| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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<br><br>The following citations represent the findings of a Non-compliance Revisit and Complaint investigation #91571, 91544, 91634. | {F 000} | | |
| {F 157} SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | {F 157} | | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 157} | Continued From page 1 | {F 157} | | |

This REQUIREMENT is not met as evidenced by:
The facility had a census of 47 residents. The sample included 7 residents. Based on interview and record review the facility failed to notify a resident's physician of multiple occasions of decreased oxygen saturations, who used supplemental oxygen. (#7)

Findings included:

- Resident #7's physician order sheet, dated 9/1/15, revealed the following diagnoses: macular degeneration (progressive deterioration of the retina), insomnia (difficulty sleeping), (CHF) congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly (MDS) Minimum Data Set assessment, dated 7/24/15, indicated the resident had intact cognition with a (BIMS) Brief Interview of Mental Status score of 14, and required supervision with bed mobility, eating, toilet use, and personal hygiene. The MDS further indicated the resident had shortness of breath with exertion, received diuretic (removes excess water through the kidneys) medication, and received oxygen therapy.

The 7/24/15 care plan instructed staff to report signs of respiratory distress, to assess oxygen saturations (measure of the amount of oxygen that is dissolved or carried in the blood) monthly, and monitor his/her breathe sounds weekly and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 157} | Continued From page 2 | {F 157} | | |

as needed.

The 5/1/15 physician order instructed staff to administer oxygen at 2 liters by nasal cannula to maintain an oxygen saturation greater than or equal to 90%. Further review of the physician's order revealed no parameters for when to call the physician.

The August 2015 (TAR) Treatment Administration Record revealed the following days staff documented an oxygen saturation level <90%:
8/10/15 (AM shift) - 84% on room air (no supplemental oxygen)
8/10/15 (evening shift) - 86% on room air
8/11/15 (evening shift) - 80% on room air
8/15/15 (evening shift) - 88% on 02
8/16/15 (evening shift) - 89% on 02
8/18/15 (AM shift) - 88% on room air
8/18/15 (evening shift) - 89% on room air
8/19/15 (evening shift) - 89% on room air
8/19/15 (night shift) - no documentation
8/20/15 (AM shift) - 77% on room air
8/21/15 (evening shift) - 88% on 02
8/22/15 (AM shift) - 89% on 02
8/22/15 (evening shift) - 87% on 02
8/26/15 (AM shift) - 89% on 02
8/28/15 (AM shift) - 87% on 02
8/28/15 (evening shift) - 88% on 02
8/29/15 (AM shift) - 86% on 02
8/29/15 (evening shift) - 89% on 02
8/30/15 (AM shift) - 89% on 02
8/30/15 (evening shift) - 88% on 02
8/31/15 (AM shift) - 86% on 02
8/31/15 (evening shift) - 89% on 02

The medical record lacked documentation staff completed a thorough assessment and reassessment of the resident when his/her

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 157} | Continued From page 3 | {F 157} | | |

oxygen level was below 90.

The 9/2/15 at 2:12 PM, nurse's note indicated at 12:00 PM, staff observed the resident had abnormal behavior, and upon assessment noted the resident had unclear speech and decreased strength to his/her bilateral upper extremities. The note further indicated staff auscultated (listen with a stethoscope) the resident's lung sounds and heard wheezing and rubbing in the right lower lobe, with his/her blood pressure 89/57 (normal 120/80), and respirations 32 per minute (normal 12-20). The note continued to indicate the resident's speech cleared, he/she wanted to eat lunch, and had no difficulties eating or chewing. The note further indicated at 1:30 PM, staff observed the resident had an increase of shortness of breath, staff assessed the resident and were unable to maintain his/her oxygen saturations >83% with 7 liters of 02 by a mask. The note indicated the resident was responsive, but sluggish, was dusky and cyanotic (blue in color), and had pain to his/her neck. The note indicated staff notified the resident's physician and received an order to send the resident to the emergency room for evaluation and treatment.

The 9/2/15 admission hospital orders indicated the hospital admitted the resident for acute CHF, elevated Troponin (measures levels of protein, and is the most sensitive lab test for diagnosis of myocardial infarction, heart attack), and increased hypoxia (inadequate supply of oxygen).

On 10/6/15 at 9:56 AM, Nurse E stated if a resident had low oxygen saturations he/she would notify the physician for orders.

On 10/6/15 at 10:36 AM, Nurse C stated if a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 157} | Continued From page 4 | {F 157} | | |

resident had difficulty breathing and a low oxygen saturation he/she would assess cognition, skin color, and listen to his/her lung sounds. Nurse C further verified the resident had no indicators of difficulty with breathing, and obsessed over whether his/her oxygen was working right. Nurse C verified staff received an order for Ativan (an antianxiety medication) for his/her obsessions with the oxygen.

On 10/6/15 at 1:46 PM, Nurse Aide A verified he/she would notify a nurse if a resident had trouble breathing, or had a low oxygen saturation.

On 10/6/15 at 1:54 PM, Medication Aide B stated the resident had difficulty with his/her oxygen level and breathing. Medication Aide further verified the resident had trouble breathing, was anxious, almost in panic mode, constantly touching the buttons of the oxygen canister, and asking staff to verify if the oxygen was set correctly.

On 10/6/15 at 4:00 PM, Administrative Nurse D stated if a resident had a low oxygen saturation, he/she expected staff to apply or increase oxygen, and to perform an assessment of the resident. Administrative Nurse D further verified the low oxygen saturations documented by the staff, and the lack of documentation of a thorough nursing assessment of the resident at those times. Administrative Nurse D further verfied the lack of documentation the staff notified the resident's physician, and stated he/she would expect the physician to be notified, especially if the resident had a history of decreased oxygen saturations, or if the physician had ordered to be notified.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 157} | Continued From page 5<br>The facility's 10/2010 Oxygen Administration policy instructed staff while a resident is receiving oxygen to assess for cyanosis, hypoxia, oxygen toxicity, vital signs, and lung sounds. The policy further instructed staff after oxygen set up, administration, and readjustment to document date and time, oxygen flow rate, frequency and duration, reason for administration, assessment data before and after, and how the resident tolerated the procedure.<br><br>The facility failed to notify Resident #7's physician of multiple occasions of decreased oxygen saturations, who used supplemental oxygen. | {F 157} | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 47 residents. The sample included 7 residents. Based on interview and record review the facility failed to provide an accurate and thorough assessment and reassessment, for 1 of 3 residents reviewed for oxygen therapy. (#7) | F 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 328 | Continued From page 6 | F 328 | | |

Findings included:

- Resident #7's physician order sheet, dated 9/1/15, revealed the following diagnoses: macular degeneration (progressive deterioration of the retina), insomnia (difficulty sleeping), (CHF) congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The quarterly (MDS) Minimum Data Set assessment, dated 7/24/15, indicated the resident had intact cognition with a (BIMS) Brief Interview of Mental Status score of 14, and required supervision with bed mobility, eating, toilet use, and personal hygiene. The MDS further indicated the resident had shortness of breath with exertion, received diuretic (removes excess water through the kidneys) medication, and received oxygen therapy.

The 7/24/15 care plan instructed staff to report signs of respiratory distress, to assess oxygen saturations (measure of the amount of oxygen that is dissolved or carried in the blood) monthly, and monitor his/her breathe sounds weekly and as needed.

The 5/1/15 physician order instructed staff to administer oxygen at 2 liters by nasal cannula to maintain an oxygen saturation greater than or equal to 90%. Further review of the physician's order revealed no parameters for when to call the physician.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 328 | Continued From page 7 | F 328 | | |

The August 2015 (TAR) Treatment Administration Record revealed the following days staff documented an oxygen saturation level <90%:
8/10/15 (AM shift) - 84% on room air (no supplemental oxygen)
8/10/15 (evening shift) - 86% on room air
8/11/15 (evening shift) - 80% on room air
8/15/15 (evening shift) - 88% on 02
8/16/15 (evening shift) - 89% on 02
8/18/15 (AM shift) - 88% on room air
8/18/15 (evening shift) - 89% on room air
8/19/15 (evening shift) - 89% on room air
8/19/15 (night shift) - no documentation
8/20/15 (AM shift) - 77% on room air
8/21/15 (evening shift) - 88% on 02
8/22/15 (AM shift) - 89% on 02
8/22/15 (evening shift) - 87% on 02
8/26/15 (AM shift) - 89% on 02
8/28/15 (AM shift) - 87% on 02
8/28/15 (evening shift) - 88% on 02
8/29/15 (AM shift) - 86% on 02
8/29/15 (evening shift) - 89% on 02
8/30/15 (AM shift) - 89% on 02
8/30/15 (evening shift) - 88% on 02
8/31/15 (AM shift) - 86% on 02
8/31/15 (evening shift) - 89% on 02

The medical record lacked documentation staff completed a thorough assessment and reassessment of the resident when his/her oxygen level was below 90.

The 9/2/15 at 2:12 PM, nurse's note indicated at 12:00 PM, staff observed the resident had abnormal behavior, and upon assessment noted the resident had unclear speech and decreased strength to his/her bilateral upper extremities. The note further indicated staff auscultated (listen with a stethoscope) the resident's lung sounds and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 328 | Continued From page 8 | F 328 | | |

heard wheezing and rubbing in the right lower lobe, with his/her blood pressure 89/57 (normal 120/80), and respirations 32 per minute (normal 12-20). The note continued to indicate the resident's speech cleared, he/she wanted to eat lunch, and had no difficulties eating or chewing. The note further indicated at 1:30 PM, staff observed the resident had an increase of shortness of breath, staff assessed the resident and were unable to maintain his/her oxygen saturations >83% with 7 liters of 02 by a mask. The note indicated the resident was responsive, but sluggish, was dusky and cyanotic (blue in color), and had pain to his/her neck. The note indicated staff notified the resident's physician and received an order to send the resident to the emergency room for evaluation and treatment.

The 9/2/15 admission hospital orders indicated the hospital admitted the resident for acute CHF, elevated Troponin (measures levels of protein, and is the most sensitive lab test for diagnosis of myocardial infarction, heart attack), and increased hypoxia (inadequate supply of oxygen).

On 10/6/15 at 9:56 AM, Nurse E stated if a resident had low oxygen saturations he/she would notify the physician for orders.

On 10/6/15 at 10:36 AM, Nurse C stated if a resident had difficulty breathing and a low oxygen saturation he/she would assess cognition, skin color, and listen to his/her lung sounds. Nurse C further verified the resident had no indicators of difficulty with breathing, and obsessed over whether his/her oxygen was working right. Nurse C verified staff received an order for Ativan (an antianxiety medication) for his/her obsessions with the oxygen.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 328 | Continued From page 9 | F 328 | | |

On 10/6/15 at 1:46 PM, Nurse Aide A verified he/she would notify a nurse if a resident had trouble breathing, or had a low oxygen saturation.

On 10/6/15 at 1:54 PM, Medication Aide B stated the resident had difficulty with his/her oxygen level and breathing. Medication Aide further verified the resident had trouble breathing, was anxious, almost in panic mode, constantly touching the buttons of the oxygen canister, and asking staff to verify if the oxygen was set correctly.

On 10/6/15 at 4:00 PM, Administrative Nurse D stated if a resident had a low oxygen saturation, he/she expected staff to apply or increase oxygen, and to perform an assessment of the resident. Administrative Nurse D further verified the low oxygen saturations documented by the staff, and the lack of documentation of a thorough nursing assessment of the resident at those times.

The facility's 10/2010 Oxygen Administration policy instructed staff while a resident is receiving oxygen to assess for cyanosis, hypoxia, oxygen toxicity, vital signs, and lung sounds. The policy further instructed staff after oxygen set up, administration, and readjustment to document date and time, oxygen flow rate, frequency and duration, reason for administration, assessment data before and after, and how the resident tolerated the procedure.

The facility failed to thoroughly assess and reassess Resident #7 who received oxygen and had low oxygen saturations levels on multiple occasions.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175457 | A. BUILDING _____ B. WING _____ | R-C 10/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEABODY HEALTH AND REHAB | 407 N LOCUST ST PEABODY, KS 66866 |

| (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 |
|---|---|---|---|---|
| | | | | |