STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089041	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #184586, #184539, #184561, #182482, #180042, #178386, and #177167 at the above named assisted living conducted on 02/28/24 and 02/29/24.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 54 residents with three included in the sample and three closed record reviews. Based on interview and record review the operator failed to protect Resident (R) 1 from neglect by ensuring certified staff provided the services described in R1's "Negotiated Service Agreement" (NSA) to use a manual mechanical sling lift requiring two-person assist for safety during transfers. This failure resulted in harm when R1's left leg/foot came into contact with the bed frame during a transfer which resulted in injury.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 03/26/19 with a diagnosis of functional quadriplegia. The 11/10/23 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with transfers. The 11/10/23 "NSA" identified facility staff would provide assistance of two staff for all transfers using a mechanical sling lift. The 12/08/23 "Outpatient Service Documentation" note by unidentified hospice licensed nurse documented R1 stated facility "Certified Nurse Aide" (CNA) C transferred her to bed the evening before using a mechanical sling lift by herself. During the transfer R1's foot accidently "smashed" against the bed. R1's left inner ankle was swollen with increased pain upon touch. The 12/08/23 "Nurses Note" documented R1 stated CNA C accidently smashed her left foot against the bed during transfer to bed the evening before. The 12/08/23 radiology report documented an x-ray of R1's left ankle was completed and revealed acute mildly displaced fracture of the distal tibia. The 12/12/23 "Progress Note" by "Advanced Practice Registered Nurse" (APRN) D documented R1 had a fracture of left distal tibia	S3026		

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S3026	Continued From page 2 and was in a lot of pain. The 12/19/23 facility's investigation report to the department documented R1 complained of left foot pain during a routine hospice visit on 12/08/23. R1 reported that the previous evening CNA C assisted R1 to bed on her own using the mechanical sling lift and "banged" her foot on the frame of the hospital bed. An x-ray was obtained and R1 was diagnosed with an acute mildly displaced fracture of the distal tibia. On 02/28/24 at 02:07 PM Administrative Staff A confirmed CNA C used a mechanical sling lift by herself to transfer R1 which was against the facility's process. On 02/28/24 at 02:14 PM CNA C confirmed she used a mechanical sling lift by herself to transfer R1 from her chair to bed on 12/07/23. CNA C had asked for help from other staff to assist with the transfer, but none came. She did not realize at the time R1's foot hit the bed and R1 did not indicate she was in pain. On 02/29/24 at 10:10 AM Administrative Staff A stated the facility's process for using the mechanical sling lift was included in the "Competency Checklist Sling Lift" form that was used during new certified staff orientation and for the staff in-service conducted on 12/08/23. Review of the 12/08/23 at 02:00 PM "Staff Inservice" revealed 13 certified staff and one licensed nurse attended the meeting regarding correct transfer process using a mechanical lift and the importance of team communication.	S3026		

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S3026	Continued From page 3 The facility's revised 11/2011 "Competency Checklist Sling Lift" form documented two people were required for all mechanical sling lift transfers. A second caregiver was to prevent the body from rocking and from legs bumping into objects during the transfer. The operator failed to protect R1 from neglect by ensuring certified staff provided the services described in R1's "NSA" to use a manual mechanical sling lift requiring two-person assist for safety during transfers. This failure resulted in harm when R1's left leg/foot came into contact with the bed frame during a transfer which resulted in injury.	S3026		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 54 residents with three included in the sample and three closed record reviews. Based on observation,	S3155		

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S3155	Continued From page 4	S3155		

interview, and record review the operator failed to ensure a licensed nurse provided the necessary health care services that met the needs for Resident (R) 5 by the failure to include a bed assist device was used for transfers to and from bed on R5's "Negotiated Service Agreement" (NSA).

Findings included:

- Record review for R5 revealed an admission date of 01/20/22 with a diagnosis of dementia.

The 11/29/23 "Functional Capacity Screen" (FCS) identified R5 required supervision for transfers.

The 11/29/23 "NSA" identified facility staff provided R5 supervision for transfers.

The 11/29/23 "NSA" lacked evidence of documentation a bed assist device was used while transferring to and from bed.

Observation on 02/29/24 at approximately 10:20 AM revealed a bed assist device was attached to the left side of R5's bed.

On 02/29/24 at approximately 10:20 AM R5 stated she used the bed assist to transfer in and out of bed.

On 02/29/24 at approximately 10:54 AM Administrative Staff A confirmed R5 used a bed assist device for transferring in and out of bed.

On 02/29/24 at approximately 10:54 AM Administrative Nurse B confirmed R5's "NSA"

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S3155	Continued From page 5 lacked evidence of documentation a bed assist device was used while transferring to and from bed. The operator failed to ensure a licensed nurse provided the necessary health care services that met the needs for R5 by the failure to include a bed assist device was used for transfers to and from bed on R5's "NSA."	S3155		