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	10/02/2024

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 - Actual harm 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** 39752 The facility identified a census of 152 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observations, the facility failed to ensure Resident (R) 1 remained free from avoidable accidents when staff failed to provide care safely using the required number of staff per the resident's plan of care. Subsequently, R1 sustained a dislocated right shoulder and a fractured right humerus (upper arm bone). This deficient practice also placed R1 at risk for increased pain and impaired well-being. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab, recorded diagnoses of polyosteoarthritis (a condition characterized by inflammations, stiffness, and pain in five or more joints simultaneously), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) without dyskinesia (inability to execute voluntary movements), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and fibromyalgia (inability to execute voluntary movements). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R1 displayed no behaviors. R1 was dependent on staff for oral hygiene, toileting hygiene, showering or bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. R1 was dependent on staff for mobility in bed, all transfers, and mobility in her wheelc hair. The MDS recorded R1 had no falls since admission. The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 04/01/24 documented R1 as dependent on staff assistance with ADLs and transfers. R1 was monitored for changes in functioning. Staff were to ensure R1's needs were met and R1's room was kept free from clutter. The Falls CAA dated 04/01/24 documented R1 was dependent on staff assistance with ADLs and with transfers. R1 was a fall risk due to weakness and was monitored for changes in functioning. The Pain CAA dated 04/01/24 documented that R1 complained of pain and received scheduled and as-needed medications. (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 - Actual harm Residents Affected - Few	The Quarterly MDS dated [DATE] documented a BIMS score of three, which indicated severely impaired cognition. R1 displayed no behaviors. R1 had no changes in her level of assistance needed from staff from the previous MDS. The MDS recorded R1 had two or more falls with no injury, and two or more falls with injuries. R1's Care Plan implemented on 04/10/23 documented R1 required maximum assistance of two staff members for all bed mobility and showering. An intervention implemented on 12/01/23 documented that staff would provide care in pairs for R1 so that R1 felt safe. An intervention implemented on 05/15/24 documented that staff would provide care in pairs so R1 felt safe. An intervention revised on 06/03/24 documented that R1 required the maximum assistance of two staff members with dressing, personal hygiene, and oral care. A review of the Staffing Care Sheet updated on 07/22/24 documented R1's fall interventions and directed staff to have two aides with care at all times. On 09/27/24 at 02:48 PM a Nurse's Note documented R1's representative expressed concerns about R1 being transferred with a mechanical lift and felt it was not being used consistently by all facility staff. R1's representative requested an order to have physical therapy screen R1 for falls, transfers, and recliner safety. On 09/27/24 at 04:54 PM a Weekly Skin Check documented R1 had extensive bruising to her face and forehead due to a fall the prior week. R1 also had a large hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to her posterior (back) right forearm. On 09/28/24 at 07:57 AM a Nurse's Note documented R1 was on the floor in her room. R1 laid flat on her abdomen and face down, with her head towards the bed, and R1 had no skid socks on her feet. When R1 was asked what happened, R1 stated she fell , and her right arm was hurting. Staff rolled R1 to her back and assessed her. R1 was visibly agitated and continuously waving her right arm around. R1 had a hematoma forming on her head. Certified Nurse Aide (CNA) M stated she was assisting R1 to change her clothing, while she was in the recliner. R1 leaned forward and fell out of the recliner onto the floor. R1's provider was notified and ordered R1 to be sent to the emergency room (ER) to be evaluated. On 09/28/24 at 08:35 PM a Nurse's Note documented R1 returned from the ER very agitated and inconsolable. R1 had a closed fracture of her right shoulder, with a new order for pain medication, and an order to keep her right arm in a sling until she followed up with orthopedics (a branch of medicine that focuses on the care of the skeletal system and its interconnecting parts). R1 was very frustrated due to her good arm being injured. R1's Care Progress Note dated 10/01/24 documented R1 was seen in theER on [DATE] and found to have a dislocation of the right shoulder with a fracture of the proximal (nearer to a point of reference or attachment) end of the humerus. R1's shoulder was reducted (to restore a fracture or dislocation to the correct alignment) at the bedside. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 12:40 PM, R1 sat in her wheelchair at the nurse's station with her right arm in a sling. Her right hand was swollen and bruised throughout her hand. R1 had a hematoma, dark purple in appearance, approximately two to two and a half inches in diameter above her right eye. R1 stated that she fell out of her recliner when CNA M was helping her. R1 stated CNA M did not have a hold of her and she jerked and fell to the floor. R1 revealed that it was only CNA M helping her when she fell . R1 called out in pain and asked Licensed Nurse (LN) H for a pain pill. R1 stated it was for her right shoulder because it was hurting and broken since shefell . R1 stated she was glad she did not have to have surgery but was upset her arm needed to stay in the sling. R1 stated she just saw the orthopedic doctor that morning and was told about what was being done with her arm. On 10/02/24 at 01:20 PM CNA M stated that when working on the hall that R1 lived on, staff were given a staffing care sheet, so staff know of knew what was going on with the residents. CNA M stated she received report when she got onto the unit. CNA M was told R1 required a Hoyer lift (full-body mechanical lift) for transfers. CNA M stated she went to provide R1 with peri care and change her clothing but was not getting R1 up, so CNA M did not get another staff member to assist with R1. When CNA M turned R1 in her recliner, R1 jerked and then fell . CNA M stated sometimes she could get into the residents' Point Of Care (POC) or Kardex (a nursing tool that gives a brief overview of the care needs of each resident) and sometimes she would get locked out. CNA M stated she was able to get into the POC and Kardex but it was not until halfway into her shift. On 10/02/24 at 03:17 PM, CNA N stated she heard that CNA M was not fully aware of how R1 transferred or how R1 received care. CNA N stated she was working a different hall when CNA M told her about R1's fall. On 10/02/24 at 03:21 PM LN G stated that she had not witnessed R1's fall, but CNA M alerted her to the fall around 06:00 AM. LN G arrived at R1's room and R1 was lying on the floor on her stomach, face down, with her right arm extended straight out, her head towards her bed and her feet towards the recliner. LN G said CNA M informed her that CNA M attempted to get R1's wet gown off, when R1 jolted forward, and the CNA could not catch R1. LN G revealed the CNAs gave report to oncoming CNAs before their shift started and there was also a staffing care sheet to tell the CNAs how to care for the residents. On 10/02/24 at 04:05 PM Administrative Nurse D stated she expected staff to follow the resident's care plan. Administrative Nurse D stated with R1, she expected two staff members at all times to go into R1's room to provide care. Administrative Nurse D stated R1 did not always listen to staff, and that is why Administrative Nurse D informed the staff there were to be two staff members entering R1's room to care for her. On 10/02/24 at 04:21 PM Administrative Staff A stated he expected staff to follow the residents' care plan and Kardex when providing care for the residents. The facility's policy Accidents and Supervision dated 02/01/20 documented a resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision to prevent accidents. The policy documented facility-based interventions may include educating staff, implementing specific interventions as part of the plan of care, supervising staff and residents, and facility records documenting the implementation of these interventions. The facility's policy documented that monitoring was a process of evaluating the effectiveness of the interventions and modification of adjusting the interventions as needed to address hazards and risks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure R1 remained free from avoidable accidents resulting in a dislocated right shoulder and a fracture of the humerus. This deficient practice also placed R1 at risk for increased pain and impaired well-being.