STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Jackson County	1121 W 7th Street Holton, KS 66436

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 28 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure staff provided safe activities of daily living (ADLs) care to Resident (R) 2, consistent with her level of need. This deficient practice resulted in a fracture across the right distal femur (fracture of the thigh bone near the knee) for R2. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) and cerebral infarction (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). The Annual Minimum Data Set (MDS) dated [DATE], documented R2 had long-term and short-term memory problems. R2 was dependent on staff for all ADLs. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/25/24, documented R2 had a diagnosis of dementia that led to her memory impairment. R2's Care Plan, initiated 04/26/24, documented R2 had an ADL self-care performance deficit related to confusion, dementia, impaired balance, limited mobility, and poor trunk control. The plan documented an intervention, initiated 07/01/24 and created 07/26/24, that directed staff to know R2 required total dependence on staff for transferring. The intervention, revised on 08/12/24, directed staff to provide total assistance with a Hoyer (mechanical lift) lift and non-weight bearing for R2's transfers. Certified Nurse Aide (CNA) M's undated Witness Statement documented on 08/12/24 at 07:20 AM, she went into R2's room to get her up for breakfast. CNA M stated she noticed a bruise on R2's right knee and assumed it happened over the weekend. She stated she continued to dress R2 for the day and then transferred her into her wheelchair. CNA M stated she transferred R2 one-to-one with her right hand around R2's shoulders and her left hand under R2's knees. (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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F 0677 Level of Harm - Actual harm Residents Affected - Few	CNA O's undated Witness Statement documented she provided care to R2 over the weekend from 08/10/24 to 08/11/24. She stated she checked and changed R2 every two hours and R2 had no indications of bruising or swelling. CNA O stated on 08/12/24 at 05:30 AM, staff completed their last check and change and did not notice any bruising or swelling on R2. She stated staff left R2 in bed that morning because she did not want to get up. CNA P's undated Witness Statement documented she did not notice any marks on R2's body all weekend from 08/10/24 to 08/11/24. She stated on 08/12/24 at 05:30 AM, staff completed the last check and change on R2, and she had no bruising or marks of any kind. The facility's Investigation, dated 08/19/24, documented on 08/12/24 at 11:40 AM, staff assisted R2 up for lunch and noted a purple bruise to her right knee that measured 18 centimeters (cm) by 12 cm with swelling and pain with touching. The nurse reported the bruise, and the facility started an investigation. The facility notified the physician and hospice and obtained an order for an x-ray. X-ray results indicated a fracture across the right distal femur. After interviewing all staff who had contact with R2 over the previous three days, the facility established a timeline. Staff did not notice bruising on 08/12/24 at 05:30 AM but did notice bruising at 11:40 AM. The facility interviewed CNA M, who described the way she transferred R2 that morning and she indicated she transferred her alone and without a lift. The facility placed CNA M on the do not return list. R2's EMR revealed a Patient Report for x-ray results on 08/12/24 at 01:42 PM that documented R2 had a fracture across the right distal femur. R2's EMR revealed the following: An Order Note on 08/12/24 at 12:38 PM documented R2's right knee had a purple bruise that measured 18 cm by 12 cm with swelling and pain. The facility obtained an order from R2's provider for a two-view x-ray of her right knee due to swelling and bruising. A Nurse Note on 08/12/24 at 01:04 PM documented at 11:40 AM, staff assisted R2 up for lunch and noted purple bruising to her right knee that measured 18 cm by 12 cm with swelling and pain. The facility obtained an order for a right knee x-ray and notified her husband. A Nurse Note on 08/12/24 at 03:39 PM documented right knee x-ray results showed a fracture across R2's distal femur with diffuse soft tissue swelling. The facility notified R2's provider, hospice, and her husband. On 08/19/24 at 03:11 PM, R2 lay in bed with her eyes closed. Her right knee had an immobilizer in place. On 08/19/24 at 11:47 AM, Administrative Staff A stated she interviewed all staff who worked with R2 that weekend and they had not seen any bruising until the morning of 08/12/24. She stated from CNA M's witness statement, she seemed to cradle R2 to transfer her. On 08/19/24 at 12:57 PM, CNA N stated she knew how to care for a resident by looking at the care plan and from training on the floor. She stated R2 transferred with a Hoyer lift and it had been that way for a few months. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 08/19/24 at 01:09 PM, Licensed Nurse (LN) G stated staff knew how to care for residents by using the care plans and all direct nursing staff including the agency should have access to them. He stated the care plans directed staff to know how a resident transferred and if the care plan directed the use of a Hoyer lift, then the staff used a Hoyer lift. LN G stated if the care plan directed total dependence for transfers, that meant a Hoyer lift. He stated staff used a Hoyer lift with R2 for a while now and if a resident had a transfer status change, staff passed it on in the shift report. On 08/19/24 at 01:53 PM, Administrative Nurse D stated staff had access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) which included assistance needed for transfers, behaviors, and safety interventions. She stated if a care plan directed a resident was dependent on staff for transfers, she would ask more questions on what that meant because it needed more information. Administrative Nurse D stated CNA M stated she transferred R2 with one hand under her shoulders and one under her knees, cradling R2. On 08/20/24 at 12:15 PM, CNA M stated on 08/12/24, she went to get R2 up for the day and noticed she had a pink area on her knee, not purple. She stated the facility staff told her they do not use the Hoyer lift on her, and they pick her up by her arms. CNA M stated she went off of what staff told her and she did not have access to the care plan. On 08/20/24 at 01:32 PM, CNA O stated on 08/12/24, she completed their final check and change at 05:30 AM and did not see any bruising on R2. She stated R2 was not combative and did not want to get up yet, so they left her in bed. CNA O stated staff always transferred R2 using the Hoyer lift and two staff because one staff distracted R2 while the other hooked up the lift. She stated she informed all agency staff that R2 required two staff with the Hoyer lift. The facility's ADL, Supporting policy, revised in March 2018, directed staff to provide residents with care, treatment, and services to ensure that their ADLs did not diminish unless the circumstances of their clinical conditions demonstrated unavoidable diminishing ADLs. The policy directed the facility to provide appropriate care and services to residents who were unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with hygiene, mobility, elimination, dining, and communication. The facility failed to ensure R2 received safe and appropriate ADL assistance consistent with her level of need. This deficient practice resulted in a fracture across R2's right distal femur.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 28 residents. The sample included three residents. Based on record review and interviews, the facility failed to ensure Resident (R) 1 received care consistent with the standards of practice when staff failed to report abnormal x-ray findings and obtain physician involvement for treatment. On 06/04/24, R1 had a fall in the facility's van. On 06/06/24, R1 complained of right shoulder pain and staff obtained an order for an x-ray. The x-ray showed a medial subluxation (dislocation) of R1's right glenohumeral joint (ball and socket joint at the shoulder). Staff failed to notify R1's physician of the results. On 06/27/24, after continued complaints of right shoulder pain affecting R1's activities of daily living (ADLs), staff obtained an order for a referral to an orthopedic (specializing in bones) doctor. Staff called to schedule an appointment but did not follow up or ensure an appointment was made for R1 until 07/18/24 when staff received a call from the orthopedic physician's office for a scheduled appointment on 07/31/24 at 09:45 AM. At the 07/31/24 appointment, the orthopedic physician noted R1 had an anterior (near the front of the body) subluxation of the humeral head with a probable impaction fracture (fracture that occurs when the broken ends of the bone are jammed together by the force of the injury) of the humeral head on the right side and would require surgical repair. The facility's failure to report abnormal X-ray findings to the physician and the delay in physician involvement in R1's injury placed R1 in immediate jeopardy. Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on 08/16/24. R1's EMR documented diagnoses of essential hypertension (high blood pressure) and other specified disorders of bone density and structure of the right shoulder. The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 had impairment on one side of her upper extremities and both sides of her lower extremities. R1 used a walker and a wheelchair. R1 required substantial/maximal assistance with showering, upper and lower body dressing, rolling left to right, sitting to lying, and lying to sitting on the side of the bed; partial/moderate assistance with toileting hygiene, sitting to standing, chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers; and was independent with personal hygiene, oral hygiene, and eating. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 15, which indicated intact cognition. R1 had no impairment and used a walker and wheelchair. R1 required substantial/maximal assistance with showering, rolling left to right, and tub/shower transfers; partial/moderate assistance with upper and lower body dressing, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfers; supervision with toileting hygiene and toilet transfers, and was independent with eating, oral hygiene, and personal hygiene. The Functional Abilities Care Area Assessment (CAA) dated 04/24/24, documented R1 had a self-care deficit related to weakness and required assistance with ADLs. R1 had limitations with her right upper extremity and bilateral lower extremities. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Falls CAA dated 04/24/24, documented R1 had an increased risk for falls with injury due to impaired balance, limitations with range of motion, pain, and staff assistance with transfers. R1's Care Plan, initiated 05/13/24, documented R1 had a risk for falls with injury related to incontinence, impaired mobility with balance, and need for continuous oxygen. The care plan documented interventions, dated 05/28/24, that directed R1 needed a safe environment with even floors from spills and/or clutter and R1 used an electric wheelchair for independent mobility. R1's Care Plan, initiated 07/28/24, documented R1 had chronic pain in her shoulder and back related to arthritis and had a recent injury to her right shoulder from a fall. The care plan directed staff administered analgesia as per orders; staff evaluated the effectiveness of pain interventions; staff identified, recorded, and treated R1's existing conditions which increased pain; staff monitored/documented for probable cause of each pain episode and removed or limited the cause where possible; staff monitored/documented for side effects of pain medication and reported occurrences to the physician; staff monitored/recorded pain characteristics every shift and as needed (PRN); and staff notified the physician if interventions were unsuccessful or if current complaint was a significant change from R1's past experiences of pain. The Orders tab of R1's EMR documented an order with a start date of 04/10/24 for acetaminophen (pain medication) 650 milligrams (mg) every six hours as needed (PRN) for pain. R1's Medication Administration Record (MAR) for May 2024 revealed R1 received PRN acetaminophen for pain one time, on 05/31/24. R1's MAR for June 2024 revealed R1 did not receive any acetaminophen before 06/07/24. R1 received PRN acetaminophen for pain 14 times from 06/07/24 to 06/30/24. R1's MAR for July 2024 revealed R1 received PRN acetaminophen for pain 11 times. R1's MAR for 08/01/24 to 08/16/24 revealed R1 received PRN acetaminophen for pain 10 times. The facility's report on 08/15/24, documented on 06/04/24, Transportation Staff W transported R1 to a dental appointment, and during the ride, when the van took a turn, R1 heard a pop and the seatbelt came unbuckled. R1's electric wheelchair tipped sideways to the right. R1 stated the seat belt did not break but had come unlocked. R1 stated she stood up and held onto the seat and Transportation Staff W immediately pulled the van over to put R1's wheelchair back on all four wheels and helped R1 into her wheelchair. R1 had a skin tear on her right elbow which Transportation Staff W bandaged. Transportation Staff W and R1 continued to her appointment. On 06/06/24, R1 reported pain in her shoulder, which she stated was chronic. The provider ordered an x-ray, which showed a medial subluxation of the glenohumeral joint. R1's EMR revealed the following: A Skin/Wound Note on 06/04/24 at 02:28 PM documented R1 had a skin tear to her right elbow. R1 went to a dental appointment in the facility van and when the van made a turn, her wheelchair leaned, and her right elbow hit the van. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Health Status Note on 06/06/24 at 04:45 PM documented facility called Consultant GG regarding R1. R1 requested an x-ray of her right shoulder. Consultant GG ordered a portable two-view x-ray of R1's right shoulder. R1's medical record lacked evidence the facility notified R1's provider of the x-ray results on 06/06/24. R1's medical record lacked evidence the facility notified R1's provider of R1's continued right shoulder pain from 06/07/24 to 06/26/24. A Nurse Note on 06/27/24 at 01:38 PM documented R1 continued to complain of right shoulder pain affecting her ADL ability. The facility received an order for referral to orthopedics. The facility placed a call to orthopedics and waited for a return call for an appointment. R1's medical record lacked evidence the facility followed up with the orthopedic office to schedule an appointment for her referral from 06/28/24 to 07/17/24. A Nurse Note on 07/18/24 at 11:12 AM documented Administrative Nurse E and Social Services X made several calls over the past few weeks to orthopedics regarding setting up an appointment for a new referral due to continued right shoulder pain. The facility received a return call from orthopedics with an appointment scheduled for 07/31/24 at 09:45 AM. A Nurse Note on 08/05/24 at 02:30 PM documented R1 had an initial consult at orthopedics regarding her right shoulder pain. R1 informed the facility she needed surgery and needed clearance from a pulmonologist (a doctor who specializes in diagnosing and treating diseases of the lungs). The facility obtained an order for a referral to a pulmonologist, faxed the referral order to the pulmonologist, and awaited a reply to schedule the consult. R1's medical record lacked evidence the facility followed up with the pulmonologist's office to schedule an appointment for her referral from 08/06/24 to 08/14/24. A Nurse Note on 08/15/24 at 03:28 PM documented the facility notified the pulmonologist's office regarding the new referral and requested an appointment to assess clearance for shoulder surgery. The pulmonologist's office nurse informed the facility that late October was the earliest available. Social Services X notified another pulmonology clinic of the referral and requested an appointment. A Transfer to Hospital Summary on 08/16/24 at 05:12 AM documented R1 voiced complaints of lower abdominal pain, dizziness, and altered mental status. R1 requested to be sent to the hospital for evaluation and treatment. Upon request, the facility was unable to provide progress notes from R1's provider from 06/04/24 to the present. Upon request, the facility supplied a fax confirmation that revealed the facility faxed R1's referral to the orthopedic office on 07/02/24 at 02:19 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon request, the facility provided Progress Notes from R1's orthopedic consultation on 07/31/24. The Progress Notes documented R1 fell out of her wheelchair due to the seatbelt breaking onto her right shoulder against a lift gate and had pain ever since the incident. R1 could not raise her arm above waist level and when she tried to move it, her shoulder popped. R1 had not seen anyone about her shoulder since the injury. R1's x-ray of her right shoulder from 07/31/24 revealed an anterior subluxation of the humeral head with probable impaction fracture of the humeral head and possibly a fracture extending up superiorly into the humeral head as well. The Impression/Plan for R1 documented R1 had right shoulder pain after a fall two months ago with what appeared to be an impacted head fracture anteriorly subluxated and she might have had a rotator cuff (a capsule of fused tendons that supports the arm at the shoulder joint) tear. The orthopedic provider gave R1 the option of therapy injection medications which he did not believe would do much for her or a shoulder replacement. He recommended R1 think about her options and if she wanted surgery, she would need medical clearance. On 08/19/24 at 12:57 PM, Certified Nurse Aide (CNA) N stated R1 complained of right shoulder pain that had worsened over the last couple of months and slowed down her ability to perform ADLs. On 08/19/24 at 01:09 PM, Licensed Nurse (LN) G stated R1 complained of right shoulder pain after the van incident, and it affected her ADLs. He stated after the facility received X-ray results, the nurse notified the provider and documented the notification in a note. LN G stated if a resident had continued pain for more than a couple of days, he notified the provider and documented it in a note. He stated generally, the provider saw residents following incidents or new pain. He stated the facility should have followed up with R1's provider about her right shoulder pain prior to 06/27/24. LN G stated he thought Social Services X set up any referral appointments. He stated if he received a referral, he sent it to Social Services X. He stated there should be a follow-up system for setting up a referral appointment. On 08/19/24 at 01:23 PM, Social Services X stated Administrative Nurse E sent the referrals to the provider the referral was for. She stated sometimes the facility received a call back from the referred provider to schedule the appointment. Social Services X stated the facility called the referred provider within a couple of days to make the appointment and sometimes the referred provider stated they did not receive the referral or they would have to call back. Social Services X stated she did not put a note in every time she tried to call the referred provider to set up an appointment and she only handled the referrals when Administrative Nurse E was gone. She stated the facility faxed the referral as soon as they received it and followed up within a couple of days. She stated the facility faxed R1's orthopedic referral on 06/27/24 but when she called to follow up, they said they did not get it, so she refaxed it on 07/02/24. On 08/19/24 at 01:34 PM, Administrative Nurse E stated she did not know R1 had right shoulder pain until a week after the van incident and an x-ray had been completed. She stated R1 reported to her on 06/27/24 that her right shoulder pain affected her ADL ability and Administrative Nurse E received an order for a referral to orthopedics. She stated she called the orthopedic office that day and received a number to fax the referral order. Administrative Nurse E stated she called the orthopedic office at least three times between 06/27/24 and 07/18/24 and the office told her she would receive a call back. She stated she did not know why she did not document the follow-up attempts. She stated any nurse handled the referrals and the Director of Nursing (DON) at the time should have followed up with the referral. Administrative Nurse E stated the nurse on the floor should handle the referrals and keep calling until they get a reply. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/19/24 at 01:53 PM, Administrative Nurse D stated if a resident had new or increased pain, she expected nursing to assess the resident and notify the physician then document it in a note. She stated she expected the nurse to notify the physician of the X-ray results and document the notification. Administrative Nurse D stated the charge nurse sent referrals and she expected nursing to follow up in a couple of days to make the appointment and then document. The facility's Acute Condition Changes- Clinical Protocol policy, revised 07/05/24, documented that staff contacted the physician based on the urgency of the situation and the attending physician responded in a timely manner to the notification of problems or changes in condition or status. The policy directed staff to monitor and document the resident's progress and responses to treatment. The policy directed the physician to review the status of the condition change and document their evaluation at the next visit. On 08/19/24 at 02:07 PM Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the facility's failure to ensure R1 received care consistent with the standards of practice which placed R1 in immediate jeopardy. The facility completed the following corrective actions to remove the immediacy for R1: Licensed nurses were educated on physician recommendations and order follow-ups including appointments starting 08/19/24 and all licensed nurses were educated prior to their next shift. Licensed nurses were educated on post-incident follow-up starting on 08/19/24 and all licensed nurses were educated prior to their next shift. Licensed nurses were educated on pain management and observation starting on 08/19/24 and all licensed nurses were educated prior to their next shift. Licensed nurses were educated on physician notifications to include abnormal diagnostic testing starting 08/19/24 and all licensed nurses were educated prior to their next shift. All current staff were educated on abuse, neglect, and exploitation on 08/16/24. Staff notified R1's physician of abnormal x-ray findings and requested the physician to review pain medications to ensure pain control for R1 on 08/19/24. An ad-hoc Quality Assurance and Performance Improvement (QAPI) meeting with the facility's medical director occurred on 08/19/24. The onsite surveyor verified the implementation of the above corrective actions and removal of the immediacy on 08/19/24. The scope and severity of the deficient practice remained at a G to reflect the actual injury to R1.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 28 residents. The sample included three residents. Based on record review and interviews, the facility failed to prevent accidents for Resident (R) 1 when on 06/04/24 during a van transport to an appointment, R1's seatbelt came unfastened. Her electric wheelchair tipped towards the right to the lift gate, and she hit her right arm/shoulder on the lift gate. R1 complained of right shoulder pain on 06/06/24 and the facility obtained an x-ray. This deficient practice resulted in a medial subluxation (dislocation) of R1's right glenohumeral joint (ball and socket joint at the shoulder). Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on 08/16/24. R1's Electronic Medical Record (EMR) documented diagnoses of essential hypertension (high blood pressure) and other specified disorders of bone density and structure of the right shoulder. The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 had impairment on one side of her upper extremities and both sides of her lower extremities. R1 used a walker and a wheelchair. R1 required substantial/maximal assistance with showering, upper and lower body dressing, rolling left to right, sitting to lying, and lying to sitting on the side of the bed; partial/moderate assistance with toileting hygiene, sitting to standing, chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers; and was independent with personal hygiene, oral hygiene, and eating. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 15 which indicated intact cognition. R1 had no impairment and used a walker and wheelchair. R1 required substantial/maximal assistance with showering, rolling left to right, and tub/shower transfers; partial/moderate assistance with upper and lower body dressing, sitting to lying, lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfers; supervision with toileting hygiene and toilet transfers, and was independent with eating, oral hygiene, and personal hygiene. The Functional Abilities Care Area Assessment (CAA) dated 04/24/24, documented R1 had a self-care deficit related to weakness and required assistance with ADLs. R1 had limitations with her right upper extremity and bilateral lower extremities. The Falls CAA dated 04/24/24, documented R1 had an increased risk for falls with injury due to impaired balance, limitations with range of motion, pain, and staff assistance with transfers. R1's Care Plan, initiated 05/13/24, documented R1 had a risk for falls with injury related to incontinence, impaired mobility with balance, and need for continuous oxygen. The care plan documented interventions, dated 05/28/24, that directed R1 needed a safe environment with even floors from spills and/or clutter and R1 used an electric wheelchair for independent mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Jackson County	1121 W 7th Street Holton, KS 66436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan, initiated 07/28/24, documented R1 had chronic pain in her shoulder and back related to arthritis and had a recent injury to her right shoulder from a fall. The care plan directed staff administered analgesia as per orders; staff evaluated the effectiveness of pain interventions; staff identified, recorded, and treated R1's existing conditions which increased pain; staff monitored/documented for probable cause of each pain episode and removed or limited the cause where possible; staff monitored/documented for side effects of pain medication and reported occurrences to the physician; staff monitored/recorded pain characteristics every shift and as needed (PRN); and staff notified the physician if interventions were unsuccessful or if current complaint was a significant change from R1's past experiences of pain. Transportation Staff W's Witness Statement, dated 06/05/24, documented Transportation W anchored and buckled R1's chair in the van to transport her to an appointment. They turned at a stop sign and R1's chair tipped over, resulting in a skin tear. Transportation W checked on R1 and bandaged her skin tear. She had R1 stand up so she could get R1's wheelchair upright. The facility's report on 08/15/24, documented on 06/04/24, Transportation Staff W transported R1 to a dental appointment, and during the ride, when the van took a turn, R1 heard a pop, and the seatbelt came unbuckled. R1's electric wheelchair tipped sideways to the right. R1 stated the seat belt did not break but had come unlocked. R1 stated she stood up and held onto the seat and Transportation Staff W immediately pulled the van over to put R1's wheelchair back on all four wheels and helped R1 into her wheelchair. R1 had a skin tear on her right elbow which Transportation Staff W bandaged. Transportation Staff W and R1 continued to her appointment. On 06/06/24, R1 reported pain in her shoulder, which she stated was chronic. The provider ordered an x-ray, which showed a medial subluxation of the glenohumeral joint. R1's EMR revealed the following: A Skin/Wound Note on 06/04/24 at 02:28 PM documented R1 had a skin tear to her right elbow. R1 went to a dental appointment in the facility van and when the van made a turn, her wheelchair leaned, and her right elbow hit the van. A Health Status Note on 06/06/24 at 04:45 PM documented facility called Consultant GG regarding R1. R1 requested an x-ray of her right shoulder. Consultant GG ordered a portable two-view x-ray of R1's right shoulder. A Nurse Note on 06/27/24 at 01:38 PM documented R1 continued to complain of right shoulder pain affecting her ADL ability. The facility received an order for referral to orthopedics. The facility placed a call to orthopedics and waited for a return call for an appointment. A Nurse Note on 07/18/24 at 11:12 AM documented Administrative Nurse E and Social Services X made several calls over the past few weeks to orthopedics about setting up an appointment for a new referral due to continued right shoulder pain. The facility received a return call from orthopedics with an appointment scheduled for 07/31/24 at 09:45 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurse Note on 08/05/24 at 02:30 PM documented R1 had an initial consult at orthopedics regarding her right shoulder pain. R1 informed the facility she needed surgery and needed clearance from a pulmonologist (a doctor who specializes in diagnosing and treating diseases of the lungs). The facility obtained an order for a referral to a pulmonologist, faxed the referral order to the pulmonologist, and awaited a reply to schedule the consult. A Nurse Note on 08/15/24 at 03:28 PM documented the facility notified the pulmonologist's office regarding the new referral and requested an appointment to assess clearance for shoulder surgery. The pulmonologist's office nurse informed the facility that late October was the earliest available. Social Services X notified another pulmonology clinic of the referral and requested an appointment. A Transfer to Hospital Summary on 08/16/24 at 05:12 AM documented R1 voiced complaints of lower abdominal pain, dizziness, and altered mental status. R1 requested to be sent to the hospital for evaluation and treatment. Upon request, the facility was unable to provide progress notes from R1's provider from 06/04/24 to the present. Upon request, the facility provided Progress Notes from R1's orthopedic consultation on 07/31/24. The Progress Notes documented R1 fell out of her wheelchair due to the seatbelt breaking onto her right shoulder against a lift gate and had pain ever since the incident. R1 could not raise her arm above waist level and when she tried to move it, her shoulder popped. R1 had not seen anyone about her shoulder since the injury. R1's x-ray of her right shoulder from 07/31/24 revealed an anterior subluxation of the humeral head with probable impaction fracture of the humeral head and possibly a fracture extending up superiorly into the humeral head as well. The Impression/Plan for R1 documented R1 had right shoulder pain after a fall two months ago with what appeared to be an impacted head fracture anteriorly subluxated and she might have had a rotator cuff (a capsule of fused tendons that supports the arm at the shoulder joint) tear. The orthopedic provider gave R1 the option of therapy injection medications which he did not believe would do much for her or a shoulder replacement. He recommended R1 think about her options and if she wanted surgery, she would need medical clearance. Upon request, the facility provided a Monthly Vehicle Inspection Report, dated 08/19/24, that documented safety belts/tether all worked but one sticks, and staff had to make sure it clicked into place. On 08/19/24 at 12:57 PM, Certified Nurse Aide (CNA) N stated R1 complained of right shoulder pain that had gotten worse over the last couple of months and slowed down her ADLs. On 08/19/24 at 01:09 PM, Licensed Nurse (LN) G stated R1 complained of right shoulder pain after the van incident, and it affected her ADLs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/19/24 at 01:47 PM, Administrative Staff A stated on 06/04/24, staff notified her that R1 had an incident in the transportation van and received a skin tear. She stated R1 did not complain of right shoulder pain until 06/06/24. Administrative Staff A stated for wheelchair transportation, the driver strapped in the wheelchair and placed a seat belt on the resident. She stated per Transportation W and R1, Transportation W strapped in the wheelchair with the ratchet straps and R1 stated she heard a pop, and the seatbelt came unclamped. Administrative Staff A stated the facility had not been able to come to a conclusion on how the seat belt came unbuckled and how R1's wheelchair tipped over. On 08/20/24 at 12:11 PM, Transportation Staff W stated on 06/04/24, she got R1 into the transportation van and fastened her wheelchair down with four anchors and a lap band over R1. She stated they came to a stop and when she started to turn, R1's wheelchair tipped over towards the ramp on the right. Transportation Staff W stated she stopped and got R1's wheelchair situated back over and put some gauze on her skin tear. She stated none of the anchors had come undone, but the seat belt did. The facility's Transportation Policy, not dated, directed the policy to provide guidelines for transportation services at the facility and ensure the safety and well-being of the residents while promoting efficient use of resources. The policy did not address wheelchair use, seat belt safety, and/or accident prevention. The facility failed to prevent accidents for R1 when on 06/04/24 during a van transport to an appointment, R1's seatbelt came unfastened. Her electric wheelchair tipped towards the right to the lift gate, and she hit her right arm/shoulder on the lift gate. R1 complained of right shoulder pain on 06/06/24 and the facility obtained an x-ray. This deficient practice resulted in a medial subluxation of R1's right glenohumeral joint.