

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

PRINTED: 01/11/2023
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 12/27/2022
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	F 000			
F 689 SS=G	The following citation represents the findings of complaint investigations #KS00176673 and KS00176130. The 2567 was sent electronically on 01/11/23. 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 70 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from accidents when Certified Nurse Aide (CNA) M transferred R1 from R1's wheelchair to the bed alone though R1's plan of care directed a two-person transfer. This deficient practice resulted in R1's right leg getting trapped under the bed and she suffered a fracture that required surgical intervention. Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, fracture of shaft	F 689	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/11/2023

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 of right tibia (bone of the lower leg) subsequent encounter for closed fracture with routine healing, and history of falling. The "Significant Change Minimum Data Set (MDS)" dated 01/30/22, documented a Brief Interview for Mental Status (BIMS) score was not conducted due to R1 rarely/never understood. R1 required extensive physical assistance with one staff for bed mobility, transfers, dressing, and toileting; independent with locomotion; supervision with one staff for eating; and limited physical assistance with one staff for personal hygiene. R1 had no falls since the last assessment. The "Quarterly MDS" dated 10/19/22, documented a BIMS score of two, which indicated severe cognitive impairment. R1 required extensive physical assistance with one staff for bed mobility, dressing, and personal hygiene; extensive physical assistance with two staff for transfers and toileting; limited physical assistance with one staff for locomotion; and supervision with one staff for eating. R1 had two or more noninjury falls and one injury fall since the last assessment. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 01/28/22, lacked an analysis of findings. The "Falls CAA" dated 02/02/22, documented R1 was at risk of falling and staff assisted with all activities of daily living (ADLs) and cares as needed. The "Care Plan," last revised 09/21/21, directed R1 needed one assist with ADLs and staff	F 689			

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F 689	Continued From page 2 encouraged her to ask for assistance with ADLs. The "Care Plan" documented an intervention, initiated on 09/01/21 (resolved on 12/15/22), that R1 needed assistance with two staff for transfers with Hoyer (mechanical lift) lift if she showed increased weakness and when she felt stronger, two staff assistance. The "Care Plan" documented an intervention, initiated on 12/15/22 after the incident, that R1 required two staff assistance with Hoyer lift for transfers. The facility's "Investigation" dated 12/15/22, documented on 12/08/22 around 08:30 PM, Administrative Nurse E received a call from Administrative Nurse F that R1 was being sent to the hospital for further evaluation due to possible right leg fracture. Upon investigation, it was reported that CNA M attempted to transfer R1 and during the transfer, R1's right leg got caught under the bed. Root cause analysis of the incident indicated R1 required two persons assist for all transfers. When a one-person assist was performed, R1's leg was not properly positioned during the transfer causing her leg to break. Staff statements were reviewed, and though the statements were inconsistent, there was a failure to follow R1's care plan. The "X-ray" report on 12/08/22 documented an acute mildly displaced right distal tibia and fibular (bone of the lower leg) fractures. In a notarized "Witness Statement" on 12/09/22, CNA M stated she walked into R1's room between 07:30 PM and 08:00 PM to help her get ready for bed. CNA M propelled R1 to the bathroom but R1 was too weak to stand so CNA M went to get help from another CNA. She returned with CNA N and assisted R1 with	F 689			

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F 689	Continued From page 3 toileting and putting her pajamas on. CNA M stated she and CNA N took R1 back into R1's room by the bed and R1 was able to hold onto the bed rail while CNA M transferred her. CNA N stood beside R1 while CNA M transferred her and R1 complained of right leg pain. CNA M stated she put R1 back into the wheelchair to see what R1 was talking about. Both CNAs noticed that R1 was holding her leg, stating it hurt. CNA N went to get the nurse for assessment. Licensed Nurse (LN) G assessed R1 and told CNA M to put R1 in the bed while she called to notify someone about R1's leg. In a notarized "Witness Statement" on 12/09/22, CNA N stated she asked CNA M if she needed help and CNA M said yes. CNA N stated she entered R1's room and R1 was sitting on the toilet. CNA N put on gloves and assisted CNA M with care. Both CNAs transferred R1 from the toilet to her wheelchair without any issues. CNA M propelled R1 out of the bathroom while CNA N picked up trash from R1's bathroom. CNA N exited R1's bathroom and saw CNA M transferring R1, she noted CNA M lifted R1 and turned her inwards to the bed when her right foot got caught under the bed and twisted. CNA N stated she heard a pop and told CNA M that she thought R1's leg looked broken. CNA N left the room and told LN G that there was an incident in R1's room and it appeared R1's leg was broken. LN G stated CNA N alerted her at approximately 07:05 PM that R1 needed to be assessed for a possible broken leg. In a notarized "Witness Statement" on 12/13/22, Administrative Nurse D stated on 12/09/22 around 11:00 AM, she called the hospital for a report regarding R1's status in the emergency	F 689			

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F 689	Continued From page 4 room (ER). She spoke with the nurse taking care of R1 who stated R1's tibia was broken and R1 was to have surgery that day. In a notarized "Witness Statement" on 12/14/22, Administrative Nurse E stated on 12/08/22 around 08:30 PM, she was the on-call nurse manager when she received a call from Administrative Nurse F reporting that R1 was being sent to the hospital for further evaluation due to possible right leg fracture. She stated she directed Administrative Nurse F to find out what happened and how R1 broke her leg and obtain staff statements regarding the incident. Administrative Nurse E stated Administrative Nurse F informed her that LN G told her that CNA N was in R1's bathroom cleaning up trash and clothing while CNA M was with R1 in her bedroom. CNA N stated to LN G that she heard a pop and looked over to see CNA M transferring R1 from her wheelchair to her bed and that R1's right foot got caught under the bed and twisted. In a notarized "Witness Statement" on 12/15/22, LN G stated upon arrival to R1's room, R1 was sitting on the edge of her bed with legs in front of her. LN G immediately noticed that there was an area on the right lower leg that appeared concave with moderate swelling above the concave area, the skin was slightly discolored and warm to touch. LN G stated when she gently touched the area, R1 stated "ooh, that's sore" and she was moving her ankle and toes without the appearance of pain. During this movement, LN G witnessed what looked like two bones under the skin separating. LN G advised CNA M to stay with R1 while she made a phone call to the doctor. R1 was transported to the hospital via EMS at 08:13 PM. LN G stated she asked CNA N what	F 689			

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F 689	Continued From page 5 happened, and CNA N told her she was in R1's bathroom picking up trash and clothing while CNA M was with R1 in her bedroom. CNA N stated she heard a "pop" and looked over to see CNA M transferring R1 from her wheelchair to her bed. CNA N told LN G that R1's foot got caught under her bed and twisted. On 12/27/22 at 02:21 PM, R1 laid in bed with her eyes closed, there was a pillow under her right side, and she appeared comfortable. On 12/27/22 at 02:30 PM, CNA O stated she knew how to transfer a resident by looking at their care plan that she carried with her. She stated if a resident required two staff for transfers, they always had two staff for transfers. On 12/27/22 at 02:49 PM, LN H stated staff knew how to transfer a resident by looking at the care plan and staff always carried the care plan on them. She stated staff were always expected to have two staff for transfers if the resident required two staff for transfers. On 12/27/22 at 03:00 PM, Administrative Nurse D stated staff knew how to transfer a resident by looking at the care plans which they were expected to always carry on them. She expected staff to always have two staff for transfers if the resident required two staff for transfers. She stated she did immediate education to staff that were present and working on 12/09/22 and most of the staff had been educated on following care plans and transfers by the end of the investigation on 12/15/22 with education ongoing for any staff new to the building. The facility's "Fall and Accident Prevention and	F 689			

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F 689	Continued From page 6 Management" policy, last revised 2022, directed each resident was provided services and care that ensured the resident's environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. The facility's "non-mechanical lift transfers" policy, last revised 2022, directed staff followed individualized comprehensive care plan related to type of transfer and staff followed care plan instructions for number of assistants required. The facility failed to ensure R1 remained free from accidents when CNA M transferred R1 from her wheelchair to her bed by herself for a two-person transfer. This deficient practice resulted in R1's right leg getting trapped under the bed and she suffered a fracture that required surgical intervention. The facility completed the following corrective measures: On 12/09/22, CNA M was terminated from the facility. On 12/09/22, staff working the day of the incident were educated on following care plans and transfers. Between 12/10/22 to 12/15/22 all facility staff were educated on following care plans and transfers. On 12/15/22 R1's care plan was updated to reflect that R1 required a two-person Hoyer lift with transfers. This deficient practice was cited as past non-compliance.	F 689			