STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175254	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SEDGWICK	712 N MONROE AVENUE, BOX 49 SEDGWICK, KS 67135

(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 The following citations represent the findings of complaint investigation #KS 147202. This 2567 was electroncially sent to the facility on 11/7/19.	F 000		
F 678 SS=J	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: A complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 11/01/19. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 11/01/19 at 5:00 P.M., the facility administrator was provided a copy of the IJ template and informed of the IJ. The facility reported a census of 56 residents and identified 5 with hospice services. Of the 56 residents the facility also identified 40 residents with a full code status, leaving 16 residents with a Do Not Resuscitate (DNR) code status. Based on interview and record review the facility had 4 hospice residents with DNR codes and 1 Resident (R) 1 with a full code status. The staff failed to provide CPR (cardiopulmonary	F 678	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 678	Continued From page 1	F 678		

resuscitation) to R1 when he was found unresponsive and without vital signs present.

Findings included:

- The electronic medical record (EMR) for Resident (R) 1 revealed the facility re-admitted the resident on 09/14/19 following a hospital stay. The readmission physician orders evidenced the resident returned to the facility with a diagnosis of metastasized cancer (cancer that has spread to other organs) to the bone.

The significant change "Minimum Data Set" (MDS), dated 09/26/19, identified the resident with a Brief Interview for Mental Status score of 15/15, indicating cognition intact. The resident required extensive assistance with all activities of daily living except eating.

The "Care Area Assessment" (CAA) dated 09/26/19 for "Activities of Daily Living" (ADLs) included the resident required one staff member for assistance with ADLs, except eating.

The Care Plan, dated 09/26/19, included the resident's need for extensive assistance of one staff member for all ADLs, except eating. The care plan included, on 07/09/19 that the resident had a full code status.

R1's "Physician Orders" dated 07/09/19, included an order for Full Code Status (to provide CPR if no pulse or breath). A 9/26/19 physician's order stated, "Admit to hospice for end of life care." The EMR lacked a change in code status.

The "Facility Investigation" verified, on 10/29/19 at 04:30 AM, certified nurse aide (CNA) E entered

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F 678	Continued From page 2	F 678		

R1's room to answer the roommate's call light. While in the room the CNA assisted the roommate. When finished the CNA pulled the privacy curtain open between the residents at approximately 4:40 AM and noted R1 was without pulse or respirations. After R1 failed to respond to a tap on the shoulder, CNA E called for Licensed Nurse (LN) C. Then LN C assessed the resident and provided sternal rub with no response. LN C notified hospice but failed to perform any Cardiopulmonary Resuscitation "CPR" to the resident when found without pulse or respirations. In a notarized statement, written on 10/29/19, LN C documented she assumed since the resident was in end stage cancer and on hospice, he had a DNR (do not resuscitate) order. At that time (approximately 5:00 AM) she made no attempt to verify the resident's code status, but later noted in the record the resident had a full code status.

On 11/01/19 at 9:20 A.M., Administrative Staff A reported the facility suspended licensed nurse C on 10/29/19, reported the incident to the State complaint report hot line, and investigated the lack of CPR provided to the resident with a full code.

On 11/01/19 at 2:00 PM, Social Service Designee (SSD) D verified meeting with R1 and the resident's sister after the resident decided to sign onto hospice services for end of life care, on 09/25/19. During the meeting, R1 appointed his sister as his Durable Power of Attorney (DPOA). The sister then realized the cancer had spread and she became very upset and cried. The resident commented to SSD D that due to his sister's reaction he would not consider putting a DNR in place which would upset her more.

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F 678	Continued From page 3	F 678		

On 11/01/19, interviews with four licensed nurses on duty, including LN F at 9:40 AM, LN G at 10:10 AM, LN H at 2:15 PM and LN I at 3:40 PM, all reported that the residents' code status were identified on their report sheets, as well as in the paper and electronic charts.

On 11/01/19 at 2:20 PM, Administrative Licensed Staff B verified the facility always had at least one staff member with a current CPR certification on duty on each shift.

On 11/02/19, interviews with seven CNA/CMA (Certified medication Aide) staff members including CNA J at 9:45 AM, CMA K at 10:20 AM, CNA L at 10:30 AM, CMA M at 10:40 AM, CNA N at 1:50 AM, CMA O at 2:00 PM and CNA P at 2:30 PM, all reported they carried the code status of each resident on their pocket care records.

On 11/01/19 at 5:00 PM, Administrative Staff A and Administrative Licensed Staff B were informed that the facility was in immediate jeopardy, past non-compliance after they completed the following prior to surveyor entrance on 11/01/19 at 9:15 A.M.:

a). Special Quality Assurance and Performance Improvement meeting held on 10/29/19 at 2:30 P.M., with plans to correct the incident.
b). All staff re-education related to CPR and the facility policy completed on 10/30/19 at 3:30 P.M.
c). All resident charts reviewed for code status and orders verified to assure accuracy for the total census of 56 residents.
d). Code drills completed on all shifts on 10/29/19 and 10/30/19 .
e). The facility plan included to continue to provide CPR training for all employees.

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F 678	Continued From page 4 The facility policy effective and last reviewed in 12/2018 included: CPR will be initiated when cardiac arrest occurs for residents who have requested CPR in their advanced directives, or who do not have valid DNR order signed by a physician. The facility staff failed to check code status and provide CPR to the resident who was a full code, when staff found the resident without pulse or respirations. This placed the resident in immediate jeopardy.	F 678		