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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>265532 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY COMPLETED<br><br>08/19/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Parkway Health Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2323 Swope Parkway<br>Kansas City, MO 64130 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35013</p> <p>Based on interview and record review, the facility staff failed to notify the next of kin timely of one sampled resident's (Resident #1) significant change of condition out of five sampled residents. The facility census was 89 residents.</p> <p>Review of the facility policy for Notification of Changes revised [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician, and notified, consistent with his/her authority, the resident's representative when there was a change in the resident's condition.</li> <li>-Significant changes in the resident's physical, mental or psychosocial condition such as a deterioration in the resident's health, mental or psychosocial status.</li> <li>-Changes in the resident's condition could have been life-threatening conditions, or clinical complications.</li> <li>-In the case of a resident incapable of making decisions, the resident's family representative would make any decisions that had to be made.</li> </ul> <p>1. Review of Resident #1's facility Admission Record showed the resident was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Dementia.</li> <li>-Dysphagia (inability or difficulty swallowing).</li> <li>-Heart disease.</li> <li>-Stroke.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated [DATE] showed he/she was severely cognitively impaired.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the resident's Nursing Care Plan dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The resident had a Full Code status.</li> <li>-Facility staff were to honor the resident's code status by calling 911 and beginning Cardiac Pulmonary Resuscitation (CPR-an emergency life-saving procedure done when someone's breathing and heartbeat has stopped, combining breathing and chest compressions) define in the event the resident was without pulse, respirations and/or Blood Pressure (B/P).</li> <li>-The facility staff was to notify the next of kin/resident representative of life-saving measures taken.</li> </ul> <p>Review of the resident's Nurse's Note dated [DATE] at 3:04 P.M., showed:</p> <ul style="list-style-type: none"> <li>-Certified Nursing Assistant (CNA) A came to Licensed Practical Nurse (LPN) A stating the resident was cold and unresponsive.</li> <li>-The resident's pulse rate was 42 beats per minute (BPM - normal resting heart rate is between 60 and 100 BPM).</li> <li>-His/her temperature was 97.7 degrees (F) (the normal range of body temperature is 97 F to 99 F). His/her skin felt cold to touch.</li> <li>-The physician was notified of the resident's change of condition.</li> <li>-The physician gave an order to get a hospice (end of life care) evaluation.</li> <li>-The facility Social Services Coordinator was informed so the family could be notified.</li> </ul> <p>Review of the resident's Social Work Coordinator Notes dated [DATE] at 3:36 P.M., showed:</p> <ul style="list-style-type: none"> <li>-911 was called and the family indicated the preferred hospital to send the resident.</li> <li>-The Social Work Coordinator informed the staff on the unit where the resident resided.</li> </ul> <p>Review of the resident's Nurse's Notes dated [DATE] at 6:04 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident's condition did not improve since the morning.</li> <li>-His/her skin was cold to touch, his/her heart rate was 35 BPM, Oxygen saturation was 91% on room air (normal oxygen saturation is between 95% and 100%), and LPN A was not able to palpate a B/P on the resident.</li> <li>-911 was called and the resident was transported to the hospital via ambulance.</li> <li>-LPN A called a report to the hospital and the physician was notified.</li> </ul> <p>During an interview on [DATE] at 12:30 P.M., LPN A said:</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>-On the morning of [DATE] at around 10:11 A.M., he/she was notified by CNA A and LPN B that the resident was very tired and felt very cold to the touch.</p> <p>-The resident's pulse was around 45 BPM and his/her temperature was 97.7 degrees F, even though he/she felt colder to the touch.</p> <p>-He/she then spoke with the Social Work Coordinator to ask him/her to contact the family as the resident was not doing well.</p> <p>-He/she was unable to obtain a B/P on the resident so called 911 to have the resident sent to the hospital for evaluation and treatment.</p> <p>During an interview on [DATE] at 12:30 P.M., LPN A said when the physician called back and said to call the family about hospice, he/she asked the Social Work Coordinator to call the family about hospice as the resident might not live long.</p> <p>During an interview on [DATE] at 1:29 P.M., the Social Work Coordinator said:</p> <p>-He/she was not notified he/she needed to call the family regarding the resident's condition and potential need for hospice services until late in the afternoon.</p> <p>-He/she believed he/she spoke with the family around 4:00 P.M.</p> <p>-At the time he/she spoke with the family, he/she was only told to tell them the resident was not doing well and they needed to know which hospital to send the resident.</p> <p>-He/she was never told anything about hospice services.</p> <p>During an interview on [DATE] at 11:31 A.M., the resident's family representative said:</p> <p>-He/she thought he/she received a call around 4:00 P.M., on [DATE] and a message was left on his/her cell phone, but he/she did not remember who left the message.</p> <p>-He/she could not tell for sure what time the message was left, but he/she did not even see a message had been left until he/she was called again by the facility and noticed the message blinking.</p> <p>-He/she received the last call from a nurse whom he/she could not remember their name, he/she thought it was around 5:00 P.M., but again, was not sure.</p> <p>-In the call, he/she was told the resident was not doing well, the family might want to discuss hospice care, but at the time, the facility was sending the resident to the hospital and needed to know which hospital to use.</p> <p>-He/she gave them the hospital name and told the facility he/she would meet the resident at the hospital.</p> <p>-He/she had not received a call on [DATE] or before around 4:00 P.M., on [DATE].</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview on [DATE] at 2:45 P.M., the Regional Nurse-West Division/Acting Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-He/she was covering for the DON at the time the resident had issues.</li> <li>-The unit staff notified him/her of the situation with the resident's decline.</li> <li>-He/she called the family representative and left a message on his/her cell phone around 3:00 P.M., [DATE].</li> <li>-The family representative called back but he/she was not for sure what time. He/she believed the resident was sent out of the facility around 3:45 P.M., on [DATE].</li> </ul> <p>During an interview on [DATE] at 10:15 A.M., LPN A said:</p> <ul style="list-style-type: none"> <li>-He/she went and found the Social Services Coordinator who was in the therapy gym, and told him/her face to face to call the family to notify them of the resident's decline and question them about obtaining hospice care or sending the resident to the hospital.</li> <li>-He/she did not check back with the Social Services Coordinator to ensure that the family was called as he/she got busy in the afternoon and did not think about it.</li> </ul> <p>During an interview on [DATE] at 1:30 P.M., the physician said:</p> <ul style="list-style-type: none"> <li>-He/she recalled getting either a phone call or a text from the office nurse regarding the call from the facility and issues with the resident's status.</li> <li>-He/she remembered being asked if the facility could approach the family regarding hospice services.</li> <li>-He/she gave the okay for the facility nurse to notify the family of the resident's status and ask about obtaining hospice.</li> </ul> <p>During an interview on [DATE] at 3:40 P.M., the Regional Nurse-West Division/Acting DON said:</p> <ul style="list-style-type: none"> <li>-He/she would have expected the facility staff notify the resident's family of any changes in condition as soon as those changes in condition occurred.</li> <li>-He/she would have expected LPN A to call the family regarding whether or not they wanted the resident sent to the hospital or a hospice consult, not ask the Social Work Coordinator to do so.</li> <li>-Since LPN A had asked the Social Work Coordinator to call the family, he/she would have expected LPN A to follow up with the Social Work Coordinator to make sure the family had been notified.</li> </ul> <p>During an interview on [DATE] at 3:45 P.M., the facility Administrator said:</p> <ul style="list-style-type: none"> <li>-He/she would have expected resident families to have been notified any time a resident had a change in condition as long as the resident had okayed for the family to know.</li> </ul> <p>(continued on next page)</p> |  |  |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-He/she would have expected nursing staff to always follow up if they have directed a team member to complete an important task.</p> <p>MO00240529</p> |