STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to keep residents free from accidents when one staff (Certified Nurse Aide (CNA) A) assisted one resident (Resident #1) in a hurried manner resulting in a fall from a wheelchair. The facility census was 31.Review of the facility's policy titled, Repositioning, dated 2001, showed staff to ask the resident's permission to reposition or assist in the resident in repositioning. Review of the facility's policy titled, Safe Lifting and Movement of Residents, dated 2001, showed the following: -Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents;-Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques;-Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order.1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admission date of 02/21/25;-Diagnoses included contracture of muscle, unspecified lower leg (a condition in which a muscle becomes permanently shortened and stiff, limiting its range of motion), dementia (a general term for a number of neurological conditions that cause a decline in cognitive abilities), and intracapsular fracture of right femur (a break in the femoral neck, the part of the femur (thigh bone) inside the hip joint capsule). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/06/25, showed the following: -The resident was cognitively intact;-The resident used a wheelchair for mobility.Review of the resident's care plan, revised 10/09/25, showed the following: -The resident was dependent on staff for meeting physical needs;-All staff should converse with resident while providing care;-The resident was dependent on staff for locomotion in wheelchair. He/she did not propel self.Review of the resident's October 2025 Physician Order Summary (POS) report showed the following: -An order, dated 04/03/25, for activity as tolerated, assist of two using Hoyer (mechanical lift used for non-weight bearing residents) for all transfers; -An order, dated 03/21/25, to admit to hospice services on 03/21/25; -An order, dated 04/29/25, for pain monitoring and staff to assess for pain and document every shift.Review of the Facility Incident Report, dated 10/09/25, showed the following: -When Certified Nurse Aide (CNA) A attempted to incline resident in the wheelchair, resident tipped forward in the wheelchair and fell to his/her knees;-Resident had blood noted to his/her mouth. Resident had bit his/her lip;-Range of motion and neurological checks were within normal limits (WNL) for this resident;-Resident unable to give description.During an interview on 10/16/25, at 2:16 P.M., CNA A said the following:-He/she had worked at the facility since July 2025;-He/she did not complete any skills competencies with staff from the facility;-CNA A had gone to the dining room to assist with lunch;-The resident was sitting in his/her Broda chair next to the table;-He/she approached the resident and announced him/herself;-CNA A told the resident that he/she was going to reposition his/her Broda chair;-The lever on the residents Broda chair was stuck. CNA A pushed on the lever which caused the resident to fall out of the chair;-CNA A had no intention to harm the resident. Review of CNA A's personnel record showed the following: -CNA A was hired on 06/30/25;-CNA A started work on 07/22/25;-Staff did not document trainings or skills competency reviews completed in the CNA A's file.Review of the resident's care plan, revised 10/09/25, showed on 10/09/25, staff added resident fell out of wheelchair while being repositioned and landed on the floor on his/her knees. Resident was sent to emergency room (ER) per resident and family's request. Fracture identified below right knee.During an interview on 10/15/25, at 11:07 A.M., the resident's Family Member A said he/she was told by another family member an aide had flipped the resident out of his/her wheelchair causing a hairline fracture of the resident's knee.During an interview on 10/15/25, at 11:36 A.M., the resident's Family Member B said the following: -The resident had been at the facility since January 2025;-The family member received a call on 10/09/25, that the resident had fallen out of his/her wheelchair while at the dining room table during lunch;-CNA B told the family member that the resident was being repositioned in his/her chair by CNA A when the resident was catapulted out of his/her chair;-The resident landed on his/her hands and knees and hit his/her mouth on a wooden chair causing a laceration to the resident's mouth.During an interview on 10/15/25, at 12:43 P.M., the Dietary Aide (DA) E said the following: -The DA was in the dining room preparing for lunch when he/she saw the resident sitting too far forward in his/her Broda chair (a specialized, high-durability seating system designed for individuals with mobility challenges, such as the elderly or those with chronic conditions);-While CNA A was repositioning the resident and he/she fell out of the chair and landed on his/her hands and