STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	7541 SWITZER ROAD OVERLAND PARK, KS 66214

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 116 residents with nine residents on the Covid-19 isolation unit. The sample included seven residents. Based on interviews and record reviews, the facility failed to provide cardiopulmonary resuscitation (CPR-full code, a life-saving medical procedure that consists of chest compressions to allow [MEDICATION NAME] blood to circulate to vital organs, such as the brain and heart and artificial ventilation) to Resident (R)1, whose Advanced Directives (a written document which indicated the medical decisions for health care professionals when the person could not speak) and physician orders [REDACTED]. The facility also failed to ensure staff knew how to confirm a resident's code status. This deficient practice placed R1 and two other residents (R6 and R7) with a full code status on the COVID-19 isolation unit in immediate jeopardy. Findings included: - The [DIAGNOSES REDACTED]. R1's Admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. He required extensive staff assistance with his Activities of Daily Living (ADLs). R1's Quarterly MDS dated [DATE] documented a BIMS score of zero. He required extensive staff assistance with his ADLs. The Care Area Assessment (CAA) for cognition dated [DATE] documented R1 had inattention and disorganized thinking due to his [MEDICAL CONDITION] diagnosis. The facility staff received training to care for residents with [MEDICAL CONDITION]. R1's Care Plan revised [DATE] documented R1 had the potential for exposure to Covid-19. The facility staff observed for changes in his level of consciousness, mental status, and lethargy (a lack of energy). The staff notified R1's physician when respiratory conditions developed. The care plan directed staff to monitor oxygen saturation levels (the fraction of oxygen saturated hemoglobin relative to total hemoglobin in the blood) as indicated. The care plan lacked documentation on R1's advanced directives. The physician's orders [REDACTED]. The Progress Notes tab recorded a note dated [DATE] at 06:38 AM which documented R1's oxygen saturation dropped to 80% at 01:15 AM and staff notified the physician. New orders included a chest x-ray and laboratory blood work. The physician also ordered supplemental oxygen use at two liters per minute. With administration of oxygen R1's oxygen saturation level rose to 93%. At 12:50 PM R1's oxygen saturation level dropped to 80% and his temperature was 99.8 F. He had a productive cough and congestion. Staff notified the physician and received an order for [REDACTED]. He had a [DIAGNOSES REDACTED]. Staff repositioned the resident and secured an air mask (a plastic mask which covers the nose and mouth to deliver oxygen) to deliver five liters of supplemental oxygen per minute. The Progress Notes dated [DATE] documented R1 was under isolation for suspected Covid-19. His oxygen saturation levels were up to the lower limits when on supplemental oxygen at five liters per minute at 09:36 AM. At 01:09 PM his laboratory results were positive for Covid-19. At 08:05 PM his pulse was regular at 90 beats per minute, blood pressure was ,[DATE] mmHg (millimeters of Mercury), and his respirations were 18 breaths per minute. The Vital Signs tab of the EMR dated [DATE] documented an oxygen saturation level of 87% on high flow supplemental oxygen, a temperature of 98.5 F, a blood pressure of ,[DATE] mmHg at 07:15 AM. R1's respirations were 46 breaths per minute at 07:50 AM. The EMR lacked documentation for physician notification of the vital signs listed above. The Progress Notes tab recorded a note dated [DATE] at 09:10 AM which documented Licensed Nurse (LN) J found R1, not breathing and with no heartbeat. Staff attempted to notify facility administrative staff but were unable to. Staff notified Consultant Physician GG at 09:16 AM and the medical examiner at 09:21 AM. The facility released R1's body for cremation at 11:17 AM. A Late Entry Note under the Progress Notes dated [DATE] at 11:16 AM recorded Certified Nurse Aid (CNA) N observed R1 did not look good and reported to LN J. LN J and CNA N entered R1's room and identified R1 had no vital signs. LN J informed LN H. The note recorded LN J did not receive instruction to initiate CPR at that time. An anonymous staff member's notarized Witness Statement dated [DATE] documented R1 was a full code and the staff did not perform CPR. The nurse on the Covid-19 unit was unable to access Point Click Care (PCC- a computer system used for resident records). On [DATE] LN J was unavailable for interview. On [DATE] at 11:49 AM LN G stated she worked in facility a few weeks and received instructions for the access to the residents' records when she started. LN G stated the residents' advanced directive wishes were noted on the EMR and there was a printed list of residents who were full codes at the nurses' station. She first noted this list on a sticky note but, the lists were now on a sheet of paper. On [DATE] at 12:14 PM LN H stated she had not worked with the PCC system (a computer system used for resident records) prior to her shift on [DATE]. She did not know R1's code status. She arrived at the Covid-19 isolation unit around 06:40 AM on [DATE]. She received report and counted narcotics with the night shift nurse. She started a medication pass and another nurse told her R1 had no heartbeat or respirations. She stated she entered R1's room and he had no vital signs, his extremities were cold, his trunk was warm, and his neck appeared stiff. She stated she did not start CPR since she did not know R1's code status. On [DATE] at 12:34 PM CNA M stated she was on the opposite end of the hall when the incident occurred on [DATE]. She reported documentation of the residents' code status was in the PCC records. On [DATE] at 01:41 PM Administrative Nurse D stated residents' code status was found in the PCC records. She expected the staff to initiate CPR when the records indicated the resident was a full code. On [DATE] at 03:51 PM LN H stated she obtained vital signs on R1 between 07:00 AM and 07:30 AM on the morning of [DATE]. At that time, his mouth was open, and his respirations were rapid. He was on five liters of supplemental oxygen. LN H stated she assumed R1 had a Do Not Resuscitate (DNR-an advanced directive to withhold resuscitative measures) order since he was on the Covid-19 unit, so she did not need to call the physician with his change in status or start CPR. On [DATE] at 12:57 PM Physician Consultant GG stated respirations above 24 breaths per minute and a pulse above 85 beats per minute were a sign of [MEDICAL CONDITION] (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead). He expected nurses to notify him of respirations of 46 breaths a minute, a blood pressure of ,[DATE] mmHg, or an oxygen saturation level of 87%. The facility's Advance Directives policy revised [DATE] documented the residents have the right to self-determination regarding their medical care. This includes right of an individual to direct his/or her own medical treatment, including the right to execute or refuse to execute and advance directive. The Admissions Director or designee interviews the resident and/or family upon admission to determine the need and knowledge relative to advance directives. Regardless of whether the resident is in a persistent vegetative state or has a terminal condition, all Life Care Centers of America's residents receive full resuscitative measures unless a DNR is written in the resident's medical record and is identified in the resident's Advanced Directive. The facility's Cardiopulmonary Resuscitation (CPR) Guidelines revised [DATE] recorded the facility was able and does provide emergency basic life support immediately when needed. It further documented if a resident experienced a cardiac or respiratory arrest in the resident does not show signs of irreversible death (rigor mortis (stiffening of the joints and muscles of a body a few hours after death), dependent lividity (a purplish red discoloration of the skin following death), decapitation (to cut of the head), transection (creation of a cut or division of a body part) or

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 IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	7541 SWITZER ROAD OVERLAND PARK, KS 66214

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) decomposition (process of breaking down an organic matte) facility staff must provide basic life support including CPR. The facility failed to provide resuscitative measures to R1 whose advance directives and physician's orders [REDACTED]. The facility also failed to ensure the nursing staff knew the process for confirmation of a resident's code status. These failures resulted in the non-adherence to R1's wish for resuscitative measures and R1 was pronounced dead in the facility. This deficient practice had the potential to place all residents on the Covid-19 unit, who desired a full code, in immediate jeopardy. The facility removed the immediate jeopardy when it implemented the following: The Staff Development Coordinator or designee re-educated facility nursing staff, agency nursing staff and therapy staff currently on duty on where to locate code status, and when to initiate CPR, per Cardiopulmonary Resuscitation Guidelines Policy, if a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident's advance directives and any related physician order, such as code status, or in accordance with the documented verbal wishes of the resident or the resident's representative while the physician's orders [REDACTED]. The Staff Development Coordinator or designee will reeducate facility nursing staff, agency nursing staff and therapy staff prior to working their next scheduled shift on where to locate code status, and when to initiate CPR, per Cardiopulmonary Resuscitation Guidelines Policy, if a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident's advance directives and any related physician order, such as code status, or in accordance with the documented verbal wishes of the resident or the resident's representative while the physician's orders [REDACTED]. ADHOC QAPI Meeting was held on [DATE] with the QAPI Committee and Medical Director via telephone to address the alleged deficient practice incident that occurred on [DATE]. The Director of Nursing or designee audited current in house residents to verify the code status was accurate and Resident's Profile Screen, Care Plan and Kardex were updated accordingly. The agency staff are no longer employed at the facility. This deficient practice remains at the scope and severity of a G.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 116 residents. The sample included five residents. Based on record reviews and interviews, the facility failed to ensure Resident (R) 1 received treatment and care in accordance with professional standards of practice when the facility failed to notify the physician with potentially life-threatening vital signs. R1 expired in the facilty before the physician was notified of his vital signs. Findings included: - The [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R1 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. R1 required extensive assistance of one to two staff members for dressing, bed mobility, transfers, toileting, eating, and personal hygiene. The Quarterly MDS dated [DATE] revealed no changes in R1's BIMS score. R1 required extensive assistance of one to two staff members for dressing, bed mobility, transfers, toileting, and personal hygiene. R1 required supervision with set up help with eating. The Cognitive Loss and Dementia Care Area Assessment (CAA) dated [DATE] documented R1 had inattention and disorganized thinking. The Care Plan dated [DATE] revised [DATE] documented R1 was at risk for COVID-19 and directed staff to perform routine respiratory User Defined Assessments (UDA) as scheduled and to obtain routine vital signs not included in the respiratory UDA. The Care Plan directed staff to follow oxygen saturation parameters as indicated and to notify physician and responsible party if respiratory condition developed. The care plan directed staff to clean nebulizers per policy if indicated and weekly replacement of oxygen tubing and nebulizer components if indicated. The Care Plan dated [DATE] documented R1 had potential exposure to COVID-19 and directed staff to observe for changes in level of consciousness, mental status, and lethargy as needed. The Orders tab of R1's EMR documented an order with a start date of [DATE] for full code (resuscitative measures). The Orders tab of R1's EMR documented an order with a start date of [DATE] for oxygen up to five liters per minute to maintain oxygen saturation at or above 90 percent (%). The Progress Notes tab in EMR revealed progress note on [DATE] at 06:38 AM documented R1's oxygen saturation dropped to 80% at 01:15 AM and the physician was notified. New orders were obtained for a chest x-ray, laboratory blood work was ordered. The physician also ordered supplemental oxygen use at two liters per minute. The oxygen was administered and R1's oxygen saturation level rose to 93%. At 12:50 PM R1's oxygen saturation level dropped to 80%, his temperature was 99.8 F. He had a productive cough and congestion. The physician was notified and ordered Tylenol (medication used to lower body temperature) 1000 milligrams orally every four hours as needed for and elevated temperature and to increase the supplemental oxygen to be administered at five liters per minute. At 08:27 PM R1 had crackles in his lungs. He had a [DIAGNOSES REDACTED]. He was repositioned and an air mask (a plastic mask which covers the nose and mouth to deliver oxygen) was secured to deliver five liters of supplemental oxygen per minute. The progress notes on [DATE] at 09:36 documented R1 was under isolation for suspected Covid-19. His oxygen saturation levels were up to the lower limits when on supplemental oxygen at five liters per minute at 09:36 AM. At 01:09 PM his laboratory results were positive for Covid-19. At 08:05 PM his pulse was regular at 90 beats per minute, blood pressure was ,[DATE], and his respirations were 18 per minute. The Weight/Vitals tab in EMR revealed R1's blood pressure on [DATE] at 07:15 AM was ,[DATE] millimeters of mercury (mmHg) and oxygen saturation (the fraction of oxygen saturated hemoglobin relative to total hemoglobin in the blood) was 87% on high flow supplemental oxygen, R1's respirations at 07:50 AM were 46 breaths a minute. The EMR lacked documentation of physician notification for the above vital signs. The progress notes on [DATE] at 09:10 AM documented another nurse made rounds and found resident not breathing with no heartbeat. Licensed Nurse (LN) H entered R1's room and observed R1 was not breathing nor had a heartbeat. LN H notified R1's wife and Director of Nursing at 09:15 AM, the physician at 09:16 AM, and the medical examiner at 09:21 AM. On [DATE] at 03:51 PM, LN H stated she had seen R1 at the beginning of the shift to do vital signs and his mouth was open and his respirations were rapid. She stated did not call the doctor about the vital signs and did not start CPR because she thought since R1 was on the COVID unit, he was a no code (do not resuscitate). LN H stated she notified the doctor after R1 died . On [DATE] at 04:28 PM, Administrative Nurse D stated she would expect the nurse to check code status if a blood pressure is abnormal, look at previous blood pressures to see what they had been, and to call the doctor. She stated she expected the nurse to use her nursing education. On [DATE] at 12:57 PM, Consultant GG stated he had parameters for vital signs but did not know where the facility kept them, but he expected to be called with abnormal vitals such as respirations greater than 24 and heartrate greater than 95. Consultant GG stated those may be signs of [MEDICAL CONDITION] and he should have been notified of R1's abnormal vital signs. The Change in Resident's Condition or Status Policy last reviewed [DATE] documented the facility must immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status which included a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications The facility must immediately consult with the resident's physician when there was a need to alter treatment significantly which included a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. The facility failed to ensure a cognitively impaired resident received treatment and care in accordance with professional standards of practice when they failed to identify a change in R1's health status as evidenced by abnormal vital signs on [DATE] and failed to notify the physician. R1 was pronounced dead in the facilty on [DATE].