STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 147934. The 2567 was electronically sent to the facility on 12/04/19.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/03/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1	F 657		

The facility reported a census of 30 residents with three residents selected for review for falls. Based on observation, record review, and interview, the facility failed to review and revise the care plan for one of the three residents reviewed, Resident (R) 3 related to failure to care plan the guidance for staff to apply a soft cervical collar while the resident was out of bed.

Findings included:

- The signed physician order sheet, dated 10/23/19, of Resident (R) 3, documented the resident admitted to the facility on 07/21/16. She was re-admitted to the facility on 11/23/19, with a diagnosis of unspecified fracture of the second thoracic vertebra ([T2] middle segment of the vertebrae) following a fall.

The annual "Minimum Data Set" (MDS), dated 01/03/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating impaired cognition. She required limited assistance of staff for activities of daily living (ADL's). She required a walker and wheelchair for mobility. The resident's balance was unsteady. The resident had one non- injury fall during the assessment.

The "Falls Care Area Assessment" (CAA), dated 01/09/19, revealed the resident had cognitive and ADL impairments. She had a fall since her last MDS. Her gait/balance with transitions and walking were unsteady. The resident was a fall risk.

The Quarterly MDS, dated 09/06/19, documented the resident had a BIMS score of seven, and revealed impaired cognition. She required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2	F 657		

extensive assistance from staff for transfers, toileting, and walking. Her gait remained unsteady, and she used a walker and a wheelchair for mobility.

The care plan, dated 08/05/19, lacked an update with guidance to staff to apply the soft cervical collar when the resident was out of the bed.

Review of the nurse "Progress note", located in the electronic medical record (EMR), documented the resident was hospitalized on 11/21/19 and returned on 11/23/19 following a fall from the wheelchair.

On 11/21/19, the CT scan (an X-ray image made using a form of tomography in which a computer controls the motion of the X-ray source and detectors, processes the data, and produces the image) of the resident's cervical spine, revealed a thoracic two (T2) compression fracture.

The Nurse Practitioner (NP) orders included a soft cervical collar for use, when upright, ordered on 11/27/19.

On 12/02/19 at 8:25 AM, the resident was in her bed. The resident attempted to rub her forehead, and a family member intervened. The resident reported she had a headache.

On 12/02/19 at 9:37 AM, Certified Nurse Aide (CNA) M and CNA N, transferred the resident from her bed to the wheelchair. Staff failed to apply the soft cervical collar to the resident's neck, when staff assisted her out of the bed.

On 12/02/19 at 11:30 AM, therapy staff worked with the resident. The resident did not have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3 cervical collar to her neck. On 12/02/19 at 12:13 PM, a family member propelled the resident in the hallway. The resident did not have the soft cervical collar on her neck. On 12/02/19 at 02:05 PM, CNA N and CNA O, transferred the resident in the common's bathroom. The resident lacked a soft cervical collar to her neck. On 12/02/19 at 01:53 PM, Licensed Nurse G, verified the NP ordered a soft cervical collar for the resident when she was out of bed. Staff should have updated the care plan to instruct staff in the use of the soft cervical collar. The facility's policy for "Electronic Care Plan," dated 12/2018, documented the facility would develop a plan of care to attain and maintain the highest practical level ... in the facility, which included care plan revision. The facility failed to review and revise this resident's care plan, related to the use of the soft cervical collar and instruction to staff for use when the resident was out of the bed.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 30 residents with three residents selected for review for falls. Based on observation, record review, and interview, the facility failed to apply a soft cervical collar when the resident was out of her bed, related to a thoracic (longest region of the spine, that runs from the base of the neck down to the abdomen) fracture, for pain control.

Findings included:

- The signed physician order sheet, dated 10/23/19, of Resident (R) 3, documented the resident admitted to the facility on 07/21/16. She was re-admitted to the facility on 11/23/19, with the following diagnoses including unspecified fracture of the second thoracic vertebra ([T2] middle segment of the vertebrae.

The annual "Minimum Data Set" (MDS), dated 01/03/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating impaired cognition. She required limited assistance of staff for activities of daily living (ADL's). She required a walker and wheelchair for mobility. The resident's balance was unsteady. The resident had one non- injury fall during the assessment.

The "Falls Care Area Assessment" (CAA), dated 01/09/19, revealed the resident had cognitive and ADL impairments. She had a fall since her last MDS. Her gait/balance with transitions and walking were unsteady. The resident was a fall risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

The Quarterly MDS, dated 09/06/19, documented the resident had a BIMS score of seven, and revealed impaired cognition. She required extensive assistance from staff for transfers, toileting, and walking. Her gait remained unsteady, and she used a walker and a wheelchair for mobility.

The care plan for ADL function, dated 08/05/19, lacked guidance to staff to apply the soft collar when the resident was out of the bed.

Review of the "Risk Progress Note," located in the electronic medical record (EMR) documented, on 11/21/19, staff toileted the resident in a common area bathroom. Staff propelled the resident from the bathroom towards the resident's room. Staff failed to place the resident's feet onto the wheelchair pedals, related to the wheelchair pedals not engaged (in the down position), and were in the "Up" position. The facility's root cause for the resident's fall determined as staff propelled the resident, without her feet on the wheelchair pedals, the resident's foot hit the floor, and she fell out of the wheelchair.

The resident was hospitalized on 11/21/19 and returned on 11/23/19.

On 11/21/19, the CT scan (an X-ray image made using a form of tomography in which a computer controls the motion of the X-ray source and detectors, processes the data, and produces the image) of the resident's cervical spine, revealed a thoracic two (T2) compression fracture .

The Nurse Practitioner (NP) orders included a soft cervical collar for use, when upright, ordered on 11/27/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 On 12/02/19 at 8:25 AM, the resident was in her bed. The resident attempted to rub her forehead, and a family member intervened. The resident reported she had a headache. On 12/02/19 at 9:37 AM, Certified Nurse Aide (CNA) M and CNA N, transferred the resident from her bed to the wheelchair. Staff failed to apply the soft cervical collar to the resident's neck, when staff assisted her out of the bed. On 12/02/19 at 11:30 AM, therapy staff worked with the resident. The resident did not have a cervical collar to her neck. On 12/02/19 at 12:13 PM, a family member propelled the resident in the hallway. The resident did not have the soft cervical collar on her neck. On 12/02/19 at 02:05 PM, CNA N and CNA O, transferred the resident in the common's bathroom. The resident lacked a soft cervical collar to her neck. On 12/02/19 at 01:53 PM, Licensed Nurse G, verified the NP ordered a soft cervical collar for the resident when she was out of bed. On 12/02/19 at 03:00 PM, Nurse Practitioner KK, reported the resident went face forward out of her wheelchair, and received sutures for a laceration on her forehead. The resident admitted to the hospital, and the hospital completed a CT scan, and confirmed she had a T2 compression fracture. Nurse Practitioner KK stated she ordered a soft cervical collar for six weeks while she was out of bed, and in bed as needed if she complained of pain.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 On 12/03/19 at 10:34 PM, Administrative Nurse D, reported the facility had the soft collar, and verified staff failed to apply the collar, when the resident out of bed, as ordered. The facility's policy for "Falls Management," dated 12/2017, documented the facility would minimize the risk for resident falls and reduce injuries associated with resident falls. The plan of care addressed individualized resident focus, goals, and interventions directed towards reduction of resident's risk of injury and potential re-occurrence of falls. The facility failed to apply a soft cervical collar when the resident was out of her bed, related to a thoracic fracture, as ordered.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 30 residents with three residents selected for review for falls. Based on observation, record review, and interview, the facility failed to provide planned interventions and/or assistive devices to prevent an injury fall for one of the three residents reviewed. The facility failed to implement planned	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

interventions of placement of the Resident (R) 3's wheelchair pedals on her wheelchair while the resident was out of her room. In addition, after the injury fall, the facility failed to position a footboard on the resident's wheelchair to prevent further falls .

Findings included:

- Resident (R) 3's 10/23/19 signed "Physician Order Sheet documented the resident admitted to the facility on 07/21/16. She re-admitted to the facility on 11/23/19, with the following diagnoses including unspecified fracture of the second thoracic vertebra (T2 - middle segment of the vertebrae), laceration (a cut in the skin) of the head, injury of the head, and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).

The annual "Minimum Data Set" (MDS), dated 01/03/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight, indicating impaired cognition. She required limited assistance of staff for activities of daily living (ADL's). She required a walker and wheelchair for mobility. The resident's balance was unsteady. The resident had one non-injury fall during the assessment.

The "Falls Care Area Assessment" (CAA), dated 01/09/19, revealed the resident had cognitive and ADL impairments. She had a fall since her last MDS. Her gait/balance with transitions and walking were unsteady. The resident was a fall risk.

The Quarterly MDS, dated 09/06/19, documented the resident had a BIMS score of seven which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

revealed severely impaired cognition. She required extensive assistance from staff for transfers, toileting, and walking. Her gait remained unsteady, and she used a walker and a wheelchair for mobility.

The "Care Plan" for ADL function, dated 08/05/19, included staff to ensure pedals were on the resident's wheelchair, originated on 10/05/16. After the resident's injury fall, the care plan's update included staff to apply a foot board on the resident's wheelchair when the resident was out of the room and to remove the footboard when the resident was in her room.

The "Fall Risk Assessment," dated 08/16/19, revealed a score of 16, which placed the resident as a high risk for falls.

Review of the "Risk Progress Note," located in the electronic medical record (EMR) documented staff toileted the resident in a common area bathroom on 11/21/19. Staff propelled the resident from the bathroom towards the resident's room. Staff failed to place the resident's feet onto the wheelchair pedals, related to the wheelchair pedals not engaged (in the down position) and were in the "up" position. The facility's root cause for the resident's fall determined as staff propelled the resident, without her feet on the wheelchair pedals, the resident's foot hit the floor, and she fell out of the wheelchair.

Review of the facility's undated investigation, revealed on 11/21/19, staff failed to place the resident's wheelchair pedals down for the resident to rest her feet on and the resident toppled forward out of her wheelchair. The resident received a 5-centimeter (cm) by 6 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

skin tear to her left hand, a 2 by 4 cm skin tear to her left forearm, a 3 by 4 cm skin tear to her left (facial) cheek, and a 0.5 by 1 cm laceration to her left temple.

The resident was hospitalized on 11/21/19 and returned to the facility on 11/23/19.

On 11/21/19, the CT scan (an X-ray image made using a form of tomography in which a computer controls the motion of the X-ray source and detectors, processes the data, and produces the image) of the resident's cervical spine, revealed a thoracic two (T2) compression fracture .

The Nurse Practitioner (NP) orders included a soft cervical collar for use, when upright, ordered 11/27/19.

On 12/02/19 at 8:25 AM, the resident was in her bed. The resident's left side of her forehead had abrasions and intact sutures on a laceration to the left side of her forehead. The resident had bruises that extended from the left side of her forehead down and over her left eye. The resident's left hand had a skin tear, her left forearm with two skin tears, and above the left elbow with a skin tear. The resident attempted to rub her forehead, and a family member intervened. The resident reported she had a headache.

On 12/02/19 at 9:37 AM, Certified Nurse Aide (CNA) M and CNA N, transferred the resident from her bed to the wheelchair. Staff engaged the wheelchair pedals, however, failed to apply the footboard to the wheelchair. CNA M verified she was taking the resident for a shower. The resident complained of a headache. Staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

apply the soft cervical collar to the resident's neck, when staff assisted her out of the bed.

On 12/02/19 at 11:30 AM, therapy staff worked with the resident. The resident did not have a foot board on her wheelchair pedals, or a cervical collar to her neck.

On 12/02/19 at 12:13 PM, a family member propelled the resident in the hallway. The resident had her feet on the foot pedals, however, the resident's wheelchair lacked a footboard as care planned while the resident was out of her bedroom. Administrative Nurse D verified staff failed to apply the resident's footboard on the wheelchair pedals.

On 12/02/19 at 02:05 PM, CNA N and CNA O, transferred the resident in the common's bathroom. The resident lacked a soft cervical collar to her neck.

On 12/03/19 at 8:25 AM, a family member reported the resident had a fall that required hospitalization after staff "forgot" to put the resident's wheelchair pedals into the proper position, and the resident fell forward out of her wheelchair. She reported the resident required hospitalization and she returned with four sutures to her head laceration.

On 12/02/19 at 09:25 AM, Administrative Nurse D, reported two staff toileted the resident in the common's bathroom and staff propelled the resident from the bathroom towards her room. Staff failed to put the resident's wheelchair pedals down for the resident to rest her feet on. The resident's feet went to the floor, the resident fell forward, out of the chair, and onto the floor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

resulting in laceration that required sutures to her forehead, and a possible T2 fracture.

On 12/02/19 at 09:29 AM, CNA P, reported she propelled the resident from the common's bathroom to her room in a wheelchair, approximately 50 feet from the resident's room. While staff propelled the resident in the wheelchair, the resident "stomped" her foot down and she fell forward to the floor. She verified she failed to have the wheelchair pedals in the right position, because staff was going to transfer her to her bed.

On 12/02/19 at 09:34 AM, CNA Q reported she assisted CNA P with the resident's toileting needs. She verified staff failed to engage the resident's wheelchair pedals before propelling the resident to her room, because she "forgot" to engage the wheelchair pedals. The resident required hospitalization.

On 12/02/19 at 09:37 AM, CNA N reported staff should keep the resident's feet on the wheelchair pedals when staff propelled the resident in her wheelchair.

On 12/02/19 at 01:46 PM, CNA LL reported staff should apply the resident's foot pedals and foot board on the wheelchair when propelling the resident in her wheelchair.

On 12/02/19 at 01:53 PM Licensed Nurse G reported staff should have used the wheelchair pedals to prevent the resident from falling. The resident received a laceration on her head. The resident transferred to the hospital after she fell and received approximately three sutures to the head laceration. She did not touch her head to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

count the sutures, because the resident was in too much pain when she returned. She is on routine and as needed pain medication. She verified the NP ordered a soft cervical collar for the resident when she was out of bed.

On 12/02/19 at 03:00 PM, Nurse Practitioner KK, reported the resident went face forward out of her wheelchair and received sutures for a laceration on her forehead. The resident admitted to the hospital, and the hospital completed a CT scan, and confirmed she had a T2 compression fracture. Nurse Practitioner KK stated she ordered a soft collar for six weeks while she was out of bed, or in bed as needed, if she complained of pain. If staff had the wheelchair pedals engaged, the resident probably would not have fallen out of her wheelchair.

The facility's policy for "Falls Management," dated 12/2017, documented the facility would minimize the risk for resident falls and reduce injuries associated with resident falls. The plan of care addressed individualized resident focus, goals, and interventions directed towards reduction of resident's risk of injury and potential re-occurrence of falls.

The facility failed to implement planned interventions of staff placement of the resident's wheelchair pedals in the down position while the resident was up in her wheelchair and out of her room. In addition, after the injury fall, the facility failed to position a footboard on the resident's wheelchair, to prevent further falls.