

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

PRINTED: 12/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/06/2016
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 8909 PARALLEL PKY KANSAS CITY, KS 66112		
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F 000	INITIAL COMMENTS	F 000			
F 155 SS=F	The following citation represents the findings of complaint investigation #KS00108676. 483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 155			

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 155	Continued From page 1 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 identified a census of 35 residents. Based on observation, interview, and record review, the facility failed to ensure a resident's right in self-determination regarding implementation of the formulated advanced directive, in that when resident (#1) made the determination for Do Not Resuscitate (DNR) status in the event of unresponsiveness or cardiac arrest, licensed nursing staff H failed to follow the resident's advanced directive and physician order and imitated cardio-pulmonary resuscitation (CPR) when he/she found resident #1 unresponsive. Findings included:	F 155			

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F 155	Continued From page 2 - Review of resident #1's closed clinical record documented diagnoses that included, but were not limited to major depressive disorder (a brain disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), aftercare following a revision to internal orthopedic prosthetic devices (a medical device to replace a missing joint or bone or to support a damaged bone), and presence of a cardiac pacemaker (a small device placed in the chest to help control abnormal heart rhythms and prompt the heart to beat at a normal rate). The resident was admitted to the facility on 11/02/16 from an acute care facility. The 14-Day Minimum Data Set dated 11/16/16 documented a brief interview for mental status score of 15, which indicated intact cognition. A signed physician order dated 11/04/16 documented "change code status to DNR." Review of the Outside the Hospital DNR Form dated 11/07/16 documented the resident had signed his/her agreement to the DNR order. The document was unsigned by the physician. A progress note dated 11/22/16 at 3:25 A.M. by licensed nursing staff H documented the resident was admitted with a right hip fracture (a broken bone), his/her right leg was hot and red, the physician was notified, and a physician order was obtained for an antibiotic. A progress note dated 11/22/16 at 7:30 A.M. by administrative nursing staff D documented the resident was found without vital signs at 5:10	F 155			

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F 155	Continued From page 3 A.M. per the phone call he/she had received from staff at 5:30 A.M. When administrative nursing staff D arrived to the facility at 6:10 A.M., the resident was cool to the touch and pale in color. He/she completed a skin assessment and noted bruising and edema of the right lower extremity. The right hip incision had drained a scant amount of clear fluid. The resident's pacemaker continued to fire, an order was received from the physician to place a magnet over the pacemaker, and to release his/her remains. A progress note dated 11/22/16 at 8:16 A.M. by licensed nursing staff H documented the resident was found in his/her bed by staff O who had entered the room to draw a physician ordered laboratory test. Staff O reported the resident appeared not to be breathing, had absence of chest rise, and he/she could not feel a pulse. Licensed nursing staff H began CPR while licensed nursing staff I brought the emergency cart into the room and direct care staff P called 911. Licensed nursing staff I verified the resident's code status was DNR and CPR was suspended. The resident remained non-responsive the whole time and licensed nursing staff H and I verified the resident had no pulse or respirations at approximately 5:05 A.M. Review of the notarized witness statement dated 11/23/16 by staff O documented he/she had entered the resident's room at approximately 5:10 A.M. to draw a physician ordered laboratory test. He/she turned on the lights and noted the resident was very pale in color, was laying peacefully with his/her mouth open and head slightly tipped back on a pillow, with the head of the bed slightly elevated. Staff O attempted to wake the resident by stating his/her name and	F 155			

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F 155	Continued From page 4 checked a radial pulse, which was absent. Staff O went to the nursing station, informed licensed nursing staff H and direct care staff P the resident had no pulse, they ran down the hall into the resident's room, and licensed nursing staff H started chest compressions while direct care staff P left the room to check the resident's code status. Staff O left the room and returned to the hospital when licensed nursing staff I verified the resident was a DNR and had said to stop CPR. Review of the notarized witness statement dated 11/22/16 by licensed nursing staff H documented direct care staff P had assisted the resident to the bathroom at approximately 12:40 A.M. on 11/22/16 and reported to him/her the resident's right leg was red and hot to the touch. Licensed nursing staff H noted the resident had bilateral 3+ pitting edema, had a negative Homan's sign (pain in the calf of the leg upon dorsiflexion of the foot with the leg extended that is diagnostic of thrombosis (blood clot) in the deep veins of the area), and obtained vital signs at that time: blood pressure 150/70, heart rate 63 beats per minutes, respirations 18 and a temperature of 98.1 degrees Fahrenheit. The physician returned his/her phone call at 12:50 A.M. and ordered an antibiotic used to treat infection. The resident used the bathroom at approximately 1:30 A.M., 2:20 A.M., and 3:30 A.M. The resident denied pain throughout the shift. At approximately 5:05 A.M., staff O approached the nursing station and reported the resident was not breathing, lacked chest rise, and he/she could not feel a pulse. Licensed nursing staff H verified the resident was not breathing and began chest compressions. Licensed nursing staff I obtained the emergency cart and staff O assisted with the ambu bag (a bag valve mask or hand-held device commonly	F 155			

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F 155	Continued From page 5 used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately). Direct care staff P was on the phone with 911 when licensed nursing staff I verified the resident's code status was DNR and CPR was ceased at that time. Review of the notarized witness statement dated 11/22/16 by licensed nursing staff I documented he/she was walking toward the nursing station when he/she heard direct care staff P yell, "We have a code, patient is not breathing." Licensed nursing staff I brought the emergency cart to the room, checked the chart and verified the resident was a DNR and instructed licensed nursing staff H to stop CPR. The physician was notified by licensed nursing staff H while licensed nursing staff I notified administrative nursing staff D and attempted to notify the resident's family. Review of the notarized witness statement dated 11/22/16 by direct care staff P documented at approximately 3:00 A.M., the resident asked him/her to turn off his/her television and reported to direct care staff P that he/she had just used the bathroom. At approximately 4:15 A.M., direct care staff P checked on the resident and noted he/she was snoring. At approximately 5:00 A.M., staff O reported to licensed nursing staff H and direct care staff P the resident was non-responsive and not breathing. Direct care staff P and licensed nursing staff H ran to the resident's room, licensed nursing staff H started CPR, and direct care staff ran to get licensed nursing staff I and to call 911. While on the phone with 911, licensed nursing staff I confirmed the resident was a DNR. Observation on 11/28/16 at 12:45 P.M. revealed 34 out of 35 residents had their code status	F 155			

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F 155	Continued From page 6 identified on the outside of their hard chart and outside of their room on their name card by a red circular sticker or a green circular sticker. Review of resident #2's clinical record on 11/28/16 at 12:46 P.M. documented he/she admitted to the facility on 11/18/16 and lacked documentation of his/her code status or an Outside the Hospital DNR Form as of 11/28/16. The clinical record further lacked documentation staff had addressed code status with the family or physician. During an interview on 11/28/16 at 12:47 P.M., licensed nursing staff K stated he/she was aware that resident #2's code status was not identified and stated staff had a conversation with the family who had not yet made up their mind about his/her code status. Licensed nursing staff K stated the resident was confused, oriented to person only, and could not make a decision about his/her code status so he/she would remain a full code and CPR would be administered in the event he/she became non-responsive or had no pulse until the family had made a decision. A progress note dated 11/28/16 at 2:00 P.M. by administrative staff B documented he/she had called resident #2's family and they indicated he/she was a DNR in the hospital and would remain a DNR in the facility. Observation on 11/28/16 at 2:00 P.M. revealed a red circular sticker indicating DNR status had been placed on the outside of resident #2's chart and name card outside his/her room. On 11/28/16 at 4:08 P.M., review of the facility's video surveillance with administrative nursing	F 155			

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F 155	Continued From page 7 staff D, documented at approximately 5:11 A.M., staff O ran down the hallway to the nursing station and licensed nursing staff H, direct care staff P and staff O entered resident #1's room. Direct care staff immediately exited the room and ran toward the nursing station. At approximately 5:13 A.M., the emergency cart was placed outside the resident's room and licensed staff H exited the room to obtain the ambu bag and re-entered the resident's room. At approximately 5:15 A.M., licensed nursing staff I was outside the resident's room with the clinical record and at approximately 5:17 A.M., all staff had exited the resident's room. Staff were present in the resident's room for approximately 6 minutes. During an interview on 11/28/16 at 1:10 P.M., licensed nursing staff J stated when a resident was admitted to the facility, they filled out the Outside the Hospital DNR Form, which was part of their admission packet and would place this form under the Advance Directive tab in the resident's chart. A physician order would be written to reflect the resident's code status and staff had to check the chart if they wanted to know the resident's code status. Licensed nursing staff J stated after resident #1 had passed away, the facility implemented a "dot system" and placed a red circular sticker on the resident's chart and outside of his/her room to indicate the code status of DNR and a green circular sticker to indicate the status of full code (to initiate CPR). During an interview on 11/28/16 at 1:22 P.M., licensed nursing staff K stated when staff received report prior to admission, they were informed of the resident's code status and stated the code status should also be identified on the resident's admission orders. Licensed nursing	F 155			

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F 155	Continued From page 8 staff K stated if direct care staff wanted to know a resident's code status they had to ask the licensed nurse who had to look in the chart because it was not identified on the care plan. During an interview on 11/28/16 at 1:26 P.M., licensed nursing staff L stated if a resident was not admitted with a code status order, staff would talk to the resident and their family to identify their wishes and within 24 hours should fill out the Outside the Hospital DNR form and obtain a physician order. Licensed nursing staff L stated until they receive a DNR order from the physician, the resident was considered a full code and CPR would be initiated. During an interview on 11/28/16 at 1:35 P.M., direct care staff Q stated the staff had to look in the chart to find the order for the resident's code status but had recently implemented a new system, which quickly identified a full code with a green circular sticker and a DNR with red circular sticker. Direct care staff Q stated if he/she found a resident non-responsive or without respirations or a pulse, he/she would immediately use his/her walkie-talkie to call the nurse for assistance and would wait to be directed to start CPR. During an interview on 11/28/16 at 1:37 P.M., direct care staff R stated he/she identified a resident's code status by looking at their orders and on their Kardex (a form direct care staff carried to reference the care needs of each resident). Direct care staff R stated if he/she found a resident non-responsive or without respirations or a pulse, he/she would call the nurse using the walkie-talkie and could start CPR if the resident was a full code. Direct care staff R stated the facility recently changed their system to	F 155			

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F 155	Continued From page 9 identify code status placing a green dot on the chart and outside the resident's room to signify a full code and a red dot to signify DNR. During an interview on 11/28/16 at 2:34 P.M., administrative nursing staff D stated when a resident was found without respirations or a pulse, he/she expected staff to find out their code status and act appropriately. If a resident did not have an identified code status, he/she expected staff to initiate CPR and call 911 until the family and physician changed the status to DNR. Administrative nursing staff D stated that prior to implementing the green and red sticker system, staff had to open the resident's hard chart and look for the order or the advance directive. He/she stated the resident's code status should be identified within 24 hours of admission and the facility's social worker had recently been assigned the responsibility to have a conversation with each resident and family about their code status and should document that communication in a progress note. During an interview on 11/28/16 at 2:40 P.M., administrative nursing staff D stated all employees except for housekeeping and maintenance staff were required to be CPR certified within 30 days of hire and stated the facility provided no further education regarding CPR upon hire or annually. Administrative nursing staff D called Human Resources and confirmed the staff received no education regarding CPR. He/she stated she started an in-service on 11/22/16 for facility staff which addressed the red and green sticker system and which color indicated DNR or full code. During an interview on 11/28/16 at 2:44 P.M.,	F 155			

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F 155	Continued From page 10 administrative nursing staff D stated the physician was supposed to address resident #2's code status on this date when he/she rounded and until then, the resident would remain a full code and a green sticker would be placed on his/her chart and outside his/her room. Administrative nursing staff D confirmed resident #2's clinical record lacked documentation from admission on 11/18/16 through 11/28/16 at 2:00 P.M. of the resident's code status and further lacked documentation staff had conversations with the family or physician regarding the code status. During an interview on 11/28/16 at 3:00 P.M., licensed nursing staff H confirmed his/her notarized witness statement was accurate and stated he/she was "completely shocked" the resident had expired and "it didn't make any sense" because the resident had been talking to staff throughout the night and was up several times. Licensed nursing staff H stated his first instinct was to start CPR and he started compressions until licensed nursing staff I instructed him/her to stop because the resident had a DNR. Licensed nursing staff H stated the facility changed their system and staff could quickly identify a resident's code status by the colored stickers. He/she would honor the resident's code status and only start CPR if the resident was a full code status. During an interview on 11/28/16 at 3:34 P.M., direct care staff P confirmed his/her notarized witness statement was accurate. He/she stated prior to this incident, in order to know the resident's code status, direct care staff had to ask the licensed nurse, look in the chart, or refer to the Kardex. Direct care staff P stated the facility's new colored sticker system made it easy to	F 155			

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F 155	Continued From page 11 quickly identify a resident's code status. During an interview on 11/28/16 at 3:55 P.M., administrative staff B stated he/she "thought it was odd" that he/she did not have a role in documenting the resident's code status. He/she stated as of 11/22/16, nursing staff should address the resident's code status within 24 hours of admission and he/she would follow up with residents and their family if no status had been identified and document the communication in a progress note. During an interview on 11/28/16 at 4:00 P.M. with licensed nursing staff H, he/she stated he/she performed chest compressions on resident #1 for approximately 7-8 minutes but had exited the room for approximately 10 seconds to find the ambu bag, which was located on emergency cart in the hallway. Licensed nursing staff H stated he/she provided a couple of ventilations with the ambu bag then resumed CPR while staff O took over ventilations with the ambu bag. Review of the facility provided Resuscitation policy dated 3/13/13 documented any person who had an advance directive requesting CPR would receive CPR from an individual who was trained in CPR. Code status would be identified on all residents at the facility and in the event a person had not expressed their code status, CPR would be provided. Review of the facility provided Advance Directives policy dated 3/18/13 documented it should be documented in the resident's medical record whether the individual had executed any advance directive and the attending physician should be notified if the individual wished to not be	F 155			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 8909 PARALLEL PKY KANSAS CITY, KS 66112		
(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 155	Continued From page 12 resuscitated and an appropriate order would be requested. The facility failed to honor resident #1's advance directive of DNR status when licensed nursing staff H initiated CPR and failed to identify resident #2's code status for duration of 10 days after admission.	F 155			