

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>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</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265843	Facility ID: 265843 If continuation sheet Page 1 of 3

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