated Activity Staff Z and herself had both forgotten to put her seatbelt on. R1 stated she did not know what happened to cause them to forget to put her seatbelt on. She stated it has never happened before, but this time it did for some reason. On 02/11/26 at 01:23 PM Activity Staff Z stated he had taken R1 to a doctor's appointment at a local hospital and was on the way back to the facility with her. Activity Staff Z stated he was traveling down a local highway and crested a hill. He stated as he was going over the hill he saw a school bus in the other lane that had stopped to let children off. He stated there were cars in his lane and he had to apply the brakes quickly. Activity Staff Z stated when he put on the brakes, R1 fell out of her wheelchair and onto the floor of the transport vehicle. He stated there was no shoulder to pull off from and he knew he could not get R1 back in the wheelchair. Activity Staff Z stated he and R1 were only a few minutes away from the facility, he thought about a mile and a half, so he drove her back to the facility for help. Activity Staff Z stated R1 was lying on her right side while driving back. He stated once they arrived at the facility, staff had called an ambulance. Activity Staff Z stated staff and EMS responders assisted R1 in the ambulance and she was taken to the hospital. Activity Staff Z stated staff later found out R1's arm was broken. Activity Z stated he felt terrible about the situation and the two of them had been friends for over 30 years. He stated he typically transported residents about once per week, and he had never forgotten to put a resident's seatbelt on before. He stated that was the only time I have had that happen. There was no excuse. I screwed up. He stated he has not been allowed to transport residents further and will instead help with activities in the facility. He stated he was suspended and had to go over safety and transfer protocols. On 02/11/26 at 03:36 PM Licensed Nurse (LN) G stated she was with another resident when Activity Staff Z arrived at the facility with R1. LN G stated she went out and was told that R1 had a fall in the van. LN G stated R1 was lying on her back in the van. She stated R1 had a wound to her left lower leg that was bleeding. She stated staff obtain supplies to treat her leg wound. She stated she got R1's vitals and they were good. LN G stated R1 complained of pain in right arm, so staff called the ambulance and R1 was transferred over to the hospital. She sated staff did not move R1 due to pain until the ambulance arrived. LN G stated once EMS arrived, the ambulance team (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and a few staff assisted with getting R1 onto the stretcher and she was transported to the hospital. On 02/11/26 at 11:33 AM Administrative Staff A stated Activity Staff Z was a backup driver for the facility. She stated the facility had transported residents 28 times since 01/01/26, and Activity Staff Z had done eight of those transports. She stated Activity Staff Z was suspended pending an investigation and was told he would not be able to transport residents further until the facility finished their investigation and corrective actions were taken. She stated R1 had asked the facility not to fire Activity Staff Z as he was loved by the residents in the facility. Administrative Staff A stated they decided to only have Activity Staff Z do activities with residents going forward. She stated Activity Staff Z would no longer be able to transport residents. Administrative Staff A stated the facility placed signs in the transport vans to remind staff, and residents, to use the seat belts. She stated since Activity Staff Z was no longer going to be a driver, the facility had to train three other staff to be back-up drivers. She stated they provided education and in-services for those staff. She stated they covered everything that was expected of them and went through a checklist with those staff. Administrative Staff A stated the incident was covered in their QA meetings and the incident would be discussed further today in their next meeting. She stated she spoke to three other alert and oriented residents that had been transported by Activity Staff Z before, and they had informed her Activity Staff Z always used a seatbelt with them. Administrative Staff A stated R1 had an x-ray and was found to have had a right humerus fracture and was in a sling. Administrative Staff A stated the fracture did not require surgical repair. Administrative Staff A stated R1 further had a skin tear to her left shin and was being treated by wound care for it. She stated R1 must have hit her head during the incident as R1 had a contusion to her forehead, above her right eye. She stated R1 was alert and oriented. Administrative Staff A stated R1 would be able to say what exactly happened as she was with it cognitively.The facility's undated Resident Abuse and Neglect policy documented it was the policy that every resident should be free from neglect or abuse of any type. Any allegation of neglect or abuse, either verbal, physical, mental or sexual will be investigated and if corroborated, reported to the appropriate state agency. All alleged perpetrators employed by the community may be suspended pending the completion of the investigation.The facility's undated Vehicle Use by Qualified Drivers General Procedures policy documented the purpose of this policy is to outline qualified drivers and general transportation procedures. This policy applies to anyone using a facility transportation vehicle. Qualified drivers and those who accompany elders will see that elders are safe and secure during transports. If the elder is transported in a manual wheelchair or a motorized wheelchair/scooter, the qualified driver will secure the device in the van per securement device. Any and all elders and passengers, including the qualified driver, will wear a seat belt at all times the vehicle is in motion, without exceptionOn 02/11/26 Administrative Staff A was provided a copy of the IJ template and notified of the facility failure to ensure staff applied the seatbelt to R1 prior to transporting in the facility transportation van, which led to R1 falling forward to the floor of the facility van after rapidly breaking on the highway and caused a fractured arm to R1, and placed R1 in immediate jeopardy.On 02/03/26 the facility completed corrective actions which included suspension of Activity Staff Z, education provided regarding transportation safety to their only other facility driver and placed signs in the vehicles to provide visual reminders to residents and the driver to put on seat belts. Activity staff Z was no longer allowed to drive for the facility going forward.Due to the corrective actions completed prior to the onsite survey, the deficient practice was cited as past noncompliance at a scope and severity of J.