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 12/05/2022

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

(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 are the result of complaint investigation KS00176445 and KS00175819. The 2567 was sent electronically on 12/19/22.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §483.10(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. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/19/2022

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F 578	Continued From page 1	F 578		

may give advance directive information to the individual's resident representative in accordance with State law.
(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.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents with three reviewed for advanced directives and Do Not Resuscitate (DNR) status. Based on observation, record review, and interview, the facility failed to have a to ensure staff had a system to identify Resident (R)1's DNR status while transported by facility staff. This deficient practice placed R1 at risk for impaired autonomy regarding his advance directives.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had the following diagnoses: chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The "Quarterly Minimum Data Set (MDS)," dated 11/30/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of eleven which

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indicated moderately impaired cognition. The MDS further documented R1 required limited to extensive assistance of one staff to perform bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. The MDS also documented R1 was on oxygen supplementation.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 10/02/22 documented R1 had moderate cognitive impairment and showed difficulty with memory recall.

The "Activities of Daily Living (ADL) CAA," dated 10/02/22, documented R1 required ADL assistance due to becoming short of breath due to his diagnosis of COPD and being dependent on supplemental oxygen.

The "Respiratory Care Plan," dated 10/02/22 directed staff to monitor R1 for signs and symptoms of respiratory distress and report these to R1's primary care physician. The care plan also documented R1 was a DNR.

The "Emergency Department Discharge Paperwork," dated 11/29/22, documented R1's respiratory rate was significantly improved. R1's oxygen saturation remained greater than 90 percent (%). R1's heart rated was tachycardic (rapid heart rate) and his blood pressure was normotensive (blood pressure within normal parameters). R1 was discharged back to the facility.

The "Health Status Note," dated 11/29/22, documented R1 returned from his hospital emergency room visit. R1 complained of pain when breathing and was on oxygen. R1's vital signs were obtained and R1 was alert but had no

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recall of the events that occurred that day.

The undated "Facility Investigation" recorded R1 became unresponsive during transport from the hospital back to the facility. The investigation recorded Social Services X and Maintenance U accompanied R1 in the transport van and Social Services X was uncertain of R1's code status. The investigation recorded Social Services X reported to Administrative Nurse D that Social Services X started resuscitative measures but later recanted that and said she was attempting to rouse the resident with tactile stimulation. Administrative Nurse D verified R1's DNR status for emergency responders and R1 was returned to the hospital for evaluation.

On 12/05/22 at 10:30 AM, observation revealed R1 sat in his recliner watching television. R1's oxygen was in place and R1 appeared to be anxious. R1 stated that he did not remember any part of the day when he went unresponsive on the facility's van and did not remember his time in the emergency room. R1 stated that he was a DNR.

On 12/05/22 at 11:00 AM, Social Services X stated that she was normally the staff that would drive all the residents to their appointments. Social Services X stated that when she transported residents to appointments or home from the hospital, she generally knew what their code status was. Social Services X stated on 11/29/22 when R1 had become unresponsive, she had no idea what his code status was until Administrative Nurse D got to the scene and informed them that R1's code status was a DNR. Social Services X denied performing any kind of cardio-pulmonary resuscitation (CPR), but said she did pat R1 on his arms, chest and face and

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F 578	Continued From page 4	F 578		

told him to breathe. Social Services X confirmed she was CPR certified.

On 12/05/22 at 11:30 AM, Maintenance U stated after he pulled over into the parking lot, he thought Social Services X performed CPR, so he told 911 when he placed the call. Maintenance U stated that when he hung up from 911, he called the Administrative Nurse D to tell her what was going on.

On 12/05/22 at 02:30 PM, Administrative Staff A stated that she expected all staff to know the code status of the residents to ensure the residents preferences were honored regarding full code versus DNR. Administrative Staff A stated the facility realized they did not have a standard of practice to ensure staff driving the van received code status information from the hospital when residents returned to the facility. Administrative Staff A stated now the facility will give the driver driving a resident to or from any kind of appointment a face sheet that clearly denotes the residents code status and then upon return to the facility the staff driving the van will give the face sheet back to the nurse on duty for the face sheet to be shredded.

The facility undated "Medical and Dental Transportation for Residents Policy," documented the charge nurse will provide the driver with the following information: Name of resident, destination, appointment time, assistive equipment used by resident such as wheelchair, walker, oxygen etc., escort: will a team member, family or volunteer accompany the resident, and name of the team member making the appointment.

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F 578	Continued From page 5 The facility failed to ensure transportation staff identified residents with advanced directive for DNR which placed R1 at risk for impaired autonomy regarding his advanced directives.	F 578		