

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

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/05/2017
NAME OF PROVIDER OR SUPPLIER LAKEPOINT WICHITA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1315 N WEST STREET WICHITA, KS 67203		
(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 155 SS=J	<p>The following citations represent the findings of the complaint investigation #113849.</p> <p>483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>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.</p> <p>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.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(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.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(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.</p> <p>(iv) If an adult individual is incapacitated at the</p>	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	<p>Continued From page 1</p> <p>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.</p> <p>(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.</p> <p>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 had a census of 93 residents with 3 residents sampled. Based on interview and record review, the facility failed to follow the advanced directives (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) for 1 of 3 sampled residents. Resident #1 expressed a desire for cardiopulmonary resuscitation (CPR- emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure) in the event he/she experienced a lack of pulse/respirations. Staff entered the resident's room and found the resident unresponsive and without respirations. Staff failed to initiate CPR per the resident's</p>	F 155			

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F 155	<p>Continued From page 2</p> <p>advanced directives and the resident expired. The facility's failure to honor resident #1's desire for cardiopulmonary resuscitation placed the resident in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's paper medical record revealed the resident's name label on white paper which the facility said meant the resident was a full code (to provide emergent measures in an attempt to resuscitate should the heart stop). The first page of the record included the profile information about the resident and the sheet was in a clear sleeve which meant a full code as opposed to a red colored sleeve meaning do not start CPR. Within the typed information of the profile sheet was a code status which also identified the resident's desire to be a full code. <p>Review of the entry minimum data set (MDS) dated 3/21/17 revealed the resident admitted to the facility on 3/21/17.</p> <p>The initial care plan dated 3/21/17 lacked information about the resident's advance directives (a written document which indicated the medical decisions for health care professionals when the person could not speak).</p> <p>On 3/22/17 at 9:43 AM social services made an admission note which included the resident's desire to be a full code.</p> <p>On 3/24/17 at 12:51 AM a nurse wrote the patient continued on 72 hour (new admission) charting. The resident was alert and oriented, denied pain or discomfort at this time. The nurse assessed the resident's respirations as even and</p>	F 155			

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F 155	<p>Continued From page 3 non-labored with an oxygen saturation of 92%.</p> <p>The nurse's note dated 3/26/17 at 3:05 PM noted body released to the mortuary at 6:55 AM.</p> <p>A late entry note made on 3/29/17 at 3:31 PM for the events of 3/26/17 at 4:30 AM included the nurse received notification from direct care staff (B) of a need for assistance in the resident's room. Upon entering the room the direct care staff B stated and pointed at the resident he/she "is not breathing". The nurse noted the resident's left arm was outstretched and over the edge of the bed at an even angle with purple colored fingers. The nurse noted the resident's half opened right and closed left with the left side of his/her face drooping and his/her lips were blue. The nurse attempted to place the resident's arm on the bed, however the arm would not stay and his/her extremity felt very cold. The nurse checked for a pulse on the resident's wrist with none noted. The nurse noted the resident felt very cold and the nurse placed his/her left hand on the resident's chest to feel for respirations while he/she listened for a heartbeat with a stethoscope over the resident's chest and noted no pulse or respirations. The nurse indicated the resident's chest felt very cold as well. He/she performed a sternal rub (painful stimuli applied to the breastbone applied to a person who is not alert and does not respond to verbal stimuli) watching the resident for any body movement with none noted. The nurse indicated after noting the body's cold temp to the trunk and extremities and the coloring of the resident's fingers and lips along with no pulse or respirations that he/she went to nurses' station and called the adult day care provider. He/she informed the licensed nurse who answered the phone of his/her</p>	F 155			

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F 155	<p>Continued From page 4</p> <p>assessment of the resident and asked if he/she should start cardiopulmonary resuscitation (CPR- emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure).</p> <p>Interview on 3/29/17 at 12:30 PM with direct care staff A revealed he/she worked the night of 3/25/17 into the morning of 3/26/17 but was not assigned to care for the resident. He/she reported seeing direct care staff B run to the nurses' station and then staff B and licensed nurse D ran back towards 200 hall. Then when staff B and nurse D returned to the nurses' station he/she went to see what was wrong and found out the resident had passed away. He/she assisted staff B to prep the body for the mortuary. He/she said the resident's left arm was outstretched off the bed and his/her left hand was purple on the tips but his/her body was warm. He/she reported asking the nurse if the resident was a full code and received no response then another direct care staff member entered the room and direct care staff A exited. He/she reported only visualizing the front of the resident's body and saw the resident's legs were blotchy but not different than his/her normal coloring.</p> <p>The notarized statement by direct care staff A obtained on 3/29/17 revealed the same basic information as the above interview. However, the statement indicated a timeline of about 10 minutes from the time staff A saw the licensed nurse D and direct care staff B leave the nurses' station before he/she went to the nurses' station to learn of the resident's death.</p> <p>Interview on 3/29/17 at 1:32 PM with direct care staff B revealed he/she was assigned to care for</p>	F 155			

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F 155	<p>Continued From page 5</p> <p>the resident on the 10:00 PM-6:00 AM shift 3/25/17 into 3/26/17. On 3/26/17 at about 3:30 AM he/she went to the resident's room and thought the resident looked different. He/she indicated the room lights were out with only the light from the hallway to light the room. Staff B said he/she put his/her hand under the resident's nose and felt no air so he/she pulled back the covers and he/she did not see the resident's chest moving. He/she immediately called out for help but no one was in the area so he/she ran towards the nurses' station and he/she told licensed nurse D to grab a stethoscope there was an emergency. Staff B said when he/she and nurse D got back to the resident's room and turned on the light he/she saw the resident's eyes were open, his/her left arm was outstretched off the bed which was normal for him/her but the fingertips were purple. Staff B said when he/she moved the resident's arm back onto the resident's chest the color came back a little to his/her fingertips. He/she said the resident's body was still warm and repeated the resident's fingers were purple from hanging off the bed but when he/she moved the arm the color came back. Staff B reported the resident's skin did not have discoloration anywhere other than the left fingertips. Staff B reported he/she waited in the room for nurse D to come back and he/she never did. Staff B went to the nurses' station and asked the nurse, "What are you going to do?" and the nurse responded the resident "is gone. There is nothing anyone can do."</p> <p>Interview on 3/29/17 at 2:18 PM with licensed nurse D revealed he/she had experience with performing CPR before. He/she reported the resident's code status is on the chart and knew the location. He/she said he/she was coming</p>	F 155			

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F 155	Continued From page 6 back to the area from a different hall when he/she heard voices and saw direct care staff B in the nurses' station looking around. Nurse D said, staff B said to him/her "you need to come" and when the nurse asked why staff B just said, "you need to come". When he/she got to the resident's room around 3:55 AM staff B said, "see the resident was not breathing". The nurse indicated he/she looked at the resident and saw his/her left arm outstretched off the bed and when he/she attempted to put the resident's arm back on the bed the arm immediately flopped back. He/she indicated the arm moved freely and was not stiff but the fingertips were blue. He/she felt the resident's wrist for a pulse and felt nothing, so he/she listened to his/her chest with a stethoscope and heard nothing. Nurse D reported the resident felt cold and he/she did a sternal rub watching for any type of body response with none noted. He/she described the resident with blue lips, left eye drooping and closed while the right eye remained half open. He/she reported lifting the sheet and placing his/her hand on the resident's knee and the knees felt cold. He/she did not know the resident's code status and went back to the nurses' station to check the chart and called the adult day care provider. He/she reported his/her assessment of the resident to the nurse who answered the phone who responded let me check with the doctor. The nurse called right back and reported the doctor said to start the facility's death protocol. Nurse D reported he/she asked the nurse on the phone whether the doctor wanted him/her to start CPR and the nurse" responded no, this time it is ok because of the assessment but in the future need to start CPR". Nurse D reported he/she did not start CPR because he/she felt like the resident was "too far gone" per his/her nursing judgement. He/she	F 155			

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F 155	<p>Continued From page 7</p> <p>reported upon hiring he/she received a stack of policies, "I should have read them and may have but can't honestly say that I did". He/she did not know it was the facility's policy to start CPR regardless of the resident's condition.</p> <p>Interview on 3/29/17 at 11:45 AM with administrative nurse C revealed all full code residents were to have CPR started regardless of how long the resident may have been without respirations and/or pulse per the facility policy.</p> <p>Review of the facility's policy titled Code Status Policy with a revised dated of 4/6/15 included the code status was noted on the white face sheet placed in the front of the resident's chart in a clear sleeve indicating full code status. Any nurse could and should initiate CPR on a full code resident. Before starting chest compressions, staff should place the resident on the floor and/or a hard surface. The nurse would start chest compressions immediately and not stop unless: another nurse came to relieve the nurse, and/or emergency medical staff or fire department took over. The only person that could stop the CPR process was the physician.</p> <p>The facility failed to implement the advanced directives of resident #1 in regards to staff's failure to start CPR when the resident stopped breathing and did not have a pulse on 3/26/17 at approximately 3:55 AM and the resident expired. The facility's failure to honor resident #1's advance directives for CPR placed the resident in immediate jeopardy.</p> <p>The facility abated the immediate jeopardy on 3-31-17 at 4:00 p.m. by implementation of the following measures:</p>	F 155			

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F 155	Continued From page 8 1. Director of Nursing (DON) and Assistant Director of Nursing (ADON) educated licensed nursing staff on 3/27/17 at 2:00 PM on the Code policy which included initiating CPR on all full code residents. 2. The DON and ADON conducted a post test of training to include what to do in a full code situation for licensed nurses to validate the nurses understanding and expectations. 2. Nurses would receive same training upon hire and every 6 months with a post test and review of questions missed. 3. The Administrator and DON revised the CPR/Code policy on 3/30/17 at 4:25 PM to include direct care staff's responsibilities in the event the nurse did not initiate CPR on a full code resident. 4. The DON and ADON educated direct care staff on their responsibility in regards to a full code resident with training. The deficient practiced remained at a scope and severity of a G.	F 155			