

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

PRINTED: 04/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/17/2019
NAME OF PROVIDER OR SUPPLIER SPRING HILL CARE & REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 251 E WILSON AVENUE SPRING HILL, KS 66083		
(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 678 SS=J	The following citations represent the findings of complaint investigation #KS00140362. Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents and identified 13 residents with full code status (requesting cardio-pulmonary resuscitation (CPR) in the event of sudden cardiac arrest). Of these 13, the sample included 3 residents who requested resuscitative interventions. Based on record review and interview, the facility failed to ensure 1 of 3 sampled resident's (#1) rights for self-determination, related to his/her desire for CPR, were honored. Staff entered resident #1's room, found him/her unresponsive, without a heartbeat and not breathing and failed to immediately initiate CPR per the resident's documented preference. Resident #1 expired in the facility. The facility's failure to provide CPR placed resident #1 in Immediate Jeopardy on 4/15/19 at 4:25 A.M. Findings included: - Resident #1's closed clinical record and electronic medical record (EMR) documented he/she admitted to the facility on 4/10/19 with diagnoses of: acute respiratory distress (a	F 678			

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

TITLE

(X6) DATE

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 678	Continued From page 1 life-threatening condition. characterized by acute lung inflammation, stiff lungs that increase the work of breathing, and reduced ability of the lungs to adequately oxygenate the blood), acute kidney failure (rapid loss of kidney function), diabetes mellitus (a metabolic disorder in which there are high blood sugar levels over a prolonged period), severe intellectual disability, and Down's Syndrome (a genetic disorder caused by an extra chromosome). The admission nurses data assessment dated 4/10/19 documented the resident was alert, pleasant but nonverbal. He/she required continuous use of oxygen (O2) supplied at 2 Liters per minute (lpm) by a nasal cannula (small plastic tube for air to enter through the nostrils). The assessment documented the resident's oxygen saturation level (O2 sat) (a measure of oxygenation of the blood) was 94 percent (%) on admission. This assessment also documented the resident required assistance of one to two staff with most activities of daily living such as transfers to bed, the wheelchair, toileting, and dressing. According to the MayoClinic.org, normal blood oxygen levels in humans are considered 95% to 100%. The April 2019 electronic physicians order sheet (POS) documented the resident was Full Code status (desired CPR) and an order for O2 at 2 lpm continuously. The resident's initial care plan dated 4/11/19 directed staff the resident requested CPR measures to be performed.	F 678			

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F 678	Continued From page 2 The admission nurses progress note dated 4/10/19, timed 12:00 P.M. documented the resident was admitted per stretcher, was alert and nonverbal, and without signs and/or symptoms of distress. His/her skin was dry and pink, and his/her vital signs were stable. Record review revealed a nurse progress note dated 4/15/2019, timed 5:51 A.M. recorded: at 12:05 A.M. the resident had a temperature of 101.3 degrees Fahrenheit (F). At 1:00 A.M. the resident had removed his/her oxygen cannula and it was replaced. At 2:42 A.M. the resident was given Tylenol 650 milligrams (mg) for his/her elevated temperature. The note recorded direct staff P reported to staff H that he/she had checked on the resident and repositioned the resident's oxygen nasal cannula. A nurse note documented at 2:30 A.M. recorded the resident's temperature was 99.6 degrees F. At 2:30 A.M. the resident's O2 sat was 78 percent and his/her respirations were even and unlabored. The nurse note documented the resident was checked at 3:10 A.M and his/her nasal oxygen cannula was again repositioned. On 4/15/19 at 4:25 A.M. licensed nurse H found resident #1 unresponsive, without heartbeat or respirations (the action of breathing). Licensed nurse H left the resident's bedside to obtain the emergency cart, and then left the resident's room to call emergency medical response. The nurse note documented nurse H returned to the resident's room and began CPR. This same note documented a police officer arrived and nurse H assisted the officer with the use of AED (automatic electronic defibrillator-a device used to restart the heart muscle). EMT (emergency medical technician) and fire department personnel arrived, and took over CPR, while nurse H left the resident's room due	F 678			

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F 678	Continued From page 3 to space limitations. A fire department employee informed nurse H at 4:50 A.M. the resident was still a flat line (terminology indicating no heart beat). Emergency response personnel informed nurse H they would continue CPR for 5 more minutes and stop resuscitative measures if there was no change in the resident's condition. Licensed nurse H placed a call to the resident's responsible family member and informed him/her of resident #1's condition, and that CPR was in progress with EMT and fire department personnel. The resident's family member was very upset. A call was placed to administrative licensed nurse D and ARNP (advanced resident nurse practitioner) X and informed of the resident's status. An order was received from ARNP X to release the resident's body to the mortuary. Direct care staff O's notarized witness statement dated 4/15/19 documented he/she obtained resident #1's vital signs and the resident had a temperature. His/her O2 saturation was low as well. He/she told licensed nurse H at 11:30 P.M. At 4:35 A.M. direct care staff P told staff O licensed nurse H needed assistance from the direct care staff because there was a code. Direct care staff O went into residents #1's room and licensed nurse H said to make sure the door was unlocked for the emergency personnel. After that direct care staff O did not return to the resident's room. Direct care staff P's notarized witness statement dated 4/15/19 documented resident #1 was found by licensed nurse H unresponsive, in bed, around 4:25 A.M. Staff P had previously left the room, not less than 30 minutes before, when he/she had taken resident#1's roommate to the	F 678			

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F 678	Continued From page 4 bathroom. After direct care staff P helped the roommate back to bed, he/she checked resident #1's O2 tubing and he/she had pulled it out again from his/her nose. Staff P placed it back in the resident's nose and left the room and then reported to nurse H that resident #1 had pulled his/her O2 out again. That was the last time staff P witnessed the resident. Direct care staff P's second statement also dated 4/15/19 documented staff P visualized staff O recording vital signs on resident #1. Staff O told staff P the resident was running a temperature. The next time direct care staff P was in resident #1's room, licensed nurse H was in there with and assessed the resident's oxygen saturation. Staff P stated he/she believed it was around 72%, and no higher than 80%. Licensed nurse H then mentioned resident #1's heart rate and he/she believed it was 124 BPM (beats per minute) and the resident's oxygen saturation was 88%. At approximately 11:00 P.M. staff P saw nurse H give the resident medication for his/her temperature. Nurse H stated it was Tylenol. Nurse H and direct care staff P stayed in the room for a while and observed the resident. Staff P then advised nurse H the resident's breathing appeared different and he/she was hot to the touch. Direct care staff P suggested a wash cloth be placed on the resident's forehead. Direct care staff P then wet a cold wash rag and placed on the resident's forehead. From this point on until 4:00 A.M. direct care staff P repeatedly returned to the room to replace the oxygen tubing on the resident's nose. Every single time staff P checked O2 tubing he/she reported it to nurse H. Throughout the shift direct care staff P repeatedly replaced the O2. At 4:00 AM direct care staff P was down the other hall helping direct care staff	F 678			

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F 678	Continued From page 5 O with nightly tasks when nurse H came down the hall and told both staff O and staff P that assistance was needed in resident #1's room. Nurse H stated resident #1 had coded (term used when heartbeat and breathing stops and CPR must be initiated). Direct care staff P went into resident #1's room and noticed his/her complexion was different and the resident appeared to have red spots all over his/her body. Nurse H handed staff P an orange board to place behind resident #1's back and a device to place over resident #1's mouth to force air into him/her. Nurse H instructed staff P to keep using the device. Nurse H did a few chest compressions on resident #1 and then left the room to call 911. Staff P reported the first rescue person to arrive was a police officer. The police officer asked nurse H some questions about a device that charge nurse H said he/she did not know how to use. The police officer took it out. Staff P then left the room. Licensed nurse H's notarized witness statement dated on 4/15/19 at 4:55 A.M. documented resident #1 had a temperature of 101.3 degrees F. and the resident's O2 saturation was 74%. The resident had been repeatedly removing his/her O2 cannula and it was repeatedly replaced. Nurse H gave the resident Tylenol 12:10 AM. Resident #1's respirations were even and unlabored and he/she was nonverbal but alert to care per nurse H's report. Nurse H checked resident #1 at 1:00 A.M. and the resident had removed his/her cannula and it was again replaced. Licensed nurse H rechecked the resident at 2:30 A.M. and his/her temp was 99.6 degrees F, oxygen saturation was 78% and his/her respirations were even and unlabored. At 4:25 A.M. nurse H checked the resident and found him/her	F 678			

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F 678	Continued From page 6 unresponsive, without a heartbeat and respirations. Nurse H took the crash cart to resident #1's room and placed a back board under the resident with assistance of direct care staff P. Nurse H then left resident #1's room to call 911 and returned to start CPR. A Spring Hill police officer arrived and assisted with the AED device per nurse H's report. The police officer placed the AED pads on resident #1's chest and the AED advised no shock was needed. The pads were removed, and CPR was resumed. Nurse H reported direct care staff P used an air bag and emergency personnel (EMT) and fire dept arrived and took over CPR. The resident was placed on the floor. During that time, while CPR continued, nurse H left the room due to lack of space. A fire department employee requested the resident's information and licensed nurse H printed it and gave it to him/her. At 4:50 AM emergency rescue personnel informed nurse H the resident continued with no heartbeat or respirations. Rescue personnel informed nurse H resuscitative measures would continue for 5 more minutes. A call was placed to resident #1's responsible family member and he/she was informed of the resident's condition. The family member was told emergency personnel had performed CPR, but they were suspending CPR due to no response from the resident. The family member was upset and stated he/she needed to call family and would call back. Interviewed on 4/16/19 at 10:55 A.M, administrative licensed nurse D stated his/her expectation was the nurse should have immediately initiated CPR, yelled to direct care staff for help, have direct care staff gather supplies and activate emergency medical response. Nurse D stated he/she was made	F 678			

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F 678	Continued From page 7 aware of the event on 4/15/19 at 6:00 A.M. Administrative nurse D stated the actions of the nurse were not in keeping with professional standards and/or facility policy. Nurse D stated licensed nurse H did not note a change of condition for the resident, and/or notify the physician. Staff D stated the lack of action by nurse licensed nurse H indicated a lack of nursing competency. Nurse D stated the facility conducted in-services on these types of events in orientation and throughout the year, the last being held in February 2019. Nurse D stated the residents code status is displayed on the binder of the clinical record, on the electronic physician orders, in the resident care plan and throughout the clinical record The facility's Procedure for CPR -Cardiopulmonary Resuscitation policy revised 5/2017 documented it was the policy of the facility to provide basic life support including CPR (Cardiopulmonary Resuscitation) when a resident requires such emergency care, prior to arrival of medical services. The facility failed to perform CPR in accordance the resident's advanced directives, acute medical situation and per physician's order. This deficient practice placed all facility residents in immediate jeopardy. On 4/16/19 at 4:45 P.M. administrative staff A, administrative licensed nursing staff D and administrative licensed nurse E were informed the deficient practice placed all residents in immediate jeopardy. The facility provided an acceptable plan for removal of the immediate Jeopardy on 4/16/19 at	F 678			

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F 678	Continued From page 8 5:50 P.M. The onsite review on 4/17/19 at 1:20 P.M. revealed the facility removed the immediate jeopardy when it completed the following: Licensed nurse H was immediately suspended on 4/15/19 pending investigation. Identified and verified the code status of every facility resident Identified and verified the CPR certification of all applicable facility staff Developed a teaching plan for staff to ensure resident code status is honored. Developed a teaching plan to ensure all staff know emergency (code) procedures, equipment locations and their specific role in emergency plan. Conducted in-service training regarding the facility policy and measures to ensure resident code status is acted upon. Conducted hands on training and competency assessments on all applicable staff. Developed measures for monitoring and auditing desired outcomes and incorporating into the facilities Quality Assurance Performance Improvement (QUAPI) plan. The deficient practice remained at a scope and severity of a G following the removal of the immediate jeopardy.	F 678			