

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1115 North Wenthe Effingham, IL 62401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview, and record review the facility failed to place resident's call lights within reach for 3 of 11 residents (R2, R9, and R10) reviewed for call lights in a sample of 11. Findings include: 1. R2 Face Sheet documents an admitted [DATE] and a discharge date of [DATE] with diagnoses including: aftercare following joint replacement surgery, presence of unspecified artificial hip joint, anxiety disorder, peripheral vascular disease, and pain. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12, indicating R2 has moderate cognitive impairment. R2's Care Plan documents: problem with a start date of 02/13/25: category: falls; (R2) is at risk for falls due to: recent hip surgery with an approach listed as: provide individualized toileting interventions based on needs/patterns dated 02/13/25. R2's Care Plan also documents a problem with a start date of 02/13/25 of (R2) is at risk for alteration in tissue perfusion due to: Dx (diagnosis) Hypertension with an approach listed of: call light within reach while in room and remind resident to call for assistance as needed dated 02/13/25. R2's Progress Note dated 02/13/25 at 7:53 AM documents in part: 5 day review complete. interview completed with (R2). (R2) is alert with adequate communication skills and is able to make needs known. R2 has some short/long term memory deficit with BIMS score of 12. (R2) is up daily with assist per staff with ADL's (Activities of Daily Living) Orientation: oriented, generally normal to person, place and time, Memory: intact (recent and past), thinking: clear and organized, speech clarity: clear speech ability to understand others: understands, current bowel continence level: always continent, current urinary continence level: always continent. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145628	Facility ID: 145628 If continuation sheet Page 1 of 8

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Progress Not dated 02/15/25 at 12:41 PM documents in part: (V3-Dietary Manager/Certified Nursing Assistant/CNA), was picking up lunch trays and resident needed to use the BR (bathroom), so she took her to the BR. (V3) states that she was telling her she didn't have her call light available last night and (V3) reported it to (V4-Licensed Practical Nurse/LPN). (V4) and (V3) went to speak with (R2) and (V10- family) who was in the room. (R2) states that at 2:00 AM she didn't have her call light and thought that they left it in recliner when putting her to bed. Stated that she needed to use the BR, but didn't know what to do. (R2) states that she called (V10). (V10) confirmed that (R2) called at 3:16 AM. (V10) stated that he tried to call the facility but no one answered, so he went back to bed. (R2) states that she could hear staff next door with resident. (R2) was asked did she yell out for help, or do anything to try and get help. (R2) stated no, she didn't want any one to think she was a bother by yelling out. (V4) and (V3) advised (R2) and (V10) to next time yell out or hit the wall or something if unable to find call light. (V4) and (V3) also programmed (facility) telephone number in her phone, so she had another option to also call the facility as well. (V10) also gave her a long stick thing to also be able to hit the wall with in case of happening again. (R2) states that she just needed to use the BR and was worried about getting a bed some for not getting up. (R2) transfers x1 assist and able to ambulate using w/w (wheeled walker) with stand by assistance. (R2) stated since her recent right hip surgery that she was worried to be ambulating by herself. (V4) stated that she would speak to staff as well in regards to issue at 2:00 AM. (V1-Administrator) made aware as well. The facility document titled, Grievance/Concern/Complaint Form with a date received of 02/15/25 and a date filed in log of 02/18/25 documents: R2 initiated and person reported to was V3. Resident (R2) states that she didn't have her call light within reach. States she didn't know where it was. States she didn't yell out for help or do anything. States she called her son at 3:16 AM. The area titled, Summary/findings documents: call light had fallen and was on the floor by the bed when staff entered room. The area titled, recommendation/action taken: documents: Secure call light on bed rail when in bed. Clips ordered. (Facility name) telephone entered into her cell phone. Educated on banging wall for help and yelling for help. On 02/21/25 at 1:25 PM, R2 was interviewed via telephone call and stated she woke up sometime around or just after 2:00 AM and needed to use the bathroom but did not have her call light. R2 said she did hear someone in a room close to hers and she yelled out to them but no one came. R2 said that just after 3:00 AM she called her son because she did not know what to do and she really needed to use the bathroom and her bed was up high and she was afraid to try to get up on her own because of her hip surgery. R2 said that the staff finally came in around 6:00 AM and changed her brief that was wet but did not even clean her off, just put a dry one on. R2 stated her call light was over in her recliner that she was sitting in before she went to bed. R2 stated she was wet by 3:15 AM because she could not wait and she does not remember anyone coming in and checking on her until 6:00 AM when she was still wet and they were getting her up for breakfast. On 02/21/25 at 1:22 PM, V10 stated R2 called him at 3:18 AM. V10 said he called the facility after that and no one answered the phone. He then came to the facility at 12:30 PM and R2 was wet again. V10 said he talked to the staff about R2 not having her call light the night before and she was told to hit the wall, yell out, and they put the facility number in her phone to call them. V10 stated R2 told him she did yell out and he tried to call the facility and no one answered. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to position residents properly to prevent injury for 1 of 3 residents (R1) reviewed for accidents in a sample of 11. This injury resulted in R1 sustaining a closed displaced fracture of right femoral neck. This past non-compliance occurred between 01/19/25 and 01/23/25. Findings include: R1's face sheet documents an admitted [DATE] with diagnoses including: fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, Alzheimer's disease, osteoarthritis, iron deficiency, shortness of breath, nutritional deficiency, anxiety disorder, insomnia, muscle weakness, rheumatoid arthritis, pain, unsteadiness on feet, age related osteoporosis without current pathological fracture, mid cognitive impairment of uncertain or unknown etiology, vitamin D deficiency, displaced intertrochanteric fracture of left femur, presence of right artificial hip joint, nausea with vomiting, major depressive disorder. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 02, indicating R1 has severe cognitive impairment. R1 is documented as being dependent for being able to wheel 50 feet with two turns in a manual wheelchair and dependent for being able to wheel 150 feet in a manual wheelchair. R1's care plan documents a problem of pain with a start date of 07/30/24 with an approach of: handle gently and try to eliminate any environmental stimuli with a start date of 07/30/24. R1's care plan documents a problem category of: ADLs (Activities of Daily Living) functional status/rehabilitation potential with a problem start date of 06/06/24 with an approach listed as: overall I (R1) require extensive assistance with oral care, extensive with bathing, extensive with grooming, limited with eating, extensive with dressing, extensive with mobility with a start date of 06/11/24 and an approach listed as: safety: I (R1) will need to be monitored to prevent falling in my new environment. I will need assistance with bed/chair mobility, assistance with transfers, assistance with locomotion to prevent falling or injury with a start date of 06/11/24. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Serious Injury Incident Report to the Illinois Department of Public Health (IDPH) dated 01/27/25 and is documented as a final report. This report documents an incident date of 1/20/25 and documents under the section titled, detailed incident summary that facility ordered an x-ray on 01-20-25 due to resident grimacing in pain and having issues standing and rolling in bed. X-ray showed an acute subcapital right femoral neck fracture. DON (Director of Nursing) notified, family POA (Power of Attorney) of x-ray results and they wanted her sent to the hospital. Resident (R1) has an extensive history of Alzheimer's disease, osteoarthritis, nutritional deficiency, muscle weakness, rheumatoid arthritis, age related osteoporosis, mild cognitive impairment, vitamin D deficiency, past MVA (motor vehicle accident) where her right side was crushed and had screws in femoral plate. Resident was sent to the hospital and admitted . Resident's last fall was 01/07/25 with no complaints or pain noted. Following facility investigation while facility attempted to weigh resident her position in the wheelchair resulting in residents leg making contact with the bar on the scale resulting in impact to the right leg/foot area. Upon immediate assessment of resident she denied any pain or discomfort, following assessment noted grimacing from resident resulting in facility initiated x-ray. Due to resident's age, medical history, ortho notes of previous ORIF (Open Reduction Internal Fixation) of hip along with the accident all being contributing factors resulting in fracture. Facility has began reeducation and training on nurse on body alignment and positioning and have scheduled additional training. Facility will continue to monitor for any additional changes and needs and address any concerns. The facility investigation documents were requested from the facility and provided for review. These documents included Incident Investigation Reports documenting interviews with V5 (Licensed Practical Nurse/LPN) and V6 (Certified Nursing Assistant/CNA) and document the following: V5's statement dated 01/21/25 documents on Sunday 01/20/25 (per calendar Sunday's date was 1/19/25) I got reweight [sic] on the scale when pushing her on the scale she had her legs crossed and right foot hit the bar. Resident (R1) said 'ouch' wheelchair backed up and repositioned. Upon assessment ankle and foot evaluated and no abnormalities noted. V6's statement dated 01/21/25 documents over the weekend I noticed the resident (R1) was a lot weaker than normal. She was a 2 assist (hard). Resident had complained of hip on Sunday for sure and foot when you put on her shoe (right foot but kept left foot straight). I had layed [sic] resident down Sunday evening, but had to get her back up to get weighed. The nurse V5 (LPN) helped me get her back in bed and I had mentioned it to her again of her hip pain and she noticed that her right leg went inward. R1's Progress Notes document the following: 01/19/25 at 4:59 PM (recorded as late entry on 01/25/2025 at 4:59 PM) This LPN (V5) needed to reweight [sic] res (resident) (R1) as a result from a previous weight not being consistent with baseline. Staff was assisting res into bed as nurse came in and explained the need to reweight [sic]. Staff and nurse assisted res back into wheelchair and this nurse pushed res to weight scale. Once weight scale was turned on res was gently pushed up the incline when nurse heard res say ouch nurse observed res right foot resting against the bar on weight scale. This nurse observed res right foot resting against the bar on weight scale. This nurse immediately retracted the WC (wheelchair) from weight scale. Skin was observed to be free of marks or abnormalities. No outward rotation or shortening noted to right lower extremity. No pain noted as evidence by no facial grimace or verbal complaints of pain upon assessment once res in bed. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	01/20/2025 at 6:32 AM documents (x-ray company) called and confirmed the order and will send to tech at this time. 01/20/2025 at 3:14 PM documents received notification via (x-ray company) that results show right hip is displaced. POA notified and stated would like resident sent to ER (emergency room) for evaluation. (V11-family) also stated that she understood that resident is a 'stinker' at times and tries to transfer self and does not communicate needs at times. Doctor notified and stated resident's osteoporosis and advanced age plays a factor in risk for fracture. PRN (as needed) Tylenol order increased, and preparations started to send resident to ER. 01/20/2025 at 3:16 PM documents (R1) is displaying sign of pain such as grimacing and withdraw. This LPN adm (administered) tyn (Tylenol) and ineffective. NP (Nurse Practitioner) made aware and tramadol recommended for pain, tramadol administered. 01/20/2025 at 3:41 PM documents (R1) left facility via EMS (Emergency Medical Services) 01/21/2025 at 7:36 AM documents (R1) admitted to hospital on 01/20/25. 01/25/2025 at 2:16 PM documents in part (R1) arrived to facility via transportation from hospital. Report was being called in while resident was arriving. Report states that (R1) was admitted on the 20th for right hip fx (fracture) .Script for Norco was sent in packet. Also states that can re-start tramadol. New order for ASA (aspirin) 325mg (milligrams) BID (twice a day) x 14 days. Trouble taking fish oil and was not able to take and states that they have been crushing meds in ice cream and no issues noted since crushing. States that resident will need a f/u (follow up) appointment with (name of physician) in 10-14 days post-surgery and surgery. R1's X-Ray report with a date of service of 1/20/25 documents an 'Impression of Acute subcapital right femoral neck fracture. R1's local hospital History and Physical dated 1/20/25 document a Chief Complaint of hip pain. R1's Discharge Summary from the local hospital dated 1/25/25 documents a Principle Problem of Closed displaced fracture of right femoral neck. On 02/21/25 at 10:16 AM, V5 (Licensed Practical Nurse) stated, R1 was weighed earlier in the morning on 1/19/25 and her weight was off so she was supposed to get a re-weight for R1. They had already put R1 to bed so they had to get her back up. R1 was in her wheelchair and had her legs crossed. When she pushed her up on the wheelchair platform her right leg/foot hit the vertical bar of the scale on R1's left side. R1 said ouch and she backed up and repositioned the wheelchair on the scale. R1 did not have foot pedals on her wheelchair. V5 stated she weighed R1 around 5:30 PM. V5 said she assessed R1 when they put her to bed and did not notice anything and then she left at 6:00 PM. V5 stated, R1 is a small lady, she did not propel herself in her wheelchair and she did not move around a lot or flail around. V5 stated R1 is confused, R1 will babble and her sentences usually do not make sense. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/20/25 at 1:36 PM, V7 (Certified Nurse Aide) stated, she worked at 6:00 AM on the Monday morning of 01/20/25. V7 stated R1 is not cognitive all the time but when she was transferring R1 she was saying ouch but she couldn't figure out where the pain was coming from. Then she saw R1's hip and it did not look right so she told the nurse and the nurse came down to evaluate R1. V7 stated she did not get R1 out of bed, the previous shift gets her up due to she gets up around 4:00 AM and moves to the recliner before breakfast, she was getting R1 ready for breakfast. On 02/20/25 at 1:50 PM, V4 (Licensed Practical Nurse/LPN) stated, V12 (CNA) came in at 10:00 PM on 1/19/25 and R1 was sleeping, they noticed on 1/20/25 at 4:00 AM when R1 gets up that she was uncomfortable and she starting assessing R1 then. On 02/20/25 at 8:52 PM, V6 (CNA) stated she assisted R1 the weekend of 01/19/25. On 01/18/25 R1 seemed weak so another girl helped her transfer her. On 01/19/25, V6 noticed R1 had not been reweighed yet and reweighed her. Over the weekend R1 seemed like she was in pain but not excruciating pain. V6 said that she did not notice her foot on 01/18/25 or 01/19/25 until the evening of 01/19 when her foot seemed like it was turned inward. V6 said she told V5 about it. On 02/20/25 at 12:05 PM, V8 (Therapy Director) stated she heard about the incident with R1 and her leg hitting the scale but she was not present. The injury R1 has can occur due to a fall, any impact with limb, depending on the person. R1 has declined after surgery, mainly due to her cognition level. R1 was evaluated for therapy but was declined due to cognition limitations. On 02/21/25 at 5:35 PM, V1 (Administrator) stated the injury with R1 they felt was a positioning concern therefore all the staff has been in-serviced on correct positioning and transferring after the injury with R1 occurred. The facility policy dated 09/08/23 titled, Safe Patient Handling Program documents: purpose: to identify, assess and develop strategies to control the risk of injury to resident, nurses and other health care workers associated with lifting, transferring, repositioning, or movement of a resident. This program applies to all staff-assisted resident lifts, transfers and ambulation performed by employees under normal conditions, during the performance of non-routine tasks and in the event of emergencies. Prior to the survey date, the facility took the following actions to correct the deficient practice: 1. A Quality Assurance and Performance Improvement meeting was held on 01/23/25. In attendance - V1, V4 (LPN), V13 (Director of Nursing/facility nurse practitioner), V15 (Registered Nurse), V16 (Medical Records), and V17 (Director of Maintenance). 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V1, V4, V13 (Director of Nursing/facility nurse practitioner) and V14 (Regional Clinical Director) provided in-service to nursing staff regarding weight management policy and body alignments in chair and positioning. Completed on 1/23/25. (continued on next page)		

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