

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

PRINTED: 12/08/2023
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 11/29/2023
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 The following citations represent the findings of complaint investigations #KS00184316, KS00184311, KS00184312, KS00184339, KS00184368, and KS00184245.	F 000			
F 689 SS=G	The 2567 was sent electronically on 12/08/23. 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 79 residents. The sample included three residents with two reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure Resident can 1 remained free from accidents when Certified Nurse Aide can (CNA) M propelled R1 down the hallway in her wheelchair, without a foot pedal for her right leg/foot. This caused R1's foot to get stuck under the wheelchair and resulted in a fracture (broken bone) to her right leg. The facility further failed to prevent accidents for R2 when CNA N failed to utilize two people with a Hoyer lift (total body mechanical lift) transfer which resulted in R2 slipping out of the lift sling and landing on the floor. This deficient practice placed R2 at risk for injuries and physical complications.	F 689			

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

TITLE

(X6) DATE

12/08/2023

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 Findings included: - The "Diagnoses" of R1's Electronic Medical Record (EMR) documented diagnoses of acquired absence of left leg above knee, other abnormalities of gait (manner or style of walk) and mobility, and generalized muscle weakness. The "Annual Minimum Data Set (MDS)" dated 05/02/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required extensive assistance with two staff for bed mobility, dressing, and toileting; supervision with setup help only for personal hygiene; and total dependence with two staff for transfers and locomotion. R1 had impairment on both sides for upper and lower extremities and used a wheelchair. The "Quarterly MDS" dated 09/30/23, documented R1 had a BIMS score of 15, which indicated intact cognition. R1 required extensive assistance with two staff for bed mobility, dressing, toileting, and personal hygiene; she required total dependence with one staff for locomotion on the unit, and locomotion off of the unit only occurred once or twice with one staff assistance. R1 was totally dependent on two staff for transfers. R1 had impairment on both sides for upper and lower extremities and used a wheelchair. The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential CAA [CAA]" dated 05/16/23, documented R1 needed extensive assistance of two staff for bed mobility and dressing; supervision with personal hygiene; and dependence with two staff for transfers,	F 689			

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F 689	Continued From page 2 toileting, and bathing. R1 had impairment to both legs and used a wheelchair. R1's "Care Plan" dated 05/14/22 and revised 08/02/23, documented R1 needed extensive assistance of two staff for bed mobility, dressing, and personal hygiene. She was dependent on two staff for transfers, toileting, and bathing and required setup help and assistance as needed for meals. R1 had impairment to both legs and used a wheelchair. The "Care Plan" documented an intervention, initiated 05/14/22 and revised on 08/02/23, that directed R1 had right sided weakness, above the knee amputation of her left leg, and partial amputation of her right foot. The "Care Plan" documented an intervention initiated 05/14/22 that directed R1 was dependent on one staff for wheelchair use as she did not walk. An "X-ray Report" dated 11/25/23 for R1's right knee, performed in the hospital, revealed R1 had an area that was highly suspicious for a nondisplaced fracture of the proximal (nearer to a point of reference or attachment) tibia (one of two lower leg bones) and a computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) scan was suggested for further evaluation. The "CT Scan Report" for R1's right lower extremity dated 11/25/23, performed in the hospital, revealed R1 had a subtle, acute, nondisplaced transverse (perpendicular to the bone) fracture of the proximal tibia and subtle, acute, nondisplaced transverse fracture of the fibula (other bone in the lower leg). In a notarized "Witness Statement" on 11/27/23,	F 689			

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F 689	Continued From page 3 CNA M stated on 11/25/23 around 07:45 AM, she just finished getting R1 dressed and into her wheelchair then went to check on another resident. When she came back, she offered to push R1 down to the small dining room for breakfast and asked R1 if she was ready to go. R1 asked for her purse and mask and when asked by CNA M again if she was ready to go. R1 stated yes, she was ready. CNA M stated they went down the hall and R1 picked up her foot on the way to the small dining area. She stated they were not even five feet into the dining room when R1 dropped her foot and screamed "ow." CNA M stated she immediately stopped and asked R1 what was wrong to which R1 replied her ankle hurt and she thought she heard it crack. R1 stated she thought she needed an x-ray. CNA M stated she asked R1 if she needed her footrest and R1 stated yes. She stated she got R1's footrest and put it onto her wheelchair. While CNA M put it in place, R1 said "ow, it hurts." CNA M stated she asked R1 if she was going to be okay and R1 repeated that she needed an x-ray. CNA M stated she told R1 she would put her in her normal spot at the table and tell the nurse what happened. CNA M stated the nurse proceeded to order the x-ray while R1 ate breakfast and around 09:30 AM, she asked to be taken back to her room. She stated she took R1 down the hall when R1 complained of pain; they asked the nurse when the x-ray would be done. The nurse stated whenever the x-ray people got there as there was no time frame. CNA M stated R1 said she needed to go to the hospital as she could not wait that long. CNA M noted she took R1 back to her room until transportation picked her up to take her to the hospital. On 11/29/23 at 12:53 PM, R1 sat in her	F 689			

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F 689	Continued From page 4 wheelchair in her room with the right-side foot pedal in place and a knee/leg immobilizer on her right leg. She stated on 11/25/23 when her and CNA M came out of her room for breakfast, CNA M pushed her wheelchair but did not put her foot pedal on. R1 stated CNA M was pushing her down the hallway fast and she tried to keep her right leg up. When CNA M stopped to talk to a man in the dining room, R1's foot went to the floor because she was tired of holding it up. R1 stated she did not think CNA M was going to take off as fast as she did. When she pushed her to her table, R1's foot was dragging under the wheelchair, and she told CNA M to stop. R1 stated at that point, her right leg hurt bad, and she had heard it pop. On 11/29/23 at 02:03 PM, CNA M stated on 11/25/23, she got R1 dressed and in the wheelchair and put the pedal in place that R1 used for her short leg. She said she asked R1 if she needed anything else before going to the dining room and R1 wanted her purse and mask. CNA M asked her once more if she was ready to go and R1 said she was, and CNA M told her to pick her right foot up. CNA M stated she propelled R1 in her wheelchair down the hall and turned into the small dining room, but as they were walking in, she told another resident she might want to move. She stated as she was propelling R1, R1 yelled "ow, ow it popped" and CNA M stopped after R1 said ow and asked her if she wanted her footrest. CNA M stated R1 stated her right leg really hurt. She stated she told R1 she would put R1 in her spot then tell the nurse and R1 stated she wanted an x-ray. CNA M stated the nurse ordered the x-ray after breakfast, but R1 did not want to wait that long for the x-ray and wanted to go to the hospital. CNA M stated a	F 689			

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F 689	Continued From page 5 couple of weeks prior, R1 had told her she did not like the right foot pedal because it made it hard to get close to the table when she ate in the small dining room. CNA M stated she was able to hold her foot up but at some point, she did end up dropping her leg and that was when she got the fracture. She stated she was educated that if staff pushed a resident in their wheelchair, they needed foot pedals regardless of the residents' wishes as it was "safety first." On 11/29/23 at 02:17 PM, Licensed Nurse (LN) H stated staff kept residents safe during wheelchair propulsion by always using foot pedals, making sure nothing was dragging from the wheelchair, and watching their speed. On 11/29/23 at 02:28 PM, Administrative Nurse D stated on 11/25/23, the charge nurse called and reported that R1 hurt her foot while staff were pushing her in the wheelchair. She stated R1 did not want to wait for an x-ray and wanted to go to the hospital, so she was sent out. Administrative Nurse D stated CNA M said she did not use a foot pedal because R1 had requested she did not use it a couple of weeks ago. She stated she expected residents to have foot pedals on their wheelchairs during propulsion for safety if they were unable to hold their feet up. On 11/29/23 at 02:47 PM, Administrative Staff A stated he expected if staff were pushing a wheelchair, they used foot pedals to keep the resident safe. The facility's "Accidents" policy, dated 04/01/23, directed the facility ensured each resident received adequate supervision and assistive devices to prevent accidents.	F 689			

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F 689	Continued From page 6 The facility failed to ensure R1 remained free from accidents when can M propelled R1 down the hallway in her wheelchair, without a foot pedal for her right leg/foot. This caused R1's foot to get stuck under the wheelchair and resulted in a fracture to her right leg. - The "Diagnoses" tab of R2's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (cerebrovascular accident [CVA] or stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting right dominant side. The "Annual Minimum Data Set (MDS)" dated 01/04/23, documented R2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R2 required extensive assistance with two staff for bed mobility and personal hygiene; total dependence with one staff for transfers, locomotion, dressing, and toileting, and was independent with setup help only for eating. The "Quarterly MDS" dated 11/06/23, documented R2 had a BIMS score of 14, which indicated intact cognition. R2 was dependent with chair/bed-to-chair transfers and toilet transfers. The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment [CAA]" dated 01/18/23, documented R2 had a CVA with residual dysphasia	F 689			

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F 689	Continued From page 7 (impairment in the production of speech) and right-sided deficits. R2's "Care Plan" dated 01/12/21 and revised on 07/24/23, documented R2 had limited range of motion in his right side due to stroke and he had hemiplegia. The "Care Plan" documented an intervention initiated 01/13/21 that directed R2 was dependent with assistance of two to three staff to turn in bed and transferred using a Hoyer lift. R2's EMR revealed a "Nurses Note" on 11/28/23 at 07:56 PM that documented CNA N yelled into the hallway she needed help now, R2 was on the floor. Licensed Nurse (LN) G and CNA O ran to R2's room and observed him laying over the legs of the Hoyer lift with sling still attached above him. R2 was left in the position he was observed in while LN G instructed CNA O to stay with R2 while she called emergency medical services (EMS). Per EMS instruction, staff were to leave R2 in the same position until they arrived. EMS arrived, assessed R2, and took him to the hospital. R2's EMR revealed a "Nurses Note" on 11/29/23 at 05:32 AM that documented R2 was admitted to the hospital for observation after the fall and was negative for fractures. In a notarized "Witness Statement" on 11/28/23, CNA N stated on 11/28/23, she was assisting R2 with a Hoyer lift transfer by herself to bed when she noticed the lift sling was up too far and not under his bottom far enough. She stated she pulled the lift sling down the best she could then proceeded to lift R2 into the air and pushed the lift and R2 over to the bed. CNA N stated once she	F 689			

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F 689	Continued From page 8 got to the side of R2's bed, he started sliding out of the sling. She stated she tried to catch him but could not because she transferred him by herself for which she knew better. CNA N stated he never hit his head and did not yell like he was in pain. She stated she told R2 to give her a second because she needed help and she yelled for help in the hallway. CNA N stated the nurse, and another CNA came to R2's room to see what she was talking about. In a notarized "Witness Statement" on 11/28/23, LN G stated on 11/28/23, CNA N yelled into the hallway that she needed help now, R2 was on the floor. LN G stated she and CNA O ran to R2's room and observed him laying over the legs of the Hoyer lift with sling still attached above him. CNA N stated to the paramedics that she had moved R2 by herself and described how he slid out of the sling. On 11/29/23 at 02:03 PM, CNA M stated residents were kept safe during Hoyer lift transfers by using two people at all times, going slow and easy, and always making sure the resident was okay. She stated two people were used for Hoyer lift transfers because one staff used the machine while the other staff made sure the resident was positioned properly. On 11/29/23 02:17 PM, LN H stated staff kept residents safe during Hoyer transfers by communicating which straps on the sling were latched onto the lift, making sure the resident was positioned well before hooking them up, and always using two staff. She stated one staff stood in front of the resident and one behind the resident to watch their feet when lifting up and watching for pain.	F 689			

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F 689	Continued From page 9 On 11/29/23 at 02:28 PM, Administrative Nurse D stated on 11/28/23, CNA N went into R2's room and he said he wanted to go to bed. She stated CNA N transferred R2 by herself and stated that she knew better, and the sling was up too high on his body. Administrative Nurse D stated she asked CNA N why she did not ask for help and CNA N stated she had no idea and that she knew better. Administrative Nurse D stated she expected staff to have two people at all times for Hoyer lift transfers, no exceptions. On 11/29/23 at 02:47 PM, Administrative Staff A stated he expected staff to always have two staff members present during Hoyer lift transfers. He stated two staff were used to make sure that the resident was safe, positioned correctly, and was kept steady while one staff controlled the lift and the other controlled the resident. The facility's "Lifting Machine, Using a Mechanical" policy, last revised July 2017, directed at least two nursing assistants were needed to safely move a resident with a mechanical lift. The facility failed to prevent accidents for R2 when CNA N failed to utilize two people with a Hoyer lift transfer which resulted in R2 falling out of the lift sling and landing on the floor. This deficient practice placed R2 at risk for injuries and physical complications.	F 689			