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	175380	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

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F 000	INITIAL COMMENTS	F 000		

The following citations represent the findings of comlpaint investigationa nd partial extedned survey KS00171318.

On 05/04/22 at 05:00 PM the facilty ws provided a copy of the "Immediate Jeopardy [IJ] template" and Administrative Staff A was notified of the IJ for R1.

On 04/03/22 at 05:15 AM LN G documented R1 had decreased oxygen saturation at 90 percent (%) (the amount of oxygen present in blood, normal is 95 to 100 %) and confusion. Administrative Nurse E faxed Consultant GG at 06:40 AM on 04/03/22 (Sunday) and reported R1 had noisy, labored breathing which worsened when R1 slept and hallucinations. Facility nursing staff failed to follow up with Consultant GG when no response was received to the fax sent on 04/03/22. On 04/04/22 at 04:51 AM LN G documented R1 was restless, confused, and was difficult to understand. R1 continued to have labored breathing and periods of not breathing for up to 10 seconds followed by gasping breaths. LN G failed to notify R1's physician of the findings. On 04/04/22 at 06:15 AM, LN H observed R1 gasping for air, coughing, and gurgling. LN H called Consultant GG and received a verbal order to send R1 to the hospital. Subsequently, R1 required intubation (insertion of a tube into the lungs to assist with breathing) and was diagnosed with pneumonia (inflammation of the lungs), sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infection which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to

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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 000	Continued From page 1 the medical emergency, septic shock) and respiratory failure. These failures placed R1 in Immediate Jeopardy. On 05/04/22 the facility removed the immediacy. The scope and severity remained at a "G." The 2567 was sent electronically on 05/12/22	F 000		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and	F 726		

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F 726	Continued From page 2	F 726		

techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:

The facility identified a census of 50 residents. The sample included three residents reviewed for quality of life/quality of care. Based on record review and interview, the facility failed to ensure licensed nursing staff possessed the skills and knowledge necessary to act immediately upon changes in Resident (R) 1's health status when Licensed Nurse (LN) G failed to ensure R1's physician received the notification regarding R1's respiratory difficulty and changes in R1's mentation. On 04/03/22 at 05:15 AM LN G documented R1 had decreased oxygen saturation at 90 percent (%) (the amount of oxygen present in blood, normal is 95 to 100 %) and confusion. Administrative Nurse E faxed Consultant GG at 06:40 AM on 04/03/22 (Sunday) and reported R1 had noisy, labored breathing which worsened when R1 slept and hallucinations. Facility nursing staff failed to follow up with Consultant GG when no response was received to the fax sent on 04/03/22. On 04/04/22 at 04:51 AM LN G documented R1 was restless, confused, and was difficult to understand. R1 continued to have labored breathing and periods of not breathing for up to 10 seconds followed by gasping breaths. LN G failed to notify R1's physician of the findings. On 04/04/22 at 06:15 AM, LN H observed R1 gasping for air, coughing, and gurgling. LN H called Consultant GG and received a verbal order to send R1 to the hospital. Subsequently, R1 required intubation (insertion of a tube into the lungs to assist with breathing) and was diagnosed with pneumonia (inflammation of the lungs), sepsis (a systemic

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reaction that develops when the chemicals in the immune system release into the blood stream to fight an infection which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock) and respiratory failure. These failures placed R1 in Immediate Jeopardy.

Findings included:

- R1's diagnosis list in the Electronic Medical Record (EMR) documented he admitted to the facility with diagnoses that included atrial fibrillation (rapid, irregular heart beat), bilateral C1 (first vertebrae [interlocking bones that form the spinal column] in the neck) lamina (thin plate in the cervical vertebrae) fracture, odontoid (a superior projecting bony element from the second cervical vertebrae, or C2), and a left orbital (bones around the eyeball) fracture with severe displacement.

The "Entry Minimum Data Set" recorded R1 admitted to the facility on 03/30/22.

The "Admission Nurses Note," dated 03/30/22, documented R1 admitted from the hospital after a traumatic injury. R1 presented with sutures (a row of stitches holding together the edges of a wound) to his left eyebrow. The number of sutures was unknown due to the amount of swelling, dried drainage and multiple bruises to R1's face, arms, and neck. R1 experienced double vision due to trauma to his left eye. R1 was alert and oriented to person, place, and time. R1's lung sounds were clear to auscultation (the action of listening to the lungs with a stethoscope), with no cough or congestion noted.

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The "Activities of Daily Living Care Plan," dated 03/30/22, directed staff that R1 required one staff assist for bed mobility, transfer, ambulation with front wheeled walker, dressing, and bathing.

The "Baseline Care Plan," dated 03/30/22, documented R1's care needs would be met, R1 was alert and oriented to person, place, and time, R1 answered questions readily, had clear speech, and was talkative.

The "Mood/Behavior Note," dated 04/01/22, documented R1 had been restless at intervals, had removed his neck brace repeatedly, and tried to get up multiple times by himself. R1 stated he was dreaming he was taking off the neck brace.

The "Physician Order Note," dated 04/01/22, documented the nurse contacted Consultant GG regarding R1's complaints of not being able to sleep at night and feeling exhausted during the day. The nurse also reported to Consultant GG R1's continuous oxygen usage as R1's oxygen saturation was 95-96% at all times on room air. Consultant GG ordered trazodone (anti-depressant that aids with sleep) 25 milligrams (mg) to be given daily at bedtime and oxygen as needed.

The "Skilled Nurses Note," dated 04/01/22, documented R1 was alert and oriented to person, place and time with intermittent confusion. R1's lung sounds were clear in all lobes and he continued to have continuous oxygen delivered per nasal canula (tube that delivers oxygen through the nares). The left side of R1's head was swollen. R1 was restless and "up and down."

The "Skilled Nurses Note," dated 04/02/22,

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documented R1 was alert and oriented to person, place and time, lung sounds were clear to auscultation, and R1 was pleasant with nursing staff and other residents.

The "Behavior/Mood Note," dated 04/03/22 at 05:15 AM by LN G documented R1 had been very restless and anxious and was found on his roommates' side of the room. When redirected, R1 became angry and said he was going outside. R1 tried to walk past staff several times to get outside. The note recorded R1 was hallucinating. R1 believed he had a piece of string that needed to be tied and tried to hand the imaginary string to the nurse. LN G assessed R1's oxygen saturation and R1's oxygen saturation was 90%. LN G applied oxygen and notified Administrative Nurse E. The note lacked evidence LN G assessed and recorded R1's lung sounds.

The "Status Note," dated 04/03/22 at 06:40 AM (Sunday), documented Administrative Nurse E reported to Consultant GG via fax that R1 had noisy, labored breathing which worsened when R1 slept and reported R1 hallucinated.

The facility documentation and R1's clinical record lacked evidence of follow up with Consultant GG when no response was received to the fax sent on 04/03/22 at 06:40 AM.

The "Behavior/Mood Note," by LN G dated 04/04/22 at 04:51 AM, twenty-three hours later, documented R1 was restless, confused, and was difficult to understand. R1 continued to have labored breathing and periods of not breathing for up to 10 seconds followed by gasping breaths.

R1's clinical record lacked evidence nursing staff

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notified R1's physician of the findings and lacked evidence LN G assessed R1's lung sounds and oxygenation status.

In an "ER [emergency room] Visit Note," dated 04/04/22 at 06:15 AM, LN H documented R1 gasped for air, coughed, and was gurgling. LN H documented R1 was unable to speak due to shortness of breath. R1's oxygen saturation was 83-88% on 3 liters of oxygen. LN H called Consultant GG and received a verbal order to send R1 to the hospital.

The "Emergency Room Documentation," dated 04/04/02 at 07:07 AM, documented R1 had audible stridor (a harsh vibrating noise when breathing). R1's upper airway required suctioning (using suction to clear mucous) and revealed a fair amount of discolored slightly bloody discharge. The emergency room's assessment of R1 revealed pneumonia, respiratory failure, and sepsis. The emergency room doctors intubated R1 and transferred him to another hospital with a higher level of care.

On 05/04/22 at 11:30 AM, Administrative Staff A stated she reviewed the documentation regarding R1. Administrative Staff A stated the nurses failed to perform a skilled nursing assessment twice a shift for R1 and when the changes started happening, they did not notify the primary care physician or family. Administrative Staff A stated nursing can pick up the phone any time and call for emergency services to take a resident to the hospital.

On 05/04/22 at 01:00 PM, Certified Nurse Aide (CNA) M, stated when she came to work on 04/04/22 R1 was "really struggling to breath" and

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he appeared very anxious and panicked.

On 05/04/22 at 01:15 PM, Certified Medication Aide (CMA) R, stated that she worked the whole weekend with R1, and he was anxious and restless all the time. CMA R stated nursing staff tried to make him comfortable but were unsuccessful.

On 05/04/22 at 01:30 PM, Administrative Nurse D stated that if a resident was having difficulty breathing and hallucinating, she would expect the nurses to call the physician so the resident could be seen in the emergency room immediately.

On 05/04/22 at 02:00 PM R1's representative stated R1 hallucinated and seemed to be having difficulty breathing on 04/03/22 during a visit. R1's representative stated the observations were relayed to facility nursing staff though no actions appeared to be taken at that time

On 05/04/22 at 15:11 PM, Consultant GG stated if a resident was having difficulty breathing, difficulty with maintaining adequate oxygenation, and/or hallucinating she expected the facility nurses to call her, or the doctor on call, to report their findings.

On 05/04/22 at 04:00 PM, LN G stated R1 had difficulty with breathing since his admission. LN G stated she was able to identify when a resident needed to go to the hospital, and she did not feel that R1 needed to go to the hospital when she cared for him on 04/03/22 through the morning of 04/04/22.

The facility's "Notification of Attending Physician" policy, revised April 2018, documented the

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attending physician and legal representative would be notified promptly of any sudden and/or marked adverse change in signs, symptoms, or behavior exhibited by the resident. The facility's inability to obtain or administer prompt and timely drugs, equipment, supplies, or services as prescribed under conditions which present a risk to the health, safety, or security to the resident.

The facility failed to ensure licensed nursing staff possessed the skills and knowledge necessary to act immediately upon changes in R1's health status when nursing staff failed to ensure R1's physician received the notification regarding R1's respiratory difficulty and changes in R1's mentation. Facility nursing staff failed to follow up with Consultant GG when no response was received to a fax communication. Subsequently, R1 was sent to the hospital on 04/04/22, required intubation and was diagnosed with pneumonia, sepsis and respiratory failure. These failures placed R1 in Immediate Jeopardy.
On 05/04/22 the facility submitted a plan to remove the immediacy and implemented the following:
Involved nursing staff received education and disciplinary action related to the lack of assessments and failure to identify and/or report a change in resident status.
All licensed nursing staff received education on change of condition and physician notification requirements (both regulator and facility policy and procedure).
All nursing assistants received education on change of condition and communication of resident status and/or changes to licensed nurses.
The deficient practice remained at a scope and

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