

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER TRS- EDWARDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(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	F 000			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 94 residents with 3 residents sampled. Based on observation, record review, and interviews, the facility failed to prevent falls for 1 (#1) of 3 residents sampled for falls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1 's admission Minimum Data Set assessment (MDS) dated 10/19/15 documented the resident 's Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognitive status. The MDS documented the resident required extensive assistance of 2 staff members with bed mobility, dressing, and toilet use. The MDS documented the resident with no falls. <p>The fall Care Area Assessment (CAA) dated 10/27/15 documented the resident had unsteady transitions that required staff assistance and the</p>	F 323			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER TRS- EDWARDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(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 323	<p>Continued From page 1 assistance of a standup lift.</p> <p>The quarterly MDS dated 1/7/16 documented the resident ' s BIMS score of 15 which indicated the resident was cognitively intact. The MDS documented the resident required extensive assistance of 2 staff member with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented the resident with no falls.</p> <p>The falls care plan revised on 12/29/15 documented the resident required a stand up lift for transfers. The interventions included that 2 staff members present during the lift use.</p> <p>The clinical record documented on 12/20/15 at 8:15 P.M. the resident was yelling, swearing, and verbally abusive to staff when the licensed nurse H removed fecal material, while the resident remained in an upright position with the aide of the sit to stand lift (mechanical lift used for transfers). The resident attempted to slide down from the sit to stand lift and landed on the licensed nurse.</p> <p>The clinical record dated 12/23/15 at 5:44 P.M., licensed nursing staff H documented further details regarding an incident on 12/20/15 at 8:15 P.M., the resident was placed in a sit to stand lift to assist in the evacuation of impacted fecal matter from his/her rectum. The resident was prompted and encouraged to bear down and push to facilitate bowel movement, to which the resident began swearing and asking the staff to stop the procedure and put him/her to bed. Licensed nursing staff H informed the resident that halting the procedure at that moment would be impossible, since the large mass of stool was</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER TRS- EDWARDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(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 323	<p>Continued From page 2</p> <p>halfway out of the body, and was almost completely evacuated from the rectum. The resident stood on both feet, which supported the resident in an upright position while the resident held onto the handlebars of the sit to stand lift. Toward the end of the fecal evacuation, the resident began to slide down on the lift, bearing less weight than necessary to provide proper positioning on the device. Staff prompted and encouraged the resident to hold on to the handlebars and to use his/her legs to support their body weight and to prevent a potential fall, however the resident was noncompliant. The res began slipping down further on the lift, and staff continued to prompt the resident to hold onto the handlebars to prevent injury or falls, and to use legs to support own weight. Resident remained noncompliant with these requests, and continued to slip downward, eventually slipping completely under the sling of the lift. The resident slid and fell backward. Licensed nursing staff H was still in the position behind and beneath the resident, which allowed the nurse to catch the resident, and the resident sat on the nurse's lap. The resident was then placed in a sling and slowly transferred to bed using a Hoyer lift (mechanical lift). The resident was assessed from head to toe, and no signs/symptoms of injury, discomfort, or distress was noted.</p> <p>Observation on 2/4/16 at 11:15 A.M. direct care staff O, P, and Q assisted the resident to sit on the side of the bed. Direct care staff O placed the sit to stand sling around the resident and direct care staff P pushed the sit to stand lift up to the resident and placed his/her feet on the foot pedal. The resident was strapped to the sit to stand lift machine and raised into a standing position, turned the lift, and sat the resident in his/her</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER TRS- EDWARDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 751 BLAKE ST. EDWARDSVILLE, KS 66111		
(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 323	<p>Continued From page 3 wheelchair.</p> <p>Interview with direct care staff Q on 2/4/16 at 9:15 A.M. stated the resident used to use the bathroom and the staff would transfer him/her into the bathroom with the sit to stand lift but he/she does not use the bathroom anymore.</p> <p>Interview with licensed nursing staff I on 2/4/16 at 11:38 A.M. stated a lift was used for transfers only.</p> <p>Interview with administrative nursing staff D on 2/4/16 at 1:45 P.M. stated the lift was not to be used for extended upright positions. The lift was used for transferring only.</p> <p>Interview with direct care staff R on 2/4/16 at 4:05 P.M. stated the lifts were used for transfers and 2 staff had to be there when a lift was used.</p> <p>The undated facility policy " Lift Program Skills Check -off Sheet, Mechanical Lifts " documented the lift assists someone from a sitting position to a standing position to accomplish pivot transfers or to help with activities such as: toileting, changing clothes, changing incontinent pads, and repositioning.</p> <p>The facility failed to ensure the staff used the sit to stand lift appropriately which lead to the resident falling from the lift after being in an upright position for an extended time.</p>	F 323			