

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  17E625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/20/2025
NAME OF PROVIDER OR SUPPLIER  Ness County Hospital Ltcu Dbc Cedar Village		STREET ADDRESS, CITY, STATE, ZIP CODE  312 Custer Street Ness City, KS 67560	

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.  (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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(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	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility identified a census of 23 residents, with three residents reviewed for falls. Based on record review, observation, and interview, the facility failed to ensure the foot pedals were on Resident (R) 1's wheelchair when staff assisted pushing her in her wheelchair, to prevent avoidable accidents. On 09/12/25, Licensed Nurse (LN) G propelled R1 in her wheelchair, without foot pedals, and R1 put her feet on the ground, which caused R1 to fall headfirst to the floor. R1 sustained a laceration (cut) on her forehead, which measured 7.5 centimeters (cm), a small hematoma, and required emergency transfer to evaluation and eight sutures to close the laceration. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Lewy body dementia (a type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), chronic pain syndrome, and repeated falls.The admission Minimum Data Set (MDS), dated [DATE], documented R1 had short and long-term memory problems, severely impaired cognition, inattention, disorganized thinking, and physical and verbal behaviors directed towards others.The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 04/25/25, documented R1 had dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors. R1's dementia affected her ability to communicate well, and she exhibited disorganized thinking.The Falls CAA, dated 04/25/25, documented R1 had previous falls. The CAA documented R1 would be monitored closely, and staff would provide activities of interest to distract R1. The CAA documented R1 required one staff assistance with ambulation in the halls and propelled herself out in the halls.R1's Care Plan, initiated 04/01/25, documented R1 had an activities of daily living (ADL) deficit due to dementia with behaviors. The care plan documented R1 was a high fall risk related to confusion and poor safety awareness, and noted she had ten falls since her admission. The care plan directed staff to encourage R1 to sit in a recliner at the nurse's station, staff to be more aware when supervising R1, staff would assist R1 to ambulate when restless, provide R1 activities that minimized the potential for falls, keep R1 in line of sight as much as possible, assist R1 out of bed when R1 awoke, and utilize an anti-roll back bar on R1's wheelchair. The care plan lacked any interventions regarding foot pedals on R1's wheelchair.LN G's Notarized Witness Statement, dated 09/15/25, documented LN G propelled R1 in her wheelchair as R1 was trying to crawl out of the chair at the nurse's station. When going down the hall, LN G stated R1 leaned forward, fell, and hit her head on the floor. R1 was assisted into her wheelchair and taken to the emergency room.Administrative Nurse E's Notarized Witness Statement, dated 09/15/25, documented Administrative Nurse E walked into the hallway and saw R1 on the floor in front of her wheelchair. Administrative Nurse E stated R1 was on one-to-one with LN G. LN G was pushing R1 down the hall when the fall occurred.The Facility Fall Investigation, dated 09/17/25, documented on 09/12/25 at approximately 03:00 PM, LN G pushed R1 down the hallway (in her wheelchair). R1 abruptly put her feet onto the floor, which caused her to fall forward out of her wheelchair onto the floor. Administrative Nurse E looked down the hall, saw R1 on the floor in front of her wheelchair, and went to assist. R1 sustained a laceration to her forehead, staff applied pressure, and the bleeding stopped. The staff assisted R1 off the floor and back into her wheelchair after foot pedals were placed, and then transferred R1 to the emergency room for evaluation. The primary care provider evaluated R1 in the emergency room. The laceration was cleansed and sutured, requiring eight sutures. 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) scan of the head was completed, and the findings showed a small frontal scalp hematoma. R1 returned to the facility and was monitored per protocol. Sutures were expected to be removed in seven days. R1 had dementia and behaviors, liked to propel herself down the hall, and did not like the pedals on the chair. The investigation documented every resident in a wheelchair would have pedals on their wheelchair or in their room so they could be placed on the wheelchair when necessary. All staff would be educated on this change. Administrative Nurse D and Administrative Nurse E would monitor to ensure this was occurring. The Facility Risk Management Summary, dated 10/01/25, documented on 09/12/25 at 03:00 PM, R1 propelled herself down the hallway, followed by LN G when R1 abruptly put her feet onto the floor, which caused R1 to fall forward out of her wheelchair onto the floor. Administrative Nurse E looked down the hall and saw R1 on the floor in front of her wheelchair. R1 sustained a laceration to her forehead. Pressure was applied, and bleeding stopped. R1 was assisted off the floor and into her wheelchair by three staff</p>		