STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens at Aldersgate	3220 SW Albright Drive Topeka, KS 66614

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 - Immediate jeopardy to resident health or safety 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** 22686 The facility reported a census of 148 residents. The sample included eight residents. Based on record review, observation, and interviews, the facility failed to ensure a safe environment free from preventable accidents for Resident (R) 1, when R1 slipped from the sling during a staff-assisted transfer using a Hoyer lift (full body mechanical lift). On 03/04/24 at 08:20 AM Certified Nurse Aide (CNA) M and CNA O attempted to transfer R1 from his bed to his chair using the Hoyer lift with a toileting sling. R1 slipped out of the opening in the toileting sling and fell to the floor. R1 hit his head on the metal leg of the Hoyer lift. As a result of the fall, R1 was admitted to the Intensive Care Unit (ICU) with a head laceration, a thoracic (mid-spine) fracture, and an intracranial (inside the skull) hemorrhage. The facility failed to ensure R1 remained free from preventable accidents when staff used the wrong sling during a mechanical lift transfer. This failure placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed 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), vascular dementia (a progressive mental disorder characterized by failing memory, and confusion), lumbar region spondylosis (a degenerative condition that affects the lower spine and causes back pain), epilepsy (brain disorder characterized by repeated seizures), and paroxysmal atrial fibrillation (a type of irregular heartbeat). The Annual Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated R1's cognition was moderately impaired. The MDS recorded R1 required the total assistance of two staff members with transfers; R1 was unable to stabilize without assistance, and used a wheelchair for mobility, The Falls Care Area Assessment [CAA] dated 04/07/23 recorded R1 was at risk for falls and required assistance of one staff with activities of daily living (ADL) and two staff with transfers using a sit-to-stand lift with transfers. The CAA recorded R1 was monitored for changes in functioning and staff would ensure R1's needs were met. The Quarterly MDS dated [DATE] recorded R1 had a BIMS score of 13, which indicated intact cognition. R1 required extensive assistance of one to two staff members with most ADL and total assistance of two staff with transfers. The resident was six feet tall and weighed 249 pounds. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan documented an intervention dated 06/04/20 and revised on 01/05/23 directed staff that due to weakness on R1's left side and poor balance, staff used a Hoyer lift with two staff for transfers. The plan recorded R1's last fall was on 07/31/23 when R1 fell out of R1's Broda chair (special wheelchair with tilt and recline capability). R1's Care Plan recorded an intervention initiated on 07/12/18 and revised on 03/04/24 that documented: due to weakness on R1's left side and poor balance, R1 used a full body mechanical lift with two staff assistance for transfers. R1's Care Plan documented an intervention added on 03/05/24 that noted on 03/04/24, R1 was transferred with the Hoyer lift when R1's body folded in half and fell from the sling. R1's bottom hit the floor first. R1's legs ended up on the legs of the lift. R1's head landed on the leg of the lift. Staff noted the back of R1's head was bleeding, and staff applied pressure. Staff did not move R1 because of a potential for injury to R1's neck. Emergency Medical Services (EMS) services applied a cervical collar and transported R1 to the hospital. R1's Care Plan lacked documentation of the specific size and type of sling used to transfer the resident. The facility Incident Report Investigation documented on 03/04/24 at 08:20 AM Certified Nurse Aide (CNA) M notified Licensed Nurse (LN) G of a fall. LN G immediately went to the room and observed R1 lying on his back. The back of R1's head rested against the leg of the Hoyer lift. R1's legs were lying on top of the Hoyer lift. There was a significant amount of blood coming from the back of R1's head. LN G immediately applied pressure and did not move the resident's head or neck. R1 was alert and oriented to his name, birth date, and year. Staff reported the resident was in the (lift) sling and staff were transferring R1 to his wheelchair. R1 folded in the sling and slid out, hitting his buttocks on the floor first, then hitting the back of his head on the corner of the leg of the Hoyer lift. Staff initiated neurological checks and continued until EMS arrived; R1's neurological checks were stable per the resident's baseline. Staff monitored R1's vital signs. R1 was able to answer questions appropriately, his speech was clear and coherent. EMS arrived, applied a neck collar then transferred R1 to the gurney. R1 complained of pain in his head. A review of the hospital's Trauma Services History and Physical dated 03/04/24 revealed R1 was dropped during a transfer with a Hoyer lift at the facility. R1 was a poor historian and did not answer questions surrounding the event. R1 confirmed he had a headache, back pain, and left lower quadrant (LLQ) abdominal pain. He had a cervical collar in place. The radiographic (X-ray) and computed tomography (CT scan- a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) scans revealed R1 sustained a subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane), bilateral (both sides) frontal subdural hematoma (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain), and a nondisplaced fracture through the T8 vertebrae (bone of the spine). CNA M's Witness Statement from 03/04/24 recorded CNA M, along with CNA N, dressed R1 and hooked up the Hoyer machine. The staff crisscrossed the bottom half of the sling between R1's legs and hooked the sling by the top to the machine, then proceeded to transfer R1 to his chair. CNA N raised the Hoyer, and CNA M grabbed R1's wheelchair and started to place it under the Hoyer machine. R1 slipped out the sling and his bottom backside first, then hit his neck and the back of his head on the corner of the Hoyer. CNA M ran and got the nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA N's Witness Statements from 03/04/24 recorded CNA and CNA M went into R1's room to get R1 up for breakfast. The CNA staff got R1 in the Hoyer lift and when CNA M was about to put his chair under him, R1 started sliding out of the sling. R1 landed on his buttocks and then hit his head on the edge of the Hoyer lift. CNA M ran to go get the nurse while CNA N held R1's head; CNA N noticed all the blood on the floor coming from the back of R1's head. Observation on 03/06/24 at 03:00 PM of the lift used for R1 revealed a standard full-body Hoyer l lift in good repair. Observation of the sling used to transfer R1 revealed a standard divided leg sling also called a shower or toilet sling. The sling had a V or U shape, with two points of contact in the back and two at the front. Interview on 03/06/24 at 12:17 PM revealed CNA M acknowledged the resident fell out the bottom of the lift sling where there was an opening around the buttocks. CNA M stated CNA N and she attached the same sling they always saw used for R1. CNA M acknowledged she subsequently received instruction on the lift use and the appropriate sling used. CNA M stated a full-body sling was to be used, not the toileting sling. Interviewed on 03/06/24 at 12:07 PM, LN G stated she was alerted by CNA M that a nurse was needed immediately in R1's room. LN G stated when she entered, she observed R1 hit the left side of his head on the lift leg, and there was a puddle of blood on the floor. LN G said she applied pressure to the back of R1's head while the CNA got a phone and LN G started neurological checks. LN G said R1 was talking after the incident and LN G could see that R1 was scared. LN G reported R1 complained of head pain, but R1 laughed a little and LN G felt like R1 was going to be ok. LN G went on to say R1's hand grips were equal bilaterally, his pupils were ok, and R1's blood pressure was elevated, but LN G attributed that to R1's fall. When LN G rechecked R1's blood pressure, it came down. LN G reported she assured R1 that emergency services were on the way. LN G stated the CNAs involved told her R1 had folded or went completely relaxed and fell through the bottom of the lift sling. LN G stated the moment she came in and visually surveyed the room, she thought the problem was the sling that was used, as she noted staff had used a toileting sling. Interview on 03/06/24 at 11:20 AM with Administrative Nurse E revealed therapy staff reviewed sling and lift use with CNA M and CNA N. Administrative Nurse D said the therapy and administrative nursing staff were working on building a wide in-service related to lift and sling use for all staff. Interview on 03/06/24 at 11:20 AM with Administrative Nurse D revealed the toileting sling had an opening around the legs and Administrative Nurse D said R1 must have had his arms inside the lift sling, relaxed, and fell through the bottom of the sling. Administrative Nurse D acknowledged the staff used the wrong sling when they transferred R1 from the bed to his wheelchair. A review of the facility's undated Patient Lifts Safety Guide revealed photographic tutorials on bed-to-chair transfers, toileting, and/or bathing transfers as well as the various types and sizes of slings used. This documentation also directed staff to make sure sling opening is not large enough to let patient slip out or too small to let the patient fall out. The facility's Safe Resident Handling / Transfers policy dated 11/29/23 documented the facility would ensure the sling designed for the lift is utilized with that specific lift; and staff would be educated on the use of safe transfer/handling practices to include the use of the mechanical lift devices upon, hire, annually and as need arises or changes in equipment occur. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure R1 remained free from preventable accidents when staff used the wrong sling during a mechanical lift transfer, and R1 fell through the sling. As a result of the fall, R1 admitted to the ICU due to a head laceration, a spinal fracture, and brain bleed and bruising. This failure placed R1 in immediate jeopardy. The facility implemented the following actions to remove the immediacy on 03/07/24: The facility retrained the staff on using the proper lift and sling for Hoyer transfers. The facility compiled a list of residents that utilized the Hoyer lift for transfers. The Kardex for each of those residents was updated to include the proper size/type of sling. The Patient Lift Safety Guide was reviewed with the nursing staff. The facility completed education on the current policy. The above actions to remove the immediacy were verified during an onsite inspection conducted on 03/07/24. The scope and severity of the deficient practice remained at a G.