STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175424	A. BUILDING _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(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 A complaint survey was conducted regarding the allegations in KS00182662, #KS00182024 The investigation revealed noncompliance was found related to the allegations and the following deficiencies were cited. This 2567 was electronically sent to the facility on 09/13/23.	F 000		
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 44 residents with three residents sampled for assisted transfers using a Hoyer lift (a total body mechanical lift used to transfer residents). Based on observation, interview, and record review, the facility failed to ensure staff used the proper Hoyer lift transfer sling for Resident (R) 1 to prevent a fall out of the sling, which required medical treatment at a hospital as a result of the fall. R1 was injured when she slipped through the opening of the lift sling after staff instructed her to cross her arms across her chest instead of holding her arms outside of the sling causing her legs to strike the Hoyer lift, and her back, hip and head to strike the floor.	F 689		

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

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.

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F 689	Continued From page 1	F 689		

Finding included:

-The "Physician's Orders" dated 05/30/23, included diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory confusion) and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set" (MDS) dated 08/17/23 revealed a "Brief Interview Mental Status" (BIMS) score of 11, indicating moderate cognitive impairment. R1 required total assistance of staff with all transfers.

The "Care Plan" dated 08/30/23 documented R1 was at risk for falls related to physical limitations, medical diagnosis, and use of high-risk medication. Staff were to use two staff members for transfers. The care plan lacked specific guidance to staff on the type of transfer sling required to transfer R1.

The "Fall Assessment" dated 09/07/23, indicated R1 had a history of one to two falls, which occurred in the last three months, while standing or changing positions.

The "Nurse's Progress Note" dated 09/07/23 at 02:08 PM, revealed staff attempted to transfer the resident from her wheelchair to her bed and the resident fell to the floor. When LN G entered the resident's room, R1 was on the floor, on her right side. The resident complained of pain in her right hip and back area. Facility staff sent the resident to the hospital for an evaluation.

The "Nurse's Progress Note" dated 09/08/23,

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F 689	Continued From page 2	F 689		

revealed R1 returned to the facility with a right knee immobilizer for a sprained right knee.

Observation on 09/11/23 at 12:40 PM revealed R1 in her bed with a brace on her right knee.

Interview with "Certified Nurse Aide" (CNA) M on 09/11/23 at 11:54 AM, revealed CNA N and CNA M were in the process of transferring the resident from the wheelchair to the bed, using a hygiene lift sling when the resident fell. CNA M stated the hygiene sling had an open area for residents to use the bathroom, the sling went around the resident's body and connected in the front like a belt. The resident did not have her arms on the outside of the sling, instead her arms were crossed across her chest, which caused her to slip out of the sling to the floor. R1 hit her legs on the lift, and her bottom and head hit the floor.

Interview with CNA N on 09/11/23 at 01:25 PM revealed after lunch CNA N and CNA M transferred R1 from the wheelchair to the bed with the use of a hygiene sling. CNA N stated R1 did not like the full sling would swing her arms around as she had anxiety with the use of the lift. CNA N stated they instructed R1 to place her arm across her chest, which caused her to fall out of the sling.

Interview with "Licensed Nurse" (LN) G on 09/11/23 at 02:05 PM, reported the nurse aides used the hygiene sling, and R1 moved her arms from the outside of the sling to the inside of the sling, which caused R1 to fall out of the sling.

Interview with Administrative Nurse D on 09/11/23 at 02:10 PM, reported they completed education with the nursing staff regarding use of transfer

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F 689	Continued From page 3 slings after the resident fell. The facility removed the hygiene slings from being used for any resident. The undated facility policy for "Using a Full Body Mechanical Lift Procedure" revealed two staff members must always use the full body mechanical lift. If assisting a resident after a fall, a nurse would guide the process. Full body mechanical lifts may be used when transferring a resident from even and uneven surfaces for the residents who are unable to bear their own weight. The resident shall be transferred using full body mechanical lift, before a team member assist a resident for the first time with a full body mechanical lift, the team member shall be tested for competency in the use of the device. The facility failed to ensure staff used the proper Hoyer lift transfer sling for Resident (R) 1 to prevent a fall out of the sling, which required medical treatment at a hospital as a result of the fall. R1 was injured when she slipped through the opening of the lift sling after staff instructed her to cross her arms across her chest instead of holding her arms outside of the sling causing her legs to strike the Hoyer lift, and her back, hip and head to strike the floor.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726		

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F 726	Continued From page 4	F 726		

resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 44 residents with three residents sampled for assisted transfer using a Hoyer lift (a total body mechanical lift used to transfer residents). Based on observations, interviews, and record review the facility failed to ensure competent nursing staff were available to provide assistance to residents with the use of a hygiene sling (sling with a large cut-out area behind the thighs and up the lower back to access the removal of clothing of the resident for toileting) when transferring using a Hoyer lift.

Findings included:

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F 726	Continued From page 5	F 726		

- Review of the "Nurse's Progress Note" dated 09/07/23 at 02:08 PM, revealed staff attempted to transfer Resident (R) 1 from her wheelchair to her bed and the resident fell to the floor.

An interview with "Certified Nurse Aide" (CNA) M on 09/11/23 at 11:54 AM, revealed CNA N and CNA M transferred the R1 from the wheelchair to the bed, using a hygiene lift sling to transfer the resident, and the resident fell out of the sling to the floor. CNA M stated the hygiene sling had an open area for residents to use the bathroom, the sling went around the resident's body, and connected in the front like a belt. The resident did not have her arms on the outside of the sling, instead her arms were crossed across her chest, which caused her to slip out of the sling to the floor. R1 hit her legs on the lift, and her bottom and head hit the floor. CNA M stated she knew the resident should have had her arms on the outside of the sling not across her chest.

Interview with CNA N on 09/11/23 at 01:25 PM revealed CNA N and CNA M transferred R1 from the wheelchair to the bed with the use of a hygiene sling. CNA N stated R1 did not like the full sling and would swing her arms around as she had anxiety with the use of the lift. CNA N stated they instructed R1 to place her arms across her chest, which caused her to fall out of the sling R1 arm are to be outside of the sling not across her chest.

Interview with "Licensed Nurse" (LN) G on 09/11/23 at 02:05 PM, reported the nurse aides used the hygiene sling and R1 moved her arms from the outside of the sling to the inside of the sling, which caused R1 to fall out of the sling. The

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F 726	Continued From page 6	F 726		

facility did not provide training to staff regarding the hygiene sling before R1's fall from the hygiene sling.

Interview with Administrative staff, which included Administrative Nurse D, Administrative Nurse E, and Administrator A on 09/11/23 at 04:00 PM revealed the facility did not provide specific training for staff on the use of the hygiene sling to prevent R1 from falling out of the hygiene sling. The facility further lacked assessment of R1 prior to the use of the hygiene sling.

The undated facility policy for "Using a Full Body Mechanical Lift Procedure" revealed two staff members must always use the full body mechanical lift. If assisting a resident after a fall, a nurse would guide the process. Full body mechanical lifts may be used when transferring a resident from even and uneven surfaces for the residents who are unable to bear their own weight. The resident shall be transferred using full body mechanical lift, before a team member assist a resident for the first time with a full body mechanical lift, the team member shall be tested for competency in the use of the device.

The facility failed to ensure competent nursing staff were available to provide assistance to residents with the use of a hygiene sling when transferring using a Hoyer lift.