STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E197	A. BUILDING _____ B. WING _____	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOKS CO SENIOR SERVICES INC DBA REDBUD VILLAGE	1000 S WASHINGTON STREET PLAINVILLE, KS 67663

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00175234. The 2567 was sent electronically on 11/04/22.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents with three reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 received the necessary respiratory services when staff failed to perform a respiratory assessment upon R1's report of feeling short or breath. The facility further failed to ensure an appropriate amount of full oxygen tanks to meet the needs of R1. This deficient practice placed R1 at increased risk for respiratory distress and/or complications. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and	F 695		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/04/2022

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F 695	Continued From page 1	F 695		

difficulty or discomfort in breathing), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and benign prostatic hypertrophy (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections).

The "Admission Minimum Data Set (MDS)," dated 10/02/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of eleven, which indicated moderately impaired cognition. The MDS documented R1 required limited assistance of one staff for all activities of daily living. The MDS further documented R1 was on oxygen and had shortness of breath with exertion (walking, bathing, transferring).

The "Activities of Daily Living (ADL) Care Area Assessment (CAA)," dated 10/02/22, documented R1 required assistance with ADLs due to becoming short of breath related to a diagnosis of COPD and being dependent of supplemental oxygen.

The "Oxygen Therapy Care Plan," dated 10/02/22, directed staff R1 was on four liters (L) of oxygen continuously. It directed staff to provide R1 with a portable oxygen cannister while out of his room or in his wheelchair, and to monitor R1 for signs and symptoms of respiratory distress (respirations, pulse oximetry, restlessness, increased heart rate, and accessory muscle usage).

The "Electronic Medication Administration Record (EMAR)," dated October 2022, directed staff to give morphine sulfate concentrate solution 20 milligrams (mg) per 1 milliliter (ml) administer 0.5

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ml by mouth every one hour as needed for shortness of breath or pain.

A" Communication with Physician" note dated 10/04/22 documented staff contacted the urologist (doctor who specializes in the urinary system) due to concerns with R1's suprapubic catheter (tube inserted through the abdominal wall into the bladder to drain urine). Staff received instruction to remove the catheter and reinsert and if continued issues to transfer R1 to the hospital for further treatment.

The "Emergency Department Report," dated 10/4/22, documented R1 arrived to the emergency department in respiratory distress and was placed on a bilevel positive airway pressure (BIPAP-a non-invasive ventilation (breathing) machine to support breathing with oxygen through a mask under positive pressure) and R1's respiratory status improved. R1 was admitted to the hospital with pneumonia, and sepsis.

The "Facility Incident Report," dated 10/16/22, documented on 10/04/22 at approximately 05:00 PM, the facility received a new order to transfer R1 to a higher level of care 23 miles away for complication related to his suprapubic catheter. Licensed Nurse (LN) G assisted R1 from his recliner to his wheelchair and placed his portable oxygen on R1 at 4L per nasal cannula. R1's portable oxygen cannister was half full. R1 was assisted down to the van where Activity Director/Van Driver Z placed R1 into the facility van; R1 was short of breath at that time. R1 stated he did not feel like he had oxygen on and wanted morphine for his shortness of breath. R1's representative went back into the facility to ask

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facility staff for the morphine and for staff to check his oxygen. CMA R came out to the facility van to give R1 0.5 mg of morphine and checked the oxygen cannister. The oxygen cannister was between a quarter to a half full. R1's oxygen was noted to be at 2.5 L, so CMA R increased the oxygen back up to 4 L. CMA R went back into the facility to obtain a full oxygen cannister and there were not extra full oxygen cannisters available. CMA R reported to LN G that there were no full oxygen cannisters available to send with R1. CMA R notified Activities Director/Van Driver Z to let the hospital know that R1 needed to be put on the hospital oxygen immediately.

R1's medical record lacked evidence of a nursing assessment when R1 reported he felt short of breath on 10/04/22 on the transport van. The record lacked evidence a licensed nurse assessed R1 oxygen saturation, lung sounds or respiratory stability prior to the non-emergent transfer.

On 10/25/22 at 11:00 AM, observation revealed R1 sat in his recliner with his oxygen on via nasal cannula at 4 L. R1 was not short of breath while sitting in his chair.

On 10/25/22 at 11:00 AM, R1 stated the facility should have sent him to the hospital by ambulance.

On 10/25/22 at 01:00 PM, LN G stated that she had helped R1 get ready for the transfer to the hospital and he was short of breath at that time which was R1's normal status with activity. LN G stated R1's oxygen cannister was half full at that time and she made sure the oxygen was on at 4 L. LN G stated that she had not performed a

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F 695	Continued From page 4	F 695		

respiratory assessment or obtained an oxygen saturation reading prior to the morphine being administered to R1. LN G stated if R1 was in respiratory distress, he should go to the hospital via ambulance instead of the facility van.

On 10/25/22 at 01:15 PM, CMA R stated that she had been instructed to give R1 0.5 ml of morphine on 10/04/22 and when she went to the van she observed R1 was short of breath and checked his oxygen setting and it was at 2.5 L of oxygen. She increased the oxygen up to 4 L and checked the oxygen cannister and it was between a quarter to half full, so she went in to get a full oxygen cannister and the facility did not have any full one, all were at half or less.

On 10/25/22 at 02:00 PM, Administrative Nurse D stated the facility did run out of full oxygen cannisters two days prior to cannisters being delivered; the facility has since increased the amount of oxygen cannisters they receive. Administrative Nurse D stated that she expected her nurses to perform a respiratory assessment and obtain oxygen saturations prior to morphine being administered for shortness of breath.

The facility's undated "Medical and Dental Transportation for Residents Policy" documented when a resident requires the use of oxygen the charge nurse will obtain a portable tank and appropriate stand and have available at time of pick up.

The facility failed to ensure R1 received the necessary respiratory care and services when staff failed to perform a respiratory assessment upon R1's report of feeling short or breath. The facility further failed to ensure an appropriate

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F 695	Continued From page 5 amount of full oxygen tanks to meet the needs of R1. This deficient practice placed R1 at increased risk for respiratory distress and/or complications.	F 695		