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	12/30/2024

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 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 32 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to prevent an avoidable accident on 12/16/24 when Certified Nurse Aide (CNA) M propelled Resident (R) 1 in her wheelchair without utilizing foot pedals. R1 planted her feet, leaned forward, and then fell out of the wheelchair, hitting the floor. The facility sent R1 to the emergency room (ER) where they discovered via a computed tomography (CT scan- a test that used X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) that she had mildly displaced bilateral (both sides) nasal bone fractures as a result of the fall. This deficient practice also placed R1 at risk for pain. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of 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), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) was not assessed. R1 had impairment on both sides of her lower extremities and was dependent on staff for wheelchair mobility. R1 had no falls since admission. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of 13 which indicated intact cognition. R1 had impairment on both sides of her lower extremities and was dependent on staff for wheelchair mobility. R1 had no falls since her last assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/11/24, documented R1 had a diagnosis of dementia, which could lead to her memory problems. The Falls CAA dated 6/16/24, documented R1 had a potential for falls related to impaired cognition and poor safety awareness. R1 required moderate to maximum assistance with mobility. (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	R1's Care Plan dated 06/08/24, documented R1 had an increased risk for falls with injury related to confusion, balance problems, and poor safety awareness. The plan directed staff to provide a safe environment with even floors free from spills and/or clutter, adequate light, a working, and reachable call light, the bed in the lowest position at night, and personal items within reach. R1's Care Plan dated 06/08/24, documented R1 had an activities of daily living (ADL) self-care performance deficit related to confusion, dementia, impaired balance with mobility, and she required extensive to maximum assistance with most ADLs. The plan directed R1 required extensive assistance of two staff for transfers and moderate to maximum assistance of one staff for repositioning. CNA M's undated Witness Statement noted on 12/16/24 around 08:05 PM, she planned to lay R1 down for the night. CNA M pushed R1's wheelchair towards her room. CNA M stated that halfway to the resident's room, R1 leaned forward and fell , headfirst, to the floor. CNA M stated she called Licensed Nurse (LN) G for help. R1 had a nosebleed and a large bump on her forehead. CNA M stated R1's foot pedals were on the chair but were not in use at the time of the incident. The facility's Investigation dated 12/23/24, documented on 12/16/24 around 08:00 PM, CNA M pushed R1 down the hallway in the wheelchair. R1 fell forward from her wheelchair to the floor, hitting her face. CNA M immediately called for LN G who assessed R1 and noted an abrasion to R1's forehead and swelling around her face. R1 reported pain in her forehead. R1's vital signs were within normal limits. The facility notified Emergency Medical Services (EMS), R1'sphysician, R1's representative, Administrative Nurse D, and Administrative Staff A of the incident. Upon investigation, the root cause analysis of the fall concluded R1's wheelchair did not have foot pedals in place while CNA M pushed her. R1 sustained a possible hairline fracture to her nose per the ER report. R1's CT Maxillofacial (refers to the face, jaws, mouth, and neck region) scan dated 12/17/24 at 12:04 AM, documented minimally displaced bilateral nasal bone fractures. R1's Clinic Note from the Ear, Nose, and Throat (ENT) specialist on 12/26/24, documented R1 presented to the clinic after falling onto her face. R1's representative reported she was in her wheelchair and her feet got below the wheelchair while she was being pushed, causing her to fall forward. On exam, R1 had a palpable right nasal fracture but it was not displaced. On 12/30/24 at 12:06 PM, R1 sat in her wheelchair at the dining room table. Her feet rested on the wheelchair pedals in front of the wheelchair. On 12/30/24 at 01:04 PM, CNA N stated she kept residents safe during wheelchair propulsion by making sure their feet were on the foot pedals. She stated if staff pushed a resident's wheelchair, the resident's feet were put on pedals. She stated if a resident used their feet to self-propel then they did not use foot pedals. On 12/30/24 at 01:13 PM, Administrative Nurse D stated on 12/16/24, LN G reported to her that CNA M pushed R1 down the hall, R1 planted her feet, and then fell down face first. She stated if staff pushed a resident in a wheelchair, she expected them to use foot pedals. Administrative Nurse D stated R1 had foot pedals on her wheelchair but they were not utilized during the incident on 12/16/24. She stated the ER did not send any orders related to the nasal bone fractures but R1's representative made the ENT appointment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/30/24 at 01:24 PM, Administrative Staff A stated her understanding of the incident was CNA M pushed R1 down the hall for bed and did not put the foot pedals on then R1 fell forward. She stated she expected staff to use foot pedals when propelling the residents in wheelchairs. On 12/30/24 at 06:13 PM, CNA M stated on 12/16/24, she got ready to take R1 to bed; normally R1's foot pedals were down. She stated she was pushing R1's wheelchair when R1 suddenly leaned forward and fell out. CNA M stated she did not realize R1's foot pedals were not in use. She stated the foot pedals were on R1's wheelchair but they were not around the front and used. CNA M stated she kept residents safe during wheelchair propulsion by making sure to check for foot pedals before pushing. The facility's Falls and Fall Risk, Managing policy, dated September 2024, directed staff to identify and implement relevant interventions to try to minimize serious consequences of falling. The facility's Assistive Devices and Equipment policy, dated December 2024, addressed the following factors to the extent possible to decrease the risk for avoidable accidents associated with devices and equipment: appropriateness for resident condition, personal fit, and device condition. The facility failed to prevent an avoidable accident for R1 when staff failed to utilize foot pedals during wheelchair propulsion. This deficient practice resulted in a fall with nasal bone fractures for R1 and also placed her at risk for pain. The facility put the following corrections into place before the onsite visit on 12/30/24: The facility updated R1's care plan to include foot pedal usage on 12/16/24. The facility started educating nursing staff on using foot pedals during staff wheelchair propulsion on 12/17/24 and continued until 12/20/24. CNA M received a corrective action on 12/18/24. Due to the facility having the corrective actions in place prior to the onsite visit, this deficient practice was cited at past noncompliance. The scope and severity remain a G.