STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175236	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutchinson Operator, LLC	2301 N Severance Street Hutchinson, KS 67502

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility reported a census of 41 residents. The sample included six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free of accident hazards when on 10/07/25 at approximately 12:15 PM, staff pushed R1 down the hallway in the shower chair. R1's right lower leg became entangled in the shower chair causing R1 to fall out of the chair, resulting in a right tibia (the large bone in the lower leg) and right fibula (the small bone in the lower leg) fractures. Findings included:- R1's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), morbid obesity (excessive body fat), abnormal involuntary movements and generalized muscle weakness.R1's 09/19/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R1 utilized a wheelchair for locomotion and required the use of a mechanical lift for transfers. R1 was dependent on staff assistance for all transfers.The 09/19/25 Activity of daily Living (ADL) Functional / Rehabilitation Potential Care Area Assessment (CAA) documented R1 had impaired balance during transfers. The 09/19/25 Falls CAA documented R1 was a high risk of falls although had no recent history of falls. R1's Care Plan documented on 09/02/17 R1 was at risk for falls. Interventions dated 09/02/17 directed staff to encourage the resident to wait for staff assistance prior to transfers if she was feeling week (revised on 01/24/24) and noted R1 would wear proper footwear during transfers. The plan directed staff would place non-skid tape on the floor in front of R1's recliner and staff would keep the floors free from clutter and spills. An update on 11/24/17 documented staff would educate R1 to take more time and go slowly with transfers and walking. On 05/13/24, the plan was updated to include two staff members would assist R1 with all transfers and an update dated 10/24/24 documented R1 required the use of a full lift and assistance of two staff members.R1's EHR, under the Progress Notes documented a late entry note, created on 10/09/25 at 11:28 AM which noted on 10/07/25 at 12:15 PM, Licensed Nurse (LN) H heard someone say they needed help, so he left the office and found R1 face down in the hallway in front of the shower chair with a Certified Nurse Aide (CNA) kneeling on the floor beside her. R1 complained of pain in her right leg. LN H documented there was swelling and discoloration to R1's right leg. Upon the arrival of additional staff, staff covered R1 with a bath blanket to protect her privacy. LN H documented staff rolled R1 onto a full lift sling and contacted Emergency Medical Services (EMS) related to R1's right leg shape displacement and noticeable shortening compared to the left leg. Upon the arrival of EMS personnel, LN H and the CNA staff moved R1 onto the EMS cot using a mechanical lift with the assistance of EMS and fire department personnel; R1 was transported to the local hospital.Review of the facility's undated fall investigation revealed on 10/07/25, staff wheeled R1 from the shower room to her room via a shower chair when R1's foot slipped off the foot rail which caused R1 to fall face first onto the floor. The investigation documented the root cause of the fall was R1 tipped forward in the shower chair while being transferred down the hall. The investigation documented camera footage was reviewed, and nothing appeared to visibly obstruct the wheels and R1's feet were still on the footrest.A Progress Note dated (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 - Actual harm Residents Affected - Few	10/11/25 at 02:20 PM documented R1 returned to the facility at approximately 02:15 PM with a diagnosis of right tibia and fibula fractures with an order to wear a splint to the right lower leg at all times and follow up with the orthopedic (bone specialist) physician within one week.A Progress Note dated 10/11/25 at 04:30 PM documented R1 was dependent on three staff for all transfers, one to stabilize the right lower leg splint and two staff to operate the full mechanical lift. On 10/14/25, R1's Care Plan The was updated with an intervention effective 10/07/25 that directed staff to wheel and/or roll R1 backward when transporting her down the hallway in the shower chair. Observation of the shower room on 10/21/25 at 01:00 PM revealed four shower chairs, two of which had an apparatus installed to hold residents' feet.On 10/21/25 at 01:25 PM, R1 reported that earlier in the month a CNA assisted her with her shower, completed the shower, covered her with two bath blankets and was propelling her back to her room to get dressed for a doctor appointment. R1 reported that the CNA was in a hurry due to R1's upcoming appointment and while the CNA pushed down the hallway in the shower chair, the footrest portion of the shower chair folded back under the chair and her legs dropped to the floor. R1 reported that her legs got caught under the front of the shower chair while the CNA was pushing the shower chair, and she fell forward onto the ground and felt extreme pain in her right leg. R1 stated the staff responded immediately and closed the doors to the common areas that were nearby and the doors to the hallways to protect her dignity as much as they could since she was naked, lying face down on the ground. R1 said staff then assessed her and determined that she needed to be seen in the Emergency Department (ED) because of the pain in her right leg. R1 stated she went to the local hospital by ambulance for and said the ED found a fracture in her right leg near the hardware from her total knee replacement. R1 said it was still uncertain whether she would require surgery as she has not yet been to see the bone doctor. On 10/22/25 at 09:00 AM CNA N that when staff propelled residents in their chairs, pedals should always be used and if a foot slipped off the pedals and the resident tumbled onto the floor, staff utilized their two-way radios to summon help. CNA N also stated that before showers, residents should be transported to the shower room in their wheelchair and then transferred to the shower chair and after the shower was over, residents would be transferred back to their wheelchair and then transported back to their rooms in their wheelchair. CNA N stated under no circumstances should residents be transported down the hallways in a shower chair. On 10/22/25 at 09:52 AM, CNA O stated that all assisted wheelchair locomotion should include the use of foot pedals. CNA O stated that if a resident's foot got caught during wheelchair locomotion and the resident tumbled out of the wheelchair, staff would call for help, close off the area and wait for assistance. CNA O also stated that residents should never be transported in the hallways in the shower chairs, only in the resident's wheelchairs. On 10/22/25 at 10:20 AM, LN I stated that if a resident's feet became entangled with a wheelchair that caused the resident to fall, staff should encourage the resident to not move and staff would summon assistance from other staff utilizing the two-way radio and close any applicable doors to protect privacy and dignity. LN I stated that the facility did have some obese residents whose wheelchairs will not fit into the shower room, so it was then acceptable to transport residents in a shower chair down the hallways if they were completely covered to provide privacy.On 10/22/25 at 10:40 AM, Administrative Nurse D stated that unless the resident has interventions care planned to the contrary, all residents should be transported to and from the shower room in their wheelchair and then be transferred into the shower in the shower room.On 10/22/25 at 11:00 AM during an interview with Administrative Staff A, Consultant GG and Administrative Nurse F, Administrative Staff A and Administrative Nurse F revealed that the facility contained three bariatric (associated with obesity) residents whose wheelchairs would not fit into the existing shower room door. The facility obtained verbal consent from those residents to transport them to and from the shower room in a shower chair. Consultant GG stated residents should be transported to and from the shower room in their wheelchairs and then transferred into the shower chairs. Consultant GG stated shower chairs were not intended for longer distance transfers. Consultant GG and Administrative Staff A stated the facility had two shower (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	rooms and one was currently under construction to accommodate the larger wheelchairs. Consultant GG suggested to Administrative Staff A and Administrative Nurse F for residents to be transported to the door to the shower room, staff would set up privacy screens then utilize mechanical lifts to lift the residents then pull the resident [and the lift] inside the shower area to transfer to the shower chairs. The facility's Accidents and Incidents - Incident Reporting F 689 policy, dated 05/2025 did not address transportation of residents in shower chairs. The facility's F 689 Accidents policy, dated 10/2025 documented the facility strived to make an environment as free from accident hazards as possible. Safety, supervision and assistance to prevent accidents were a facility-wide priority. The policy did not address the use of shower chairs.The facility's Shower/Tub Bath policy dated 10/2024 documented instructions and steps for staff to perform showers that included instructions for staff to place a robe and slippers on the resident then assist the resident into the bath chair, if applicable, and cover the resident from the neck down with a bath blanket then transport the resident to the bath area. After the completion of the bath or shower was completed, staff would assist the resident back into his or her robe and slippers, cover the resident from the neck down with a bath blanket and transport the resident back to his or her room and ensure the resident's feet did not drag on the floor. All corrective actions were completed prior to the onsite survey therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of G (actual harm, isolated).