

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

PRINTED: 01/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/10/2024
NAME OF PROVIDER OR SUPPLIER PARKWAY OPERATOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 749 BLAKE STREET 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 689 SS=G	The following citations represent the findings of complaint investigation #KS00185084, KS00184845, KS00184725, and KS00183488. The 2567 was sent electronically on 01/22/24. 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 identified a census of 39 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observations, the facility failed to ensure an adequate number of staff to provide assistance during a mechanical lift transfer to prevent accidents for Resident (R)1. As a result, R1 sustained a mid to lower coccyx (area at the base of the spine) fracture. This deficient practice also placed R1 at risk for increased pain and further impaired mobility. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnosis" tab, recorded diagnoses of restless legs syndrome, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the	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 fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) with dyskinesia (inability to execute voluntary movements), lack of coordination, reduced mobility, muscle weakness, and chronic pain syndrome. The "Admission Minimum Data Set" (MDS) dated 08/24/23 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required substantial to maximum assistance from staff with sit-to-stand activity and chair/bed to chair transfers. The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 08/24/23 documented R1 had an unsteady gait and needed assistance with ADLs. R1 worked with therapy services. The "Falls CAA" dated 08/24/23 documented R1 had an unsteady gait and required staff assistance with transfers. R1 was at increased risk for falls. The "Quarterly MDS" dated 11/24/23 documented a BIMS score of 15, which indicated intact cognition. R1 required substantial to maximum assistance from staff with sit-to-stand activity and chair/bed to chair transfers. R1's "Care Plan" initiated on 09/17/23 and revised on 10/19/23 documented R1 utilized a sit-to-stand mechanical lift to get from the chair to the commode and/or commode to chair and required a Hoyer (full body mechanical lift) lift for getting in and out of bed. R1's "Care Plan" lacked direction regarding the number of staff to assist with R1's sit-to-stand or Hoyer transfers.	F 689			

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F 689	Continued From page 2 R1's "Nursing: Lift and Transfer Evaluation" dated 09/08/23 documented R1 followed instructions, transferred with the assistance of one or two staff, and was not weight bearing. The evaluation further documented R1 used the sit-to-stand lift with one person's assistance with a medium sling. R1's "Physical Therapy: PT Discharge Summary" dated 11/15/23 documented R1 was able to transfer with the maximum assistance of two staff members with the sit-to-stand lift. The skilled interventions documented that R1 participated in techniques to improve safety with the sit-to-stand including transfer training and strengthening. The summary documented that facility staff received training. The "Nursing Change of Condition Note" dated 12/24/23 at 08:20 PM documented at 07:45 PM Certified Nurse's Aide (CNA) M called out for assistance to R1's room. R1 sat on her buttocks and reported that CNA M went "fast" with the transfer. The note documented R1 reported her legs weakened and gave out, and her hands could not hold her up any longer resulting in a fall. R1 complained of pain in her back and her upper posterior (backside) thigh. R1 requested to be checked out at the emergency room. R1's "Physical Therapy: PT Evaluation" dated 12/27/23 documented R1 was referred for therapy services related to a recent fall from the sit-to-stand lift resulting in a coccyx fracture. R1's "Physicians Progress Notes" dated 12/28/23 documented R1 was seen for a mild nondisplaced fracture of the mid to lower coccyx.	F 689			

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F 689	Continued From page 3 The "Facility Investigation" dated 01/02/24 documented R1 requested to transfer into her bed and was assisted by CNA M. CNA M utilized the sit-to-stand lift for the transfer. During the transfer, R1 fell to the ground. R1 reported she informed CNA M that she was falling, but CNA M failed to slow down. CNA M's undated "Witness Statement" documented in December 2023, CNA M used the sit-to-stand lift for R1 while she tried to put R1 into bed. CNA M further documented that due to frustration and being overwhelmed, R1 started to slide out of the sling. CNA M stated she went behind R1 and guided R1 to the floor, and called for Licensed Nurse (LN) G. LN G's undated "Witness Statement" documented on 12/24/23 LN G went to R1's room and noted R1 on the floor. R1 reported to LN G that CNA M went too fast with the transfer and R1's legs failed to support her and R1 could not hold herself up. The statement recorded R1 informed LN G that she fell. On 01/10/24 at 01:43 PM, R1 sat in her wheelchair. R1 had one leg rest on the left side of her wheelchair. R1 had hand tremors while she spoke. R1 stated when she was being transferred with the sit-to-stand lift, she started to slip. R1 said she told CNA M she was slipping but CNA M she said she was not slipping. R1 stated the next thing she knew; she fell on the floor. R1 stated CNA M said she tried to catch R1, but R1 said she fell too fast and there was no way CNA M could get around behind R1. On 01/10/24 at 12:10 PM Administrative Nurse D	F 689			

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F 689	Continued From page 4 stated when this event occurred, she looked for the manual for the sit-to-stand lift and was unable to locate it. Administrative Nurse D further stated she located a manual online, printed it off, and noted that it strongly recommended two staff members with the sit-to-stand lift. Administrative Nurse D revealed on the "Nursing: Lift and Transfer Evaluation" the only choice for the number of staff needed for the sit-to-stand lift indicated one staff member and it was not until the manual was found online that she learned it was strongly recommended for two staff members. Administrative Nurse D stated she had been educating staff to use two staff members with the sit-to-stand lift since the event. On 01/10/24 at 02:16 PM, Consultant GG stated the sit-to-stand lift was to have two staff members present to do the transfer. Consultant GG stated R1 used a sit-to-stand lift and when someone came off of therapy, staff received training regarding the therapy recommendations. Consultant GG revealed that staff would have received training instructing them two staff members should use the sit-to-stand lift for R1. On 01/10/23 at 02:23 PM Certified Medication Aide (CMA) R stated to use the sit-to-stand lift it required two staff members. CMA R revealed she always used two staff members. On 01/10/23 at 02:29 PM, LN H stated all mechanical lifts required two staff members to transfer residents. The "LF2020 Easy Lift Sit to Stand Manual" dated 2014 documented under warnings that two caregivers were strongly recommended to take part in the lifting process.	F 689			

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F 689	Continued From page 5 The facility's "Safe Lifting and Movement of Residents" policy revised on 10/09 documented staff responsible for direct resident care would be trained in the use of manual and mechanical lifting devices. The facility failed to implement safe transferring with a mechanical sit-to-stand lift for R1, which resulted in a fall. R1 sustained a mid to lower coccyx fracture. This deficient practice also placed R1 at risk for increased pain and further impaired mobility.	F 689			