| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525343 | A. Building<br>B. Wing | 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evergreen Health Services | 1250 Evergreen St<br>Shawano, WI 54166 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563<br><br>Based on observation, staff and resident interview, and record review, the facility did not ensure the provision of adequate supervision and assistance devices to prevent accidents for 3 residents (R) (R1, R4, and R3) of 3 sampled residents.<br><br>On 10/24/24, R1 had a fall with injury while smoking outside without supervision. R1 sustained a head laceration and was transferred to the emergency room (ER). A smoking assessment indicated R1 could smoke independently unsupervised, however, R1 needed assistance with locomotion and could not independently get to or return from the smoking area. In addition, R1 did not have a smoking care plan at the time of the fall.<br><br>R4 fell from a lift chair on 12/27/24. The facility did not reassess R4 for lift chair safety following the fall.<br><br>R3 fell on [DATE]. A fall intervention was not implemented or added to R3's care plan in a timely manner.<br><br>Findings include:<br><br>The facility's Smoking Policy, revised 7/14/22, indicates: .To identify factors that may put residents at risk for smoking or nicotine use independently and to provide appropriate supervision/approaches for safety .2. Risk factors identified through the assessment process shall be used in the development of the plan of care .<br><br>The facility's Fall Prevention and Management Guidelines policy, revised 7/18/24, indicates: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury .6. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care .The plan of care will be revised as needed and should be communicated to the staff, resident, and resident's family/responsible party .7. When any resident experiences a fall, the facility will .d. Review the resident's care plan and update with any new interventions to try to prevent additional falls. E. Document all assessments and actions .<br><br>(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 |
|---|---|---|

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 1. On 3/19/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including acute pulmonary edema, chronic obstructive pulmonary disease (COPD), emphysema, and weakness. R1's Minimum Data Set (MDS) assessment, dated 10/30/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions.<br><br>On 10/11/24, R1 was assessed by therapy for wheelchair mobility. The assessment indicated R1 was dependent on staff to wheel fifty feet with two turns.<br><br>A care plan, initiated 10/12/24, indicated R1 required the assistance of one staff for ambulation/locomotion.<br><br>A smoking assessment, dated 10/16/24, indicated R1 could smoke independently. A smoking care plan was not developed at that time.<br><br>A facility investigation indicated on 10/24/24 at 9:11 AM, R1 was discovered outside the door of the smoking area lying on R1's right side wearing gripper socks, clothing, and a winter coat. R1 had been outside smoking alone. R1 indicated R1 attempted to move the wheelchair with R1's feet but the chair didn't move and R1 fell forward onto R1's face. C-spine stabilization was provided by staff. R1 had significant facial bleeding and a laceration on the bridge of the nose. R1 was transferred to the hospital and received seven sutures for the laceration. The investigation indicated the incident occurred because R1 attempted to mobilize the wheelchair with R1's feet and had difficulty with one of the wheels crossing a seam in the concrete. An intervention was added for R1 to be accompanied by staff while smoking. Staff education was not provided following the incident.<br><br>A smoking care plan, initiated 10/24/24, indicated R1 should be accompanied by staff while smoking.<br><br>A nursing note, dated 10/25/24 at 3:37 PM, indicated R1 looked pretty rough with facial injuries related to an unwitnessed fall. R1 was black and blue, however, more bruising and pain were expected as a result of the fall. The note indicated to continue to monitor and update the physician with concerns, worsening pain, or injuries.<br><br>On 3/19/25 at 12:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated residents need to demonstrate they can get outside independently before they are left alone to smoke. LPN-D indicated staff would have had to bring R1 outside to smoke. LPN-D indicated a resident who smokes should have a smoking care plan and should demonstrate they are able to get outside by themselves before they are left alone.<br><br>On 3/19/25 at 2:52 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1 was independent with the ability to bring a cigarette to R1's mouth but needed to be transported to the smoking area. DON-B indicated R1 was able to wheel R1's self short distances and could wheel to the door and ring the doorbell to be let in. DON-B verified an assessment had not been completed to determine R1's ability for independent short distance mobilization. DON-B indicated staff education was not provided after the incident.<br><br>47248<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2. On 3/19/25, Surveyor reviewed R4's medical record. R4 had diagnoses including Parkinson's disease with dyskinesia, chronic respiratory failure, and asthma. R4's MDS assessment, dated 1/29/25, had a BIMS score of 14 out of 15 which indicated R4 was not cognitively impaired. R4 was responsible for R4's healthcare decisions.<br><br>R4's medical record contained a care plan and lift chair assessment dated [DATE]. The care plan indicated R4 required the assistance of one staff for transfers with a sit-to-stand lift.<br><br>R4's medical record indicated R4 fell from a lift recliner on 12/27/24. An intervention was added to reassess R4 for lift recliner safety and refer R4 to physical therapy. R4 had a physician order for physical therapy dated 12/27/24.<br><br>On 3/19/25, Surveyor requested a lift chair assessment following R4's fall on 12/27/24, R4's plan of care following the fall, and physical therapy notes.<br><br>On 3/19/25 at 11:50 AM, Surveyor interviewed Physical Therapist (PT)-C who was not aware of the PT referral after R4's fall on 12/27/24. PT-C indicated PT-C would request and provide the information to Surveyor.<br><br>On 3/19/25 at 12:45 PM, Surveyor interviewed R4 who indicated R4 continues to use the lift chair independently despite having slid out of the chair a few months ago. R4 indicated R4 did not have physical therapy following the incident and indicated R4 made a mistake and lifted the chair too high. Surveyor observed R4 use the lift chair control when R4 showed Surveyor how high R4 lifts the chair to get out of it.<br><br>On 3/19/25 at 2:53 PM, Surveyor interviewed DON-B who was unsure why R4 was not reassessed for lift chair safety following the fall on 12/27/24 and confirmed R4 should have been reassessed. DON-B indicated DON-B could not find documentation that indicated R4 received PT following the fall as ordered. DON-B verified the interventions put in place following the fall on 12/27/24 were not implemented.<br><br>3. On 3/19/25, Surveyor reviewed R3's medical record. R3 had diagnoses including hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following cerebral infarction, dysphagia (difficulty swallowing), and aphasia (a neurological disorder that affects a person's ability to communicate). R3's MDS assessment, dated 2/5/25, had a BIMS score of 12 out of 15 which indicated R3 had moderate cognitive impairment. R3 was responsible for R3's healthcare decisions.<br><br>R3's medical record indicated R3 fell on [DATE]. The investigation indicated an intervention was added to R3's care plan for a bright-colored Call don't fall sign.<br><br>R3's care plan indicated R3 was at risk for falls and contained an intervention for a Call don't fall sign with an implementation date of 1/2/25.<br><br>On 3/19/25 at 2:30 PM, Surveyor interviewed R3 who indicated R3 fell in the last couple of months. R3 indicated the sign under R3's television was posted there to remind R3 to use the call light and not get up without help.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/19/25 at 2:53 PM, Surveyor interviewed DON-B who indicated the Call don't fall sign should have been implemented immediately after R3's fall. DON-B verified the intervention was not added to R3's care plan until 1/2/25 and confirmed the care plan was not updated in a timely manner. |