

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

PRINTED: 11/05/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15A011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/25/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ESPECIALLY KIDZ HEALTH &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2325 S MILLER ST</b> <b>SHELBYVILLE, IN 46176</b>		
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F 000	INITIAL COMMENTS  This visit was for the Investigation of Complaints IN00365361. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.  Complaint IN00365361- Substantiated. Federal/State deficiencies related to the allegations are cited at F695.  Survey dates: October 21, 22, 23, 24, and 25, 2021  Facility number: 000273 Provider number: 15A011 AIM number: 100267870  Census Bed Type: NF: 126 Total: 126  Census Payor Type: Medicaid: 124 Other: 2 Total: 126  These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 000			
F 695 SS=J	Quality review completed on November 2, 2021 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	F 695			

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 695	<p>Continued From page 1</p> <p>care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to address a resident's irregular pulse oximeter reading when a Certified Nursing Assistant (CNA) recognized and reported the irregular reading to the respiratory therapist; who did not proceed to address the irregular reading. The resident was found unresponsive with no pulse, not breathing, and the oximeter was not alarming or registering the oxygen saturation and/or heart rate of the resident for 1 of 7 residents reviewed with an artificial airway. This resulted in unaddressed respiratory distress for a resident who became unresponsive and died. (Resident B)</p> <p>The Immediate Jeopardy began on October 16, 2021 when at approximately 9:30 p.m., CNA 1 was in Resident B's room and observed Resident B's pulse oximeter. It was not registering a pulse rate or oxygen saturation reading. CNA 1 did not go to the bedside and observe Resident B. She exited the room and notified Respiratory Therapist (RT) 2. RT 2 did not address. At approximately 9:40 p.m., CNA 1 returned to Resident B's room, and he was found unresponsive and without a pulse. The pulse oximeter was not alarming, not displaying a pulse rate nor oxygen saturation. The resident was pronounced deceased at 10:27 p.m. The Administrator, Nurse Consultant and the Respiratory Nurse Consultant were notified of the Immediate Jeopardy on 10/22/21 at 2:50 p.m. The Immediate Jeopardy was removed and the</p>	F 695	Past noncompliance: no plan of correction required.		

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F 695	<p>Continued From page 2</p> <p>deficient practice corrected by 10/20/21 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included the following actions: The nursing staff will assess connection from pulse oximeter to the resident and the oximeter every 2 hours as well as the continued assessment of the respiratory therapist every 4 hours. Education was provided to all staff to notify nursing and respiratory therapy of oximeters not reading.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 10/21/21 at 11:00 a.m. The diagnoses include, but were not limited to, chronic hypoxemic (abnormal low level of oxygen) respiratory failure, ventilator dependent, tracheostomy (trach) and pulmonary hypertension.</p> <p>A care plan dated 7/12/21 indicated "The resident exhibits sporadic and/or catastrophic behaviors as evidenced by: ...removing pulse oximeter probe..Goal..The resident will respond positively to staff interventions through next review...Interventions...Monitor for signs/symptoms of agitation such as change of mood, crying, restlessness, pacing, repetitive actions. Anticipate potential problems or stressors to help prevent catastrophic reactions..."</p> <p>A care plan dated 7/22/21 indicated "Resident is at risk for hypoxia. Related to Chronic hypoxia, resp. [respiratory] failure, tracheomalacia, bronchomalacia, vent [ventilator] dependent, and tracheostomy. Goals. Resident will maintain oxygen saturations per MD [medical doctor]</p>	F 695			

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F 695	<p>Continued From page 3</p> <p>orders...Interventions:..Oxygen Saturations to be checked per MD order and as needed..."</p> <p>A care plan dated 7/22/21 indicated "The resident has a tracheostomy...Interventions:...Maintain Resident's oxygen saturations per MD orders..."</p> <p>A care plan dated 7/22/21 indicated "The resident is ventilator dependent...Interventions:..May perform trach collar trials as tolerated per MD order."</p> <p>A physician order for Resident B dated 10/1/20 indicated "Trach collar trials as tolerated."</p> <p>A physician order dated 9/10/20 indicated the resident was to receive "O2 [oxygen] @ 28% via trach collar titrate to keep sats [saturations] &gt; 92%."</p> <p>A physician order dated 9/10/20 indicated Resident B was to be on "continuous pulse oximeter. May be off for bath/ADLS [Activities of Daily Living] and out of room activities."</p> <p>A medical provider progress note dated 9/8/21 indicated Resident B was on trach collar trials while awake and active. He was placed on ventilator while sleeping.</p> <p>A statement by RT 3 dated 10/21/21 indicated on October 16, 2021, she was the respiratory therapist for Resident B on day shift, 7:00 a.m. to 7:00 p.m. At approximately 4:00 p.m., she had placed the pulse oximeter probe on the resident after he was place in his bed. The pulse oximeter was displaying heart rate and oxygen saturation readings. At approximately 6:00 p.m., She had observed Resident B's oximeter, and it was</p>	F 695			

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F 695	<p>Continued From page 4</p> <p>displaying numerical values. The resident's oxygen saturations was 95% at that time.</p> <p>An interview was conducted with RT 3 on 10/22/21 at 1:48 p.m. She indicated Resident B was "very" active and frequently removed his pulse oximeter probe. She had placed the probe on his foot that day.</p> <p>An interview was conducted with License Practical Nurse (LPN) 4 on 10/21/21 at 1:00 p.m. She indicated she was Resident B's night nurse on October 16, 2021, from 7:00 p.m. to 7:00 a.m. At approximately 8:50 p.m., she had administered medications to Resident B. The resident was on trach collar at that time. The resident was responsive and was not in any distress. She had not looked to see if the pulse oximeter probe was attached to his toe nor had she observed the pulse oximeter to see if it was displaying a pulse rate and oxygen saturation reading during that time. At approximately 9:30 p.m., she was called to the resident's room by CNA 1. Resident B was assessed, and he was unresponsive and without a pulse. She had not looked to see if the pulse oximeter probe was attached to the resident's toe. The pulse oximeter was on, but not displaying any numerical numbers. It was not alarming as it should have been. At approximately 9:40 p.m., CPR was initiated and Emergency Medical Services (EMS) was notified. EMS arrived around 9:47 p.m. She was unsure if the pulse oximeter malfunctioned.</p> <p>A written statement by CNA 1 on 10/16/21 indicated "I checked to see if he [Resident B] was wet at 7:45ish, he was not so I went and did my baths. And about 9:15ish I started another bed check w/ [with] [CNA 2]. My resident on the bag</p>	F 695			

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F 695	<p>Continued From page 5</p> <p>hugger [forced-air warming device to prevent hypothermia and maintain normal temperature] was not warm enough to come off and set her bath. At 9:30 [p.m.] I walked in [Resident B]'s room to see if there were more towels. I then noticed [Resident B] SPO2 (oxygen saturations) was silenced. I asked [RT 2] why and he told me 'He will just keep pulling it off and it will just keep beeping.' I finished [resident's room] then went to [Resident B]. After looking at his brief I realised [sic] he was really cold and his eyes were rolled in his head. I put my hand on his chest and then realised [sic] he wasn't breathing..."</p> <p>An interview was conducted with CNA 1 on 10/21/21 at 2:25 p.m. She indicated she had gone into Resident B's room looking for towels between 9:20 p.m. and 9:30 p.m. She had observed Resident B's pulse oximeter displaying "dashes" instead of a pulse rate and oxygen saturation reading. It was "silenced." She did not go to the bedside and observe Resident B at that time. CNA 1 exited the resident's room and notified RT 2 Resident B's oximeter was "off." He responded, "He will just keeping pulling it off and it will just keep beeping." She then went back to the other resident's room and finished care on that resident. Resident B was active and pulled his probe off all the time. The resident's oximeter alarmed frequently. She had not reported to the nurse the oximeter was off. It was approximately 15 minutes later, she returned to Resident B's room. Resident B was observed not breathing. He was on trach collar, and the oxygen was running to it. She "yelled" for LPN 4. The pulse oximeter was not alarming at that time. The oximeter usually will alarm that will include a sentence on the display that indicates what the problem was and how to correct. It was not</p>	F 695			

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F 695	<p>Continued From page 6</p> <p>displaying any corrective sentence, any numerical values, nor making any alarming sound. She was unsure if the resident's oximeter was placed on "audible silent" or malfunctioned.</p> <p>An interview was conducted with RT 2 on 10/21/21 at 2:55 p.m. He indicated Resident B was on trach collar while awake and then placed on a ventilator at night. He normally places the resident on the ventilator and administers his treatments around 10:00 p.m. On the evening of 10/16/21, he had not seen Resident B prior to CNA 1 finding the resident unresponsive. That evening, he had been into Resident B's room, but he had provided care to other residents in the room. During the evening hours, the residents' rooms are dark, so the residents will settle down. He did not observe the Resident B's pulse oximeter nor observe him during those times in the room. At approximately 9:30 p.m., he did have a conversation with CNA 1 concerning resident care, but she had not reported anything to him about Resident B's pulse oximeter. If she had he would have addressed the resident's oximeter. At approximately 9:40 p.m., he was called to Resident B's room due to the resident was unresponsive without a pulse. The resident was on room air when he approached the bedside. The pulse oximeter was not alarming, no waves or data readings appeared on the demo screen. As a safety precaution, the residents are to be placed on a pulse oximeter while in their rooms without staff presence. He depends on the pulse oximeters to sound an alarm to alert the staff when something was wrong with residents that are not on a ventilators. After EMS transferred the resident, he had observed the resident's pulse oximeter. It had been placed on "stand by mode." That mode was normally used</p>	F 695			

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F 695	<p>Continued From page 7</p> <p>when a resident was leaving the room and going to activities, getting a bath, or taken to the nurse's station.</p> <p>The hospital emergency department report dated 10/16/21 indicated "...It sounds as if the patient was found in cardiac arrest around 9:40 p.m. CPR was initiated...The time of death was 10:27 p.m..."</p> <p>An interview was conducted the Respiratory Therapist Nurse Consultant on 10/21/21 at 3:58 p.m. She indicated there was 2 silent alarm modes on the pulse oximeter. The "stand by silence mode" means auto silenced. That mode was pushed when a resident was disconnected, and the resident would be going to activities, provided a bath, or taken to nurses station. That mode would remain off until it was manually pushed back on. The 2nd silent alarm mode would remain off for 2 minutes. That silent mode was utilized when suctioning. RT 2 should have went to assess Resident B and oximeter if CNA 1 reported a problem with the oximeter. CNA 1 should have reported it to LPN 4 if RT 2 had not reacted and addressed the situation. The oximeters are about 3 years old. There are no maintenance required to them. She was unsure what happened. Resident B's pulse oximeter either was not connected or the oximeter malfunctioned.</p> <p>An interview was conducted with the Administrator on 10/21/21 at 1:30 p.m. She indicated Resident B's pulse oximeter was immediately removed from the room after the incident. It would be sent out to determine if it malfunctioned.</p>	F 695			

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F 695	<p>Continued From page 8</p> <p>A FDA (The Food and Drug Administration) Safety Information and Adverse Event Report was provided by the Administrator on 10/21/21 at 12:02 p.m. It indicated "...Date of event 10/16/21... Pulse oximeter functional, displaying reading at 6:00 p.m.,...Describe Event or Problem..The pulse oximeter had been observed to be functioning and displaying readings within normal limits for the patient. At, or around 9:20 p.m., the demo screen was reported to be 'lit' but not displaying numerical readings. Within minutes of the finding, the resident was observed to be non-responsive with medical services provided. EMS arrived and attempted to revive the patient without success. The resident expired. Per interviews with staff it could not be determined as to cause of altered function of the device. The devices was taken out of service immediately..."</p> <p>The "Pulse Oximetry" policy was provided by the Administrator on 10/21/21 at 12:02 p.m. It indicated "...Purpose: Pulse oximetry is a non-invasive method of acquiring data on the ratio of oxygenated hemoglobin to the total hemoglobin. This ratio is called the oxygen saturation and closely related to the PaO2 [partial pressure of oxygen - measures oxygen dissolved in the blood]. Pulse oximetry is used to monitor the adequacy of arterial oxyhemoglobin saturation, quantitate the response of arterial oxyhemoglobin saturation to therapeutic intervention or to a diagnostic procedure, to facilitate prescription of proper therapeutic measures and evaluate the effectiveness of oxygen therapy...Continuous (trend) determination is the process of obtaining oxygen saturation readings for a specified period of time or continuously by applying the oximeter probe and leaving it in place for the duration of the</p>	F 695			

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F 695	<p>Continued From page 9</p> <p>testing period. This process allows evaluation of trends (peaks and troughs) in the oxygenation/perfusion status of the resident...Procedure:...4. Assure proper equipment function of the pulse oximeter..."</p> <p>The pulse oximeter operators manual was provided by the Administrator on 10/22/21 at 12:02 p.m. It indicated "...Silencing Alarms...To silence or dismiss alarms: Touch silence in the highlighted area of the status bar or the alarm silence button. If the alarm is for a specific parameter, touch the alarming parameter...Audible alarms that are temporarily suspended by pressing the alarm silence button can be unsuspected by pressing the alarm silence button again...Audio Pause. Audio Pause temporarily suspends all audible alarms...When it is active, visual alarms are not impacted and will still display. The Audio Pause icon is located on the left side of the status bar...To activate Audio Pause, press the icon. It will turn red and the remaining Audio Pause Duration time counts down next to the icon. The default duration for Audio Pause is 120 seconds...'-' (Dashes shown as parameter alarm) Unable to provide a parameter value. Check patient's vital condition..."</p> <p>The past noncompliance Immediate Jeopardy began on October 16, 2021. The Immediate Jeopardy was removed and the deficient practice corrected by 10/20/21 after the facility implemented a systemic plan that included the following actions: The nursing staff will assess connection from pulse oximeter to the resident and the oximeter every 2 hours as well as the continued assessment of the respiratory therapist every 4 hours. Education was provided to all staff</p>	F 695			

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