STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 11/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 #167362. 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 11/29/21. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. This 2567 was electronically sent to the facility on 12/07/2021.	F 000		
F 678 SS=K	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: The facility reported a census of 40 residents with 13 included in the sample. Based on interview and record review, the facility failed to initiate cardiopulmonary resuscitation (CPR-emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.) on one sampled Resident (R)1, who had a "Full Code" (CPR desired to be performed if found without respiration and/or a pulse) status when staff found her unresponsive and without a pulse. This failure had the potential to also affect the 13 other residents of the facility that desired resuscitation which could lead to serious harm or death. This	F 678		

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

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practice placed the other 13 residents in immediate jeopardy.

Findings included:

- The "Medication Review Report," dated 11/11/21, for R1, included diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, iron deficiency anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), congestive heart failure (CHF, a condition with low heart output and the body becomes congested with fluid), Atrial fibrillation (rapid, irregular heartbeat), and hypothyroidism (condition characterized by decreased activity of the thyroid gland).

The "Admission Minimum Data Set" (MDS), dated 10/28/21, assessed R1 with a "Brief Interview of Mental Status" score of 13, which indicated intact cognition.

The "Care Plan," initiated 10/21/21, indicated that R1 was a full code and instructed the staff to attempt resuscitation.

The Electronic Medical Record (EMR), under the "Orders" tab, indicated R1 had a status of "Full Code."

The "Progress Notes," dated 11/23/21 at 05:55 AM, revealed unidentified facility staff called Licensed Nurse (LN) G to R1's room at 05:05 AM where she was found to be absent of vital signs. The note lacked information regarding the resident's code status and/or if staff initiated

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CPR.

The "Progress Notes" dated 11/23/21 at 06:00 AM revealed R1's color was grayish/yellow with a waxy appearance, eyes fixed, face drawn with her jaw slightly ajar, and her body very cool to the touch and difficult to manipulate. The staff could not locate a pulse when assessed apical, brachial, or pedal. The follow-up note lacked information to include if the staff checked her code status and initiated CPR.

On 11/29/21 at 10:12 AM, Certified Nurse Aide (CNA) M stated she was not CPR certified. She went into R1's room on 11/23/21 at 05:00 AM and she was not moving, her hands were cold, her face was warm, and her eyes and mouth were open. CNA M stated she did not know what to do so she went and got Certified Medication Aide (CMA) R. He entered the resident's room, looked at R1, then went and told LN G, who responded and listened for R1's heartbeat. The staff present did not attempt CPR.

On 11/29/21 at 10:31 AM, CMA R stated he was CPR certified. CMA R further explained on 11/23/21 at 05:00 AM, CNA M alerted him that R1 was not breathing. CMA R went into R1's room and she looked like she had passed away. CMA R alerted LN G and assessed the resident for a pulse on her neck, which was warm, and noted he did not feel one. CMA R stated R1's color was pale, with her eyes and mouth open. CMA R stated the nurse did not have him check for R1's code status or instruct him to initiate CPR and LN G did not initiate CPR.

On 11/29/21 at 12:47 PM, LN G stated she was three to four rooms down the hall from R1's room

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when CMA R stated that "[R1] was gone." LN G grabbed her stethoscope, assessed skin temperature, and stated R1 was "very cold" on her arm, feet, and her face. LN G stated she did not hear or feel a pulse, her arm was "kind of stiff, difficult to manipulate," and her skin was gray/yellow in color with a "waxy" appearance. LN G stated she did not check R1's code status and did not initiate CPR as she thought R1 was "gone and there was nothing that I could do, it would have not changed the outcome."

On 11/29/21 at 01:51 PM, Administrative Nurse D stated she expected LN G to start CPR when R1 was found unresponsive.

The facility policy "Emergency Procedure-Cardiopulmonary Resuscitation," dated 02/01/21, included that if an individual (resident, visitor, or staff member) was found unresponsive and not breathing normally, a licensed staff member who was certified in CPR/BLS shall initiate CPR unless: it was known that a DNR [Do Not Resuscitate] order that specifically prohibits CPR and /or external defibrillation exists for that individual; or there are obvious signs of irreversible death (e.g., rigor mortis) and/or the performance of CPR would be medically futile. Begin CPR if the adult victim is unresponsive not breathing normally (ignoring occasional gasps), and without a pulse.

The facility failed to initiate CPR on R1, who had a "Full Code" status when staff found her unresponsive and without a pulse. This failure to initiate CPR for residents that desire resuscitation had the potential to lead to harm or death. This practice placed R1 and 13 other residents of the facility with a "Full Code" status in immediate

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F 678	Continued From page 4 jeopardy. On 11/29/21 at 04:40 PM, Administrative Staff A was provided a copy of the Immediate Jeopardy (IJ) template, informed of the IJ, and notified immediate action was needed to ensure staff initiate CPR for residents who desire resuscitation. The facility provided an acceptable plan for removal of the immediate jeopardy on 11/29/21 at 05:12 PM. The removal plan included a full house audit for code status, training of all employees on requirements of performing CPR, CPR education of all future employees on CPR education, audits to validate staff knowledge of the facility emergency procedure, with results of audits forwarded to the Quality Assurance Performance Improvement (QAPI) committee for review. The survey team validated the immediate jeopardy was removed on 12/01/21 at 09:00 AM/PM, following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at an E scope and severity, following the removal of the immediate jeopardy.	F 678		