

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

PRINTED: 08/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2023
NAME OF PROVIDER OR SUPPLIER ADVENTHEALTH CARE CENTER OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 75TH STREET OVERLAND PARK, KS 66204		
(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=D	The following citations are the result of complaint investigation KS00181942. The 2567 was sent electronically on 08/21/23. 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: DEFICIENCY TEMPLATE F 600 The facility identified a census of seventy-six residents. The sample included six residents. Based on record review, observation, and interview the facility failed to ensure Resident (R)1 was free from avoidable accidents when a staff member performed an unsafe transfer of R1. This resulted in a skin tear which placed R1 at increased risk for pain, infection or other complications. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of rheumatoid arthritis, (a long-term autoimmune disorder resulting in warm, swollen, and painful joints; Pain and stiffness often worse following rest); chronic pain syndrome, (persistent or	F 689			

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

TITLE

(X6) DATE

08/21/2023

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 intermittent pain that last for more than three months); chronic kidney disease, (damaged kidneys resulting in an inability to filter blood the way they should); and cardiomegaly (an enlarged heart, caused by damage to the heart muscle, a condition that makes the heart pump harder than usual). The "Medicare 5- day Minimum Data Set" (MDS) dated 07/02/23 documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated R1's cognition was intact. The MDS recorded R1 had limitations in range of motion, (ROM) with her upper and lower extremities. R1 required total assistance of two staff members with most activities of daily living (ADL) such as transfers from the bed to wheelchair, toileting, dressing, personal hygiene, and bed mobility. The admission "Cognitive Care Area Assessment" (CAA) dated 05/19/23 documented R1 admitted to the facility for rehabilitation. R1 had deformities of both hands and wrists and required assistance with balance activities including but not limited to transfers. The 05/15/23 "Care Plan" directed all staff to use a gait belt and two staff for all transfers including transfers for bathing, toilet use, and transfers, to the wheelchair and to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. A "Nurses Note," dated 07/28/23 at 03:10 P.M. documented: Licensed Nurse (LN) K was called to R1's room to observe a skin tear that was obtained during a transfer.	F 689			

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F 689	Continued From page 2 A "Nurses Note," dated 07/28/23 at 05:30 P.M. documented: a staff member reported to the charge nurse that Certified Nursing Assistant (CNA) N transferred R1 from the bed to the wheelchair which resulted in a skin tear. The area was cleansed with wound cleanser and covered with a sterile dressing. The EMR weekly wound observation tool date 07/28/23 documented R1 obtained a 7.5 centimeter(cm) long by 2.5 cm wide skin tear to her left outer leg, On 08/07/23 at 02:49 P.M. observation revealed R1 sat upright in a wheelchair and worked with exercise bands with a staff member. R1 had an approximately three inch by seven-inch rectangular bandage to her left outer calf. Interviewed on 08/07/23 at 02:49 P.M. R1 explained a staff member attempted to transfer her to bed (from the wheelchair) without the assistance of a second staff member. R1 said she thought her leg might have bumped something or twisted when the staff member transferred her without the a second staff member and caused a skin tear. R1 noted the staff member wore gloves and stated that may be what caused the tear. On 08/07/23 CNA N was not available for interview Interviewed on 08/07/23 at 02:40 P.M. LN G stated she was not present when R1 obtained the skin tear, but the understanding was a new nursing assistant attempted to transfer the resident without assistance. LN G stated she	F 689			

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F 689	Continued From page 3 changed the resident's dressing that morning, and the wound was approximated with steri strips (adhesive wound closures). Interviewed on 08/07/23 at 03:30 P.M. Administrative Nurse E acknowledged R1 got a skin tear when a newly certified nursing assistant (CNA N) tried to lift the resident without another staff member. Administrative Nurse E stated the CNA did not pay attention to the signs posted that informed staff R1 required two staff for transfer. Interviewed on 08/07/23 at 03:49 P.M. Administrative Staff A stated a write up was performed for the CNA who caused the skin tear, and it was easily determined that the action occurred because the CNA did not seek two persons assistance and the CNA did receive education. The facility's "Accidents" policy documented: the resident's environment would remain as free from accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. The facility failed to ensure R1 was free from avoidable accidents when a staff member performed an unsafe transfer which resulted in a skin tear. This deficient practice placed R1 at increased risk for pain, infection or other complications.	F 689			