

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

PRINTED: 10/05/2023
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 10/03/2023
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 citations represent the findings of complaint investigation #KS00183035. The 2567 was sent electronically on 10/05/23. 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 78 residents. The sample included three residents reviewed for falls. Based on observations, record review, and interviews, the facility failed to ensure staff followed Resident (R) 1's care planned interventions to prevent falls. As a result of this deficient practice, R1 fell and sustained fractures of the right superior (upper) and inferior (lower) pubic rami (two sections of bone that branch off the pubic body). Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) moderate without behavioral disturbance, dizziness and giddiness, fracture of left pubis (pair of bones forming two sides of the pelvis)	F 689	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

10/05/2023

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.

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

PRINTED: 10/05/2023
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 10/03/2023
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 subsequent encounter for fracture with routine healing, orthostatic hypotension (blood pressure dropping with change of position), need for assistance with personal care, lack of coordination, and unsteadiness on feet. The "Admission Minimum Data Set (MDS)" dated 03/24/23 documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R1 required supervision with one staff for bed mobility; limited assistance with one staff for transfers, walking, locomotion, toileting, and personal hygiene; and extensive assistance with one staff for dressing. R1 had one noninjury fall since admission. The "Quarterly MDS" dated 09/14/23, documented R1 had a BIMS score of one which indicated severe cognitive impairment. R1 required extensive assistance with two staff for bed mobility, transfers, walking, dressing, and toileting; limited assistance with one staff for personal hygiene; and extensive assistance with one staff for locomotion. R1 had two or more noninjury falls since last assessment. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 03/24/23, documented the team reported some days R1 was more confused than others and she scored a three on her BIMS assessment. The "Falls CAA" dated 03/27/23, documented R1 had poor cognition, weakness, history of falls, and a recent fall. R1 was at risk for falls and staff assisted with all activities of daily living (ADLs) and cares as needed.	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 R1's "Falls Care Plan," initiated 03/27/23, documented R1 had diagnoses of dementia, weakness, dizziness, giddiness, and a history of falling which placed her at risk for falls. R1 had experienced multiple falls at home and had poor safety awareness and at times. She initiated transfers and mobility independently. The "Care Plan" documented an intervention, dated 05/30/23, which directed staff to encourage R1 to rise slowly from a seated position and to stand in place for a minute before walking. R1's "ADLs Care Plan," initiated 04/03/23, documented R1 needed help with her ADLs. The "Care Plan" documented an intervention, dated 04/22/23, which included R1 used a gait belt with contact guard assist of one staff for transfers and mobility; R1 used a two-wheeled walker for short distance ambulation; staff were to follow with her wheelchair for longer distances. The plan directed if staff to provide assistance if they observed R1 self-transferring or walking by herself. The facility's "Investigation" dated 09/29/23, documented on 09/22/23 at approximately 09:45 AM, Certified Nurse Aide (CNA) M assisted R1 to stand from R1's bed using a gait belt and walker. R1 took a few steps toward the bathroom and communicated to CNA M she did not think she could stand much longer. CNA M wrote in her statement the wheelchair was across the room; she let go of R1 and ran to grab the wheelchair. She stated she almost made it behind R1 when R1 toppled to the right with her walker in hand and yelled "ow" when she hit the floor. The staff notified Emergency Medical Services (EMS), who then transported R1 to the hospital, where the hospital obtained a computed tomography (CT scan- test that used x-ray technology to make	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 multiple cross-sectional views of organs, bone, soft tissue and blood vessels) scan of R1's pelvis. The scan revealed nondisplaced (remained aligned) fractures (broken bone) of the right superior and inferior pubic rami (pelvic bone). R1 returned to the facility in the evening hours of 09/22/23. In a "Witness Statement" on 09/22/23, CNA M stated on 09/22/23 at 09:30 AM, she asked the other CNAs what she needed to do next, and they gave her a list of people who needed help. She stated she chose R1 because R1 was a one-person assist. When she went to R1's room, R1 was still in bed, in her nightgown. CNA M and R1 talked about what she wanted to wear for the day and R1 chose a flannel t-shirt, pants, and socks. CNA M put on R1's socks, shoes, and gait belt then set her walker in front of her. CNA M stated she encouraged R1 to stand up on the count of three and they tried three times before she felt R1 could walk. CNA M stated once R1 was up, she took a few steps toward the bathroom and her right leg seemed to have been having trouble. R1 told CNA M she did not think she could stand much longer. CNA M stated the wheelchair was across the room, so she was hesitant to let go of R1, but she did, and ran across R1's room to grab the wheelchair. She stated she almost made it behind R1 when she toppled to her right with the walker in hand, yelling "ow" when she hit the floor. CNA M stated R1 hit her head/shoulder on the closet door and laundry basket on the way down. She moved the walker because R1 was wrapped up in it then went to the hall and yelled for the nurse. She stated the nurse and Certified Medication Aide (CMA) arrived to R1's room and asked CNA M and R1 questions and called EMS for possible injury to the head	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 and neck. In a "Witness Statement" dated 09/29/23, Licensed Nurse (LN) G stated on 09/22/23 at around 09:45 AM, CNA M yelled for her. She stated she went into R1's room and saw R1's legs first. R1 laid on the floor directly in front of her closet, with her head on the inside of the closet. There was a basket on the floor in her closet and her neck/head were on that basket. LN G stated R1 laid on her right side and when asked if she hit her head, R1 stated yes, she thought she did. LN G asked R1 if she had any pain and R1 stated yes, her neck. LN G stated she told R1 not to move and she obtained R1's vital signs. After obtaining R1's vital signs, R1 stated she felt like she was going to throw up. LN G sent the CNA to call for EMS and tell them R1 possibly hit her head and had neck pain. The "Miscellaneous" tab of R1's EMR revealed a "CT Pelvis without contrast" on 09/22/23 that documented R1 had a nondisplaced fracture involving the right inferior ramus and a nondisplaced fracture of the right superior pubic ramus. On 10/03/23 at 12:45 PM, R1 sat in her recliner in her room and watched television. On 10/03/23 at 12:35 PM, CNA M stated on 09/22/23, R1 started taking a few slow steps while CNA M held onto her, then R1 stated she did not think she could stand up anymore. CNA M stated she asked R1 if she could stand for a just a moment while she got her wheelchair which she stated she could. CNA M said she was hesitant to let go of the gait belt but went to get the wheelchair on the other side of her room when	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 R1's right leg gave out. She stated she did notice her right leg was having trouble while R1 was walking. CNA M stated she almost made it behind her with the wheelchair when R1 fell. She stated she did not know there was an option of an assisted fall, but she did know that now. CNA M stated R1's walker was wrapped around her. CNA M moved it off of R1, then immediately went to the door to yell for the nurse. The nurse and CMA came by and asked both her and R1 questions. They called EMS because R1 was hurting, and EMS got her onto a stretcher then took her to the hospital. CNA M stated she had access to the care plans and usually had a care plan that they carried around with them. She stated, at the time, R1 was a one-person assist with gait belt, and she did not know about the orthostatic changes intervention. She stated she knew now that she could have lowered R1 to the ground slowly and prevented injury and if R1 got back to her previous level of function, she would have R1 stand for a second before walking. On 10/03/23 at 01:02 PM, LN H stated nursing staff had access to the care plans and knew how to care for residents by following the care plan. She stated falls were prevented depending on each resident's fall interventions. LN H stated CNA M should have held onto R1's gait belt and called for help. She stated if R1 was starting to fall, CNA M could have helped lower her down. On 10/03/23 at 01:14 PM, Administrative Nurse D stated on 09/22/23, CNA M was getting R1 up and it took some time for R1 to get up. She stated R1 was close to the bathroom and closet when she told CNA M she needed to sit down and could not walk anymore. R1's wheelchair was across the room and CNA M went to get the wheelchair	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 6 when R1 fell. Administrative Nurse D stated CNA M said it was her first-time hearing about assisted falls and the whole community was educated on assisted falls after the incident. She stated CNA M had access to R1's care plan at the time of the incident which had fall interventions on it. On 10/03/23 at 01:17 PM, Administrative Nurse E stated CNA M had never heard of assisted falls and she was educated that if in a situation like that again, CNA M could hold onto the resident and see if they could walk toward the wheelchair. She stated CNA M had access to the care plan at that time and she was educated on the care plan and the orthostatic interventions. Administrative Nurse E stated R1 did not have hypotension but experienced tachycardia (fast heart rate) when she changed positions and there was an intervention in place for R1 to sit on the edge of the bed, stand at the bedside, and allow her time before walking to regulate herself. She stated the CNAs carried the care plan and were expected to know the care plan to care for the residents. The facility's "Fall Prevention and Management" policy, last updated 09/24/23, directed every team member was responsible for checking the care plan of residents who were at risk for falls when beginning each day and throughout the assigned shift. The "Care Plan Competency Policy," not dated, directed it was the responsibility of every staff member to read, understand, and follow the comprehensive and the certified care partner care plans prior to providing direct care to a resident and to report any changes, not matter how slight or significant to the Interdisciplinary Team for immediate care plan revision if	F 689			

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

PRINTED: 10/05/2023
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 10/03/2023
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 7 indicated. If any staff member failed to adhere to the plan of care, it resulted in disciplinary action. The facility failed to ensure staff followed R1's care plan interventions to prevent falls. This deficient practice resulted in a fall with major injury for R1. The facility completed the following corrections by 09/29/23 CNA M was suspending pending investigation on 09/22/23. Education on falls was completed with community staff from 09/26/23 to 09/29/23. R1's care plan was updated on 09/27/23 with current transfer status. CNA M was educated on falls, orthostatic hypotension, and care plan competency on 09/29/23. Due to the facility corrective actions implemented prior to the start of survey, the deficient practice was cited at past-noncompliance. The scope and severity remained at a "G."	F 689			