

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 The following citations represent the findings of complaint investigation #KS00159749, KS00159062, KS00154276, KS00151042, and KS00150421. The 2567 was sent electronically to the facility on 2/4/21.	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 78 residents. The sample included six residents reviewed for accidents. Based on observation, record review, and interviews the facility failed to ensure one resident was free from injury when staff failed to provide the necessary services as directed by Resident (R) 1s' plan of care. R1 required physical assistance from two staff members with the Hoyer lift (total body mechanical lift used to transfer residents) to transfer R1 from one location to another safely. The Hoyer lift was used by one staff member to transfer R1 between the bed and Broda (specialized wheelchair with the ability to tilt and recline) chair. Subsequently, R1's bilateral arms were extended further than her documented contractures (abnormal permanent fixation of a joint) which resulted in a dislocated	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.

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 689	Continued From page 1 right elbow that required medical attention at an orthopedic office and further evaluation at an acute care hospital. Findings included: - R1's "Electronic Medical Record" (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and contracture of bilateral hands. The "Significant Change Minimum Data Set" (MDS) dated 09/16/2020 recorded R1 had short-term and long-term memory problems. R1's activities of daily living (ADL) documented total assistance of two staff members for bed mobility, transfers, dressing, toilet use and personal hygiene. It also documented R1 had functional limitation in range of motion (ROM) impairment on both sides upper and lower extremities. The "Quarterly MDS" dated 12/01/2020 recorded R1 had short-term and long-term memory problems. R1 required total assistance of two staff members for ADLs, but also included personal hygiene required two staff members. It documented R1 had functional limitation in ROM with impairment on both sides, upper and lower extremities. The "Care Area Assessment (CAA) for Activities of Daily Living Functional/Rehabilitation Potential" dated 09/16/2020 did not trigger. The "Care Plan" revised 01/21/2020 for ADLs	F 689			

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 689	Continued From page 2 directed staff that R1 needed help of two staff members with a Hoyer lift for all transfers and R1 was dependent on team members to dress and undress her. On an undated, unsigned "Witness Statement" Certified Nurse Aide (CNA) M documented he entered R1's room to wake R1 up. CNA M dressed R1 and attempted active range of motion to R1's upper extremities. After a few moments, CNA M continued to dress R1. CNA M transferred R1 to her wheelchair after he dressed her. CNA M then placed R1 in the dining room for breakfast. At approximately 03:45 PM, CNA M observed redness around R1's elbows and notified the nurse on duty. The "Progress Note" dated 01/25/2021 at 01:25 AM documented R1's arms were red, purple and swollen bilaterally around the elbow. It further documented small cuts were noted on the inner parts of the elbows. The "Progress Note" dated 01/25/2021 at 09:15 AM documented R1 had an appointment at the orthopedic office on 01/25/2021. The "Progress Note" dated 01/25/2021 at 02:06 PM documented the orthopedic physician recommended R1 be evaluated at the Emergency Room (ER). R1 transferred to the ER. The "Orthopedic Visit Note" dated 01/25/2021 at 02:38 PM documented R1's right upper extremity had a skin tear and weeping over the medial (the middle) aspect of the distal (away from the farthest point of origin or attachment) elbow, and severe ecchymoses (bruising) and swelling about the elbow and forearm. Palpation (a technique	F 689			

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 689	Continued From page 3 used in physical examination in which the examiner feels the texture, size, consistency and location of certain body parts with his/her hands) of the elbow caused outward signs of pain. The assessment documented R1 had sustained a traumatic right elbow dislocation which was still dislocated, and the physician documented he had concerns about potential elder abuse in this situation. In addition, it documented a single x-ray view of the right elbow showed an anterior (front) dislocation of the elbow. In a signed "Witness Statement" dated 01/24/2021 CNA N documented at 10:00 AM she observed R1 out for breakfast in the dining room. R1 arms looked stretched out. At 01:00 PM CNA N documented bruising started, so she reported the bruising to the nurse. The notarized "Witness Statement" dated 01/25/2021 by Certified Medication Aide (CMA) R documented at 02:30 PM, three unidentified staff members placed ice on R1's right arm which was swollen and discolored at the elbow, both arms were extended which was abnormal. There was swelling at the left elbow as well, but much less discoloration that the right. R1 did not appear to be in pain except for when the unidentified staff member touched her elbow to place the ice. The "Facility Investigation" report, signed and dated on 01/29/21, recorded on 08:26 AM on 01/24/21, CNA M was observed on facility video entering R1's room alone with the Hoyer lift, and also was observed bringing the Hoyer out by himself and then bringing R1 out in her Broda chair without having anyone else in the room to assist with the Hoyer transfer. CNA M was in the room for six minutes and then was observed on	F 689			

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 689	Continued From page 4 camera to step to the doorway of R1's room. At that time CNA M spoke to Licensed Nurse (LN) H. He held his elbow and moved his arm around during the conversation. LN H entered the room, and exited approximately 30 seconds later. The "Facility Investigation" report, signed and dated on 01/29/21, under the "Conclusion" section documented the following: "Based on investigation, statements gathered, video footage review, hospital and diagnostic reports and staff interviews, [CNA M] failed to follow the care plan and [facility] policy for safe mechanical lift transfers resulting in a major injury to [R1's] right arm." The "Facility Investigation" report, signed and dated on 01/29/21, recorded R1 transferred to the hospital to have her elbow reset and used an immobilizer afterwards. On 01/26/2021 at 11:25 AM Administrative Staff A stated that upon review of facility video footage, CNA M was the only staff member observed to leave R1's room when the Hoyer lift was brought out, and then again when R1 was brought out in her wheelchair. On 01/26/2021 at 11:26 AM Administrative Nurse D stated that the Hoyer lift required two staff members to operate and she did not see anyone else come out of R1's room. On 01/26/2021 at 12:12 PM Physician JJ stated that R1's injury to her right elbow was a high energy injury and was not something that would have happened without force. Physician JJ stated that he was told R1 received the injury during bathing, but the injury that he saw was not	F 689			

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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 689	Continued From page 5 consistent with that type of injury. He further stated the injury "had force behind it." On 1/26/2021 CNA M was unavailable for interview. On 01/26/2021 at 02:11 PM CNA P stated that upon hire, she received training to use the mechanical lifts and that it always required two staff members to use it. On 01/26/2021 at 02:30 PM Licensed Nurse (LN) G stated that it required two staff members to use a mechanical lift and R1 was easy to transfer with the Hoyer lift. On 01/26/2021 at 03:15 PM CNA O stated that she knew how to transfer residents by reading the care plans. The care plans told staff how to care for the residents. CNA O further stated she received training on the use of the Hoyer lift upon hire, and the mechanical lift required two staff members to use. She transferred R1 in the past and R1 required a two person assist with the Hoyer lift. The facility policy "Use of a Mechanical Lift for Resident Transfers" updated 04/19/2007 directed all mechanical transfers are to be conducted with two staff members. The facility failed to ensure was free from accidents and safety hazards when facility staff failed to transfer R1 with two staff members utilizing the Hoyer lift. This deficient practice caused actual harm to R1 when she sustained a dislocated right elbow, which required orthopedic intervention and evaluation at an acute care hospital.	F 689			

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

PRINTED: 02/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/26/2021
NAME OF PROVIDER OR SUPPLIER EVERGREEN COMMUNITY OF JOHNSON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 11875 S SUNSET DRIVE, SUITE 100 OLATHE, KS 66061		
(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