STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Goddard	501 Easy Street Goddard, KS 67052

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 44 residents with three residents included in the sample. Based on observation, interview, and record review the facility failed to ensure an environment free of accident hazards on 01/14/25 when Certified Nurse Aide (CNA) M did not follow the standard of care and utilize another staff member assistance during the transfer of Resident (R) 1 from his wheelchair to his bed, using a Hoyer Lift (a mechanical device that helps people with limited mobility be transferred safely with minimal physical effort). Findings included: - The Quarterly Minimum Data Set (MDS) dated [DATE] revealed R1 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The Care Plan revision dated 12/31/24 revealed R1 required assistance from staff with all transfers. An observation on 01/14/25 at 12:35 PM revealed CNA M transferred R1 from his wheelchair to his bed using the Hoyer lift by herself. An interview on 01/14/25 at 12:35 PM with CNA M revealed if the resident was light, they could use the Hoyer and lift the resident by themselves. An interview on 01/14/25 at 01:25 PM with Administrative Nurse D revealed the protocol for transfers of a resident using the Hoyer lift was two staff members to always be present to assist with transfers. An interview on 01/14/25 at 02:50 PM with CNA N revealed the facility provided training on the Hoyer and Sit-to-Stand lifts and noted they were to always have two staff members while using the lifts. On 01/14/25 at 03:00 PM Administrative Nurse D stated the facility did not have a policy regarding Transfers and further stated staff were to follow known standards of care utilizing two staff to transfer residents using a Hoyer lift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	The facility failed to ensure an environment free of accident hazards on 01/14/25 when CNA M transferred R1 from his wheelchair to his bed with the use of a Hoyer lift and did not have an additional staff member present for the transfer.