STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 18 residents with 3 residents reviewed for abuse and neglect. Based on record review and interview, the facility failed to ensure Resident (R)1 remained free from neglect and mistreatment. On [DATE] at 07:39 AM, Licensed Nurse (LN) G went to R1's room to pass medications. R1's vital signs were blood pressure ,d+[DATE] mm/Hg, heart rate 81 bpm, respirations 24 per minute, and SAO2 92% on oxygen at 4 L per nasal cannula. At 09:30 AM, Laundry Person GG went to R1's room and R1 asked him to get LN G. Laundry Person GG went directly to LN G and told LN G R1 needed her. LN G continued to pass medications and answer phone calls. R1 placed her call light on at 09:42 AM and the call light alarmed for one hour and forty-five minutes with no one answering her call light. At 11:00 AM, Environmental Services Director HH, heard Certified Nurse Aide (CNA) M state, that she had seen R1's call light going off, but CNA M was not gowning up to go into the room just to be told R1 needed LN G. At 11:27 AM, LN G looked at the call light directory and saw that R1's light was on. LN G went to R1's room and found her pale, cold to the touch, and pulseless. LN G failed to initiate CPR and pronounced R1 dead at 11:27 AM. This deficient practice placed R1 at risk for grave psychosocial outcomes including fear, anxiety, and neglect due to staff not responding to R1's needs and placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of non-ST elevation (NSTEMI) myocardial infarction (a type of heart attack that occurs when a coronary artery is partially blocked), cardiomyopathy (heart disease), hypertension, (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (rapid, irregular heartbeat), and bradycardia (low heart rate, less than 60 beats per minute). The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R1 required substantial staff assistance with bathing, dressing, transfer, and bed mobility. The MDS documented R1 required moderate staff assistance for personal hygiene, oral hygiene, and toileting hygiene. The Functional Abilities Care Area Assessment (CAA), dated [DATE], documented R1 was admitted to the facility for physical therapy and occupational therapy for weight bearing and strengthening. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan, which was not initiated until after R1's death, directed staff R1 required two staff assistance with bed mobility, R1 required two staff assistance and a full lift for transfer, R1 used a bed pan when not incontinent, and required one staff assistance for dressing and showering. The care plan documented R1 required oxygen therapy and directed staff to monitor R1 for signs and symptoms of respiratory distress: respirations, pulse oximetry (the amount of oxygen in the blood), increased heart rate, restlessness, diaphoresis (heavy sweating), headaches, lethargy, confusion, atelectasis (complete or partial collapse of a lung), hemoptysis (coughing up blood), cough, and skin color and report these signs to R1's doctor as needed. R1 required oxygen at 4 Liters (L) per nasal cannula. R1's EMR, dated [DATE] (date of admission) documented R1 was a full code. The Notes tab in R1's EMR revealed the following: The Nursing Progress Note, dated [DATE] at 11:35 AM, documented LN G went to assess R1. R1's call light was on and Laundry Person GG had stated R1 had requested a nurse. R1 had no signs of life. R1 had no visible breathing, no palpable pulse, and no audible heartbeat. LN G called R1's time of death at 11:26 AM. LN G notified R1's primary care provider, Administrative Nurse D, and R1's family. R1's primary care provider gave a verbal order to release R1's body to the funeral home. The Nursing Progress Note, dated [DATE] at 12:25 PM, documented R1 had previously been assessed by LN G at 07:39 AM. R1 was alert, oriented, and sat up at a forty-five-degree angle in her bed. R1's vital signs were normal, blood pressure ,d+[DATE] mm/Hg (millimeters of mercury), pulse 81 beats per minute, temperature of 96.6 degrees F, pulse 24 beats per minute, and pulse oximetry of 92%. R1 had been breathless which caused her to feel panicked. LN G attempted to call R1's family and coached R1 through some deep breathing to help R1 calm herself. When LN G assessed R1 again at 11:26 AM, R1 was cold to the touch, with no visible signs of life including no breathing, no palpable pulse, and no audible heartbeat. The [DATE] Working Schedule, documented LN G and Certified Nurse's Aide (CNA) M were the only two nursing staff scheduled for the [DATE] day shift to take care of 18 residents, with three of those residents being two staff assist. The list of staff certified in CPR documented LN G and CNA M were certified in CPR. The Call Light Audit Report documented R1 had put her call light on at 09:42 AM and it alarmed until 11:23 AM, one hour and forty-five minutes, and no one answered R1's call light. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN G's Notarized Witness Statement, dated [DATE], documented LN G arrived on shift at 06:00 AM. At 07:39 AM, LN G entered R1's room to administer her medications. R1 was alert and sat up in bed. R1's vital signs were within normal limits. R1 was in a panicked state because she could not find her call light or reach her table and she felt breathless. LN G repositioned R1's bedside table and call light so R1 could reach the items, assisted R1 in calling her family, helped R1 take deep breaths to calm her down, and administered R1's morning medications. R1 stated she was good and needed no further assistance. LN G continued to pass medications to other residents and answer facility phone calls. At 09:31 AM, Laundry Person GG came to LN G and told LN G R1 was requesting a nurse. LN G continued to pass medications and answer facility phone calls. At 11:20 AM, LN G went to the nurse's station and noticed R1's call light was going off on the call light directory. CNA M stated, Oh, she still needs a nurse. At 11:26 AM, LN G went to assess R1 and found her cold to the touch, with no palpable pulse, no breathing, and no audible heartbeat. Based on the temperature of the body being cold to the touch, LN G assessed in her medical opinion life resuscitation was impossible. CNA M's Notarized Witness Statement, dated [DATE], documented at 06:30 AM CNA M told LN G she was going to start showers and LN G stated she would watch the floor and answer call lights. CNA M stated when she was walking down the hall, she heard Laundry Person GG tell LN G R1 wanted her. CNA M stated she went to assist residents with COVID-19 (highly contagious respiratory virus) get up for the day. CNA M stated when she came out at about 11:15 AM and noted her pager identified R1's call light was going off. CNA M went to LN G and asked her if LN G wanted CNA M to get the call light and told LN G R1 had wanted her earlier and CNA M didn't know if LN G had been in there yet. LN G stated she would go and see what R1 needed. CNA M stated she did not know her pager was going off because she did not look at it when she was in the COVID rooms. Laundry Person GG's Notarized Witness Statement, dated [DATE], documented Laundry Person GG was in R1's room at 09:30 AM and R1 told him she needed to see LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed her. Environmental Service's Director HH's Notarized Witness Statement, dated [DATE], documented Environmental Service Director went to the nurse's station at 11:00 AM and CNA M told her Laundry Person GG had gone into R1's room around 09:30 AM and R1 needed LN G. CNA M told Environmental Service's Director HH, LN G had still not gone into R1's room. CNA M told Environmental Service's Director HH, she had seen R1's call light going off, but said she was not going to gown up to go back in R1's room for R1 to just tell her she needed LN G. Food Service Director JJ's Notarized Witness Statement documented R1 did not have a breakfast menu filled out for the morning on [DATE] which indicated R1 did not receive breakfast. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Incident Report, dated [DATE], documented on [DATE] at 11:27 AM, LN G called to inform Administrative Nurse D to inform her R1 had passed. LN G stated R1 was unresponsive and cold to the touch and had no pulse. LN G reported she had last seen R1 around 08:00 AM and R1 was sitting upright in bed and in kind of a panic state because R1 could not find her call light and was having trouble breathing. LN G stated R1's vital signs were normal and R1's call light was attached to her bed. LN G assisted R1 in calling her sister which helped R1 calm. At 09:30 AM, Laundry Person GG went into R1's room to see if R1 had any laundry that needed to be done. R1 told Laundry Person GG she wanted to see LN G. Laundry Person GG went and told LN G to inform her of R1's request. LN G continued with medication pass and other duties. At 11:20 AM, LN G noticed R1's call light was going off on the computer. LN G stated she went into R1's room and found R1 lifeless. R1's family, physician, and Administrative Nurse D were notified. During the investigation, call light information was pulled which resulted in LN G and CNA M being suspended pending investigation. LN G was terminated on [DATE]. CNA M returned to work on [DATE]. All staff were in-serviced on [DATE] on Abuse and Neglect, Advanced Directives, and call lights. On [DATE] at 10:00 AM, Laundry Person GG stated he had entered R1's room around 09:30 AM and R1 asked him to go and get LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed to see her, and LN G stated okay she would get to her. Laundry Person GG stated he heard later R1 had died . On [DATE] at 10:30 AM, CNA M stated she and LN G had been the only nursing staff on duty on [DATE]. CNA M stated she had told LN G she was going to go get showers started about 06:30 AM and LN G stated she would watch the floor and call lights. CNA M stated after showers were done, she went to the COVID rooms to start getting those residents up for the day. CNA M stated when she is gowned up and in Covid rooms she does not take her pager out of her pocket to look at it so she did not know R1's call light was going off until after she got out of the Covid rooms. CNA M stated with all of the COVID residents one nurse and one CNA were not enough staff to take care of the residents. CNA M stated she had not seen R1 at all that morning and was never in R1's room. On ,d+[DATE]/ 25 at 11:00 AM, Administrative Nurse D stated she would have expected staff to answer R1's call light before almost two hours had passed and expected LN G to start CPR on R1 right away after finding her unresponsive and pulseless and get EMS on its way to the facility. Administrative Nurse D stated LN G did not have the right to certify the time of death for R1. Administrative Nurse D stated there were other staff at work the day of the incident that could have answered R1's call light besides LN G and CNA M. Administrative Nurse D verified R1's call light had not been answered in one hour and forty-five minutes. Administrative Nurse D stated the last CPR in-service training was in November of 2023 and all staff were re-educated regarding CPR after the incident. Administrative Nurse D stated LN G could not understand why the facility terminated her employment because, in LN G's opinion, she had done nothing wrong. On [DATE] at 02:00 PM, Administrative Staff A stated one nurse and one CNA were enough staff to take care of seventeen to eighteen residents, and on the day of the incident one of the housekeeping staff and social services/activities staff were on duty and both were also CNAs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated February 2018, documented Personnel have completed training on the initiation of CPR and basic life support for victims of cardiac arrest. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms. Cardiac arrest occurs soon after symptoms appear. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. If an individual or resident is found unresponsive and not breathing normally and licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or There are obvious signs of death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression/ventilation rate of 30:2. When the AED arrives assess for need and follow AED protocol as indicated. Continue with CPR/BLS until emergency medical personnel arrive. The facility's Abuse Policy, revised [DATE], documented all allegations of abuse including physical, mental, emotional, verbal, and/or sexual abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source and any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly shall be investigated by facility management. The administrator will ensure that any further potential abuse or mistreatment is prevented. The facility failed to ensure R1 remained free from neglect and mistreatment. This deficient practice placed R1 at risk for grave psychosocial outcomes including fear, anxiety, and neglect due to staff not responding to R1's needs and placed R1 in immediate jeopardy. The following citations represent the findings of partial extended survey and complaint investigation#KS00192613. On [DATE] at 02:30 PM Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the immediate jeopardy for Resident (R)1. The facility completed the following corrective actions prior to this surveyor entering the facility: The facility submitted education regarding CPR, Advance Directives, Abuse and Neglect, and answering call lights that were completed on [DATE] and Call Light audits were implemented This deficient practice was Past Non-Compliance (PNC) as all corrections were completed prior to the surveyor entering the building. The scope and severity of the deficient practice remained at a G to reflect the actual injury to R1.

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F 0678

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43204

The facility identified a census of 18 residents with 12 residents who elected a full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest) status. Based on record review and interview, the facility failed to ensure staff provided cardiopulmonary resuscitation (CPR - emergency lifesaving procedure performed when the heart stops beating) to Resident (R) 1, who desired resuscitative measures as indicated by her full code status. On [DATE] at 07:39 AM, Licensed Nurse (LN) G went to R1's room to pass medications. R1's vital signs were blood pressure ,d+[DATE] mm/Hg, heart rate 81 bpm, respirations 24 per minute, and SAO2 92% on oxygen at 4 L per nasal cannula. At 09:30 AM, Laundry Person GG, went to R1's room and R1 asked him to get LN G. Laundry Person GG went directly to LN G and told LN G R1 needed her. LN G continued to pass medications and answer phone calls. R1 placed her call light on at 09:42 AM and the call light alarmed for one hour and forty-five minutes with no one answering her call light. At 11:27 AM, LN G looked at the call light directory and saw that R1's light was on. LN G went to R1's room and found her pale, cold to the touch, and pulseless. LN G failed to initiate CPR and pronounced R1 dead at 11:27 AM. The facility failed to activate Emergency Medical Services and withheld CPR despite R1's documented full code status. R1 died in the facility. This deficient practice placed R1 and all residents with full code status in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of non-ST elevation (NSTEMI) myocardial infarction (a type of heart attack that occurs when a coronary artery is partially blocked), cardiomyopathy (heart disease), hypertension, (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (rapid, irregular heartbeat), and bradycardia (low heart rate, less than 60 beats per minute).

The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R1 required substantial staff assistance with bathing, dressing, transfer, and bed mobility. The MDS documented R1 required moderate staff assistance for personal hygiene, oral hygiene, and toileting hygiene.

The Functional Abilities Care Area Assessment (CAA), dated [DATE], documented R1 was admitted to the facility for physical therapy and occupational therapy for weight bearing and strengthening.

R1's Care Plan, which was not initiated until after R1's death, directed staff R1 required two staff assistance with bed mobility, R1 required two staff assistance and a full lift for transfer, R1 used a bed pan when not incontinent, and required one staff assistance for dressing and showering. The care plan documented R1 required oxygen therapy and directed staff to monitor R1 for signs and symptoms of respiratory distress: respirations, pulse oximetry (the amount of oxygen in the blood), increased heart rate, restlessness, diaphoresis (heavy sweating), headaches, lethargy, confusion, atelectasis (complete or partial collapse of a lung), hemoptysis (coughing up blood), cough, and skin color and report these signs to R1's doctor as needed. R1 required oxygen at 4 Liters (L) per nasal cannula.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's EMR, dated [DATE] (date of admission) documented R1 was a full code. The Notes tab in R1's EMR revealed the following: The Nursing Progress Note, dated [DATE] at 11:35 AM, documented LN G went to assess R1. R1's call light was on and Laundry Person GG had stated R1 had requested a nurse. R1 had no signs of life. R1 had no visible breathing, no palpable pulse, and no audible heartbeat. LN G called R1's time of death at 11:26 AM. LN G notified R1's primary care provider, Administrative Nurse D, and R1's family. R1's primary care provider gave a verbal order to release R1's body to the funeral home. The Nursing Progress Note, dated [DATE] at 12:25 PM, documented R1 had previously been assessed by LN G at 07:39 AM. R1 was alert, oriented, and sat up at a forty-five-degree angle in her bed. R1's vital signs were normal, blood pressure ,d+[DATE] mm/Hg (millimeters of mercury), pulse 81 beats per minute, temperature of 96.6 degrees F, pulse 24 beats per minute, and pulse oximetry of 92%. R1 had been breathless which caused her to feel panicked. LN G attempted to call R1's family and coached R1 through some deep breathing to help R1 calm herself. When LN G assessed R1 again at 11:26 AM, R1 was cold to the touch, with no visible signs of life including no breathing, no palpable pulse, and no audible heartbeat. The [DATE] Working Schedule, documented LN G and Certified Nurse's Aide (CNA) M were the only two nursing staff scheduled for the [DATE] day shift to take care of 18 residents, with three of those residents being two staff assist. The list of staff certified in CPR documented LN G and CNA M were certified in CPR. The Call Light Audit Report documented R1 had put her call light on at 09:42 AM and it alarmed until 11:23 AM, one hour and forty-five minutes, and no one answered R1's call light. LN G's Notarized Witness Statement, dated [DATE], documented LN G arrived on shift at 06:00 AM. At 07:39 AM, LN G entered R1's room to administer her medications. R1 was alert and sat up in bed. R1's vital signs were within normal limits. R1 was in a panicked state because she could not find her call light or reach her table, and she felt breathless. LN G repositioned R1's bedside table and call light so R1 could reach the items, assisted R1 to call her family, helped R1 take deep breaths to calm her down, and administered R1's morning medications. R1 stated she was good and needed no further assistance. LN G continued to pass medications to other residents and answer facility phone calls. At 09:31 AM, Laundry Person GG came to LN G and told LN G R1 was requesting a nurse. LN G continued to pass medications and answer facility phone calls. At 11:20 AM, LN G went to the nurse's station and noticed R1's call light was going off on the call light directory. CNA M stated, Oh, she still needs a nurse. At 11:26 AM, LN G went to assess R1 and found here cold to the touch, no palpable pulse, no breathing, and no audible heartbeat. Based on the temperature of the body being cold to the touch, LN G assessed in her medical opinion life resuscitation was impossible. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA M's Notarized Witness Statement, dated [DATE], documented at 06:30 AM CNA M told LN G she was going to start showers and LN G stated she would watch the floor and answer call lights. CNA M stated when she was walking down the hall she heard Laundry Person GG tell LN G R1 wanted her. CNA M stated she went to assist residents with COVID-19 (highly contagious respiratory virus) get up for the day. CNA M stated when she came out at about 11:15 AM and noted her pager identified R1's call light was going off. CNA M went to LN G and asked her if LN G wanted CNA M to get the call light and told LN G R1 had wanted her earlier and CNA M didn't know if LN G had been in there yet. LN G stated she would go and see what R1 needed. CNA M stated she did not know her pager was going off because she did not look at it when she was in the Covid rooms. Laundry Person GG's Notarized Witness Statement, dated [DATE], documented Laundry Person GG was in R1's room at 09:30 AM and R1 told him she needed to see LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed her. Environmental Service's Director HH's Notarized Witness Statement, dated [DATE], documented Environmental Service Director went to the nurse's station at 11:00 AM and CNA M told her Laundry Person GG had gone into R1's room around 09:30 AM and R1 needed LN G. CNA M told Environmental Service's Director HH, LN G had still not gone into R1's room. CNA M told Environmental Service's Director HH, she had seen R1's call light going off, but said she was not going to gown up to go back in R1's room for R1 to just tell her she needed LN G. Food Service Director JJ's Notarized Witness Statement, documented R1 did not have a breakfast menu filled out for the morning on [DATE] which indicated R1 did not receive breakfast. The Facility Incident Report, dated [DATE], documented on [DATE] at 11:27 AM, LN G called to inform Administrative Nurse D to inform her R1 had passed. LN G stated R1 was unresponsive and cold to the touch and had no pulse. LN G reported she had last seen R1 around 08:00 AM and R1 was sitting upright in bed and in kind of a panic state because R1 could not find her call light and was having trouble breathing. LN G stated R1's vital signs were normal and R1's call light was attached to her bed. LN G assisted R1 in calling her sister which helped R1 calm. At 09:30 AM, Laundry Person GG went into R1's room to see if R1 had any laundry that needed to be done. R1 told Laundry Person GG she wanted to see LN G. Laundry Person GG went and told LN G to inform her of R1's request. LN G continued with medication pass and other duties. At 11:20 AM, LN G noticed R1's call light was going off on the computer. LN G stated she went into R1's room and found R1 lifeless. R1's family, physician, and Administrative Nurse D were notified. During the investigation, call light information was pulled which resulted in LN G and CNA M being suspended pending investigation. LN G was terminated on [DATE]. CNA M returned to work on [DATE]. All staff were in-serviced on [DATE] on Abuse and Neglect, Advanced Directives, and call lights. On [DATE] at 10:00 AM, Laundry Person GG stated he had entered R1's room around 09:30 AM and R1 asked him to go and get LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed to see her, and LN G stated okay she would get to her. Laundry Person GG stated he heard later R1 had died . (continued on next page)

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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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:30 AM, CNA M stated she and LN G had been the only nursing staff on duty on [DATE]. CNA M stated she had told LN G she was going to go get showers started about 06:30 AM and LN G stated she would watch the floor and call lights. CNA M stated after showers were done, she went to the COVID rooms to start getting those residents up for the day. CNA M stated when she is gowned up and in Covid rooms she does not take her pager out of her pocket to look at it so she did not know R1's call light was going off until after she got out of the Covid rooms. CNA M stated with all of the Covid residents one nurse and one CNA were not enough staff to take care of the residents. CNA M stated she had not seen R1 at all that morning and was never in R1's room. On ,d+[DATE]/ 25 at 11:00 AM, Administrative Nurse D stated she would have expected staff to answer R1's call light before almost two hours had passed and expected LN G to start CPR on R1 right away after finding her unresponsive and pulseless and get EMS on its way to the facility. Administrative Nurse D stated LN G did not have the right to certify the time of death for R1. Administrative Nurse D stated there were other staff at work the day of the incident that could have answered R1's call light besides LN G and CNA M. Administrative Nurse D verified R1's call light had not been answered in one hour and forty-five minutes. Administrative Nurse D stated the last CPR in-service training was in November of 2023 and all staff were re-educated regarding CPR after the incident. Administrative Nurse D stated LN G could not understand why the facility terminated her employment because, in LN G's opinion, she had done nothing wrong. On [DATE] at 02:00 PM, Administrative Staff A stated one nurse and one CNA were enough staff to take care of seventeen to eighteen residents, and on the day of the incident one of the housekeeping staff and social services/activities staff were on duty and both were also CNAs. The facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated February 2018, documented Personnel have completed training on the initiation of CPR and basic life support for victims of cardiac arrest. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms. Cardiac arrest occurs soon after symptoms appear. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. If an individual or resident is found unresponsive and not breathing normally and licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or There are obvious signs of death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression/ventilation rate of 30:2. When the AED arrives assess for need and follow AED protocol as indicated. Continue with CPR/BLS until emergency medical personnel arrive. The facility's Abuse Policy, revised [DATE], documented all allegations of abuse including physical, mental, emotional, verbal, and/or sexual abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source and any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly shall be investigated by facility management. The administrator will ensure that any further potential abuse or mistreatment is prevented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure staff provided CPR to R1, who desired resuscitative measures as indicated by her full code status. This deficient practice placed R1 and all residents with full code status in immediate jeopardy. The following citations represent the findings of a partial extended survey and complaint investigation#KS00192613. On [DATE] at 02:30 PM Administrative Staff A received a copy of the Immediate Jeopardy Template and was informed of the immediate jeopardy for Resident (R)1. The facility completed the following corrective actions prior to this surveyor entering the facility: The facility submitted education regarding CPR, Advance Directives, Abuse and Neglect, and answering call lights that were completed on [DATE] and Call Light audits were implemented This deficient practice was Past Non-Compliance (PNC) as all corrections were completed prior to the surveyor entering the building. The scope and severity of the deficient practice remained at a G to reflect the actual injury to R1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0725

Level of Harm - Actual harm

Residents Affected - Few

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43204

The facility identified a census of 18 residents. Based on record review, observation, and interview, the facility failed to provide sufficient nurse staffing with the appropriate competencies and skill sets to assure residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R)1 which resulted in R1's needs not being met and ultimately R1's death. On [DATE] at 07:39 AM, Licensed Nurse (LN) G went to R1's room to pass medications. R1's vital signs were blood pressure , d+[DATE] mm/Hg, heart rate 81 bpm, respirations 24 per minute, and SAO2 92% on oxygen at 4 L per nasal cannula. At 09:30 AM, Laundry Person GG went to R1's room and R1 asked him to get LN G. Laundry Person GG went directly to LN G and told LN G R1 needed her. LN G continued to pass medications and answer phone calls. R1 placed her call light on at 09:42 AM and the call light alarmed for one hour and forty-five minutes with no one answering her call light. At 11:00 AM, Environmental Services Director HH, heard Certified Nurse Aide (CNA) M state, that she had seen R1's call light going off, but CNA M was not gowning up to go into the room just to be told R1 needed LN G. At 11:27 AM, LN G looked at the call light directory and saw that R1's light was on. LN G went to R1's room and found her pale, cold to the touch, and pulseless. LN G failed to initiate CPR and pronounced R1 dead at 11:27 AM. This deficient practice placed R1 at risk for grave psychosocial outcomes including fear, anxiety, and neglect due to staff not responding to R1's needs.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of non-ST elevation (NSTEMI) myocardial infarction (a type of heart attack that occurs when a coronary artery is partially blocked), cardiomyopathy (heart disease), hypertension, (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (rapid, irregular heartbeat), and bradycardia (low heart rate, less than 60 beats per minute).

The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R1 required substantial staff assistance with bathing, dressing, transfer, and bed mobility. The MDS documented R1 required moderate staff assistance for personal hygiene, oral hygiene, and toileting hygiene.

The Functional Abilities Care Area Assessment (CAA), dated [DATE], documented R1 was admitted to the facility for physical therapy and occupational therapy for weight bearing and strengthening.

R1's Care Plan, which was not initiated until after R1's death, directed staff R1 required two staff assistance with bed mobility, R1 required two staff assistance and a full lift for transfer, R1 used a bed pan when not incontinent, and required one staff assistance for dressing and showering. The care plan documented R1 required oxygen therapy and directed staff to monitor R1 for signs and symptoms of respiratory distress: respirations, pulse oximetry (the amount of oxygen in the blood), increased heart rate, restlessness, diaphoresis (heavy sweating), headaches, lethargy, confusion, atelectasis (complete or partial collapse of a lung), hemoptysis (coughing up blood), cough, and skin color and report these signs to R1's doctor as needed. R1 required oxygen at 4 Liters (L) per nasal cannula.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Few	R1's EMR, dated [DATE] (date of admission) documented R1 was a full code. The Notes tab in R1's EMR revealed the following: The Nursing Progress Note, dated [DATE] at 11:35 AM, documented LN G went to assess R1. R1's call light was on and Laundry Person GG had stated R1 had requested a nurse. R1 had no signs of life. R1 had no visible breathing, no palpable pulse, and no audible heartbeat. LN G called R1's time of death at 11:26 AM. LN G notified R1's primary care provider, Administrative Nurse D, and R1's family. R1's primary care provider gave a verbal order to release R1's body to the funeral home. The Nursing Progress Note, dated [DATE] at 12:25 PM, documented R1 had previously been assessed by LN G at 07:39 AM. R1 was alert, oriented, and sat up at a forty-five-degree angle in her bed. R1's vital signs were normal, blood pressure ,d+[DATE] mm/Hg (millimeters of mercury), pulse 81 beats per minute, temperature of 96.6 degrees F, pulse 24 beats per minute, and pulse oximetry of 92%. R1 had been breathless which caused her to feel panicked. LN G attempted to call R1's family and coached R1 through some deep breathing to help R1 calm herself. When LN G assessed R1 again at 11:26 AM, R1 was cold to the touch, with no visible signs of life including no breathing, no palpable pulse, and no audible heartbeat. The [DATE] Working Schedule documented LN G and Certified Nurse's Aide (CNA) M were the only two nursing staff scheduled for the [DATE] day shift to take care of 18 residents, with three of those residents being two staff assist. The list of staff certified in CPR documented LN G and CNA M were certified in CPR. The Call Light Audit Report documented R1 had put her call light on at 09:42 AM and it alarmed until 11:23 AM, one hour and forty-five minutes, and no one answered R1's call light. LN G's Notarized Witness Statement, dated [DATE], documented LN G arrived on shift at 06:00 AM. At 07:39 AM, LN G entered R1's room to administer her medications. R1 was alert and sat up in bed. R1's vital signs were within normal limits. R1 was in a panicked state because she could not find her call light or reach her table, and she felt breathless. LN G repositioned R1's bedside table and call light so R1 could reach the items, assisted R1 in calling her family, helped R1 take deep breaths to calm her down, and administered R1's morning medications. R1 stated she was good and needed no further assistance. LN G continued to pass medications to other residents and answer facility phone calls. At 09:31 AM, Laundry Person GG came to LN G and told LN G R1 was requesting a nurse. LN G continued to pass medications and answer facility phone calls. At 11:20 AM, LN G went to the nurse's station and noticed R1's call light was going off on the call light directory. CNA M stated, Oh, she still needs a nurse. At 11:26 AM, LN G went to assess R1 and found her cold to the touch, with no palpable pulse, no breathing, and no audible heartbeat. Based on the temperature of the body being cold to the touch, LN G assessed in her medical opinion life resuscitation was impossible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER: Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 715 Liberty, Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0725

Level of Harm - Actual harm

Residents Affected - Few

CNA M's Notarized Witness Statement, dated [DATE], documented at 06:30 AM CNA M told LN G she was going to start showers and LN G stated she would watch the floor and answer call lights. CNA M stated when she was walking down the hall, she heard Laundry Person GG tell LN G R1 wanted her. CNA M stated she went to assist residents with COVID-19 (highly contagious respiratory virus) get up for the day. CNA M stated when she came out at about 11:15 AM and noted her pager identified R1's call light was going off. CNA M went to LN G and asked her if LN G wanted CNA M to get the call light and told LN G R1 had wanted her earlier and CNA M didn't know if LN G had been in there yet. LN G stated she would go and see what R1 needed. CNA M stated she did not know her pager was going off because she did not look at it when she was in the COVID rooms.

Laundry Person GG's Notarized Witness Statement, dated [DATE], documented Laundry Person GG was in R1's room at 09:30 AM and R1 told him she needed to see LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed her.

Environmental Service's Director HH's Notarized Witness Statement, dated [DATE], documented Environmental Service Director went to the nurse's station at 11:00 AM and CNA M told her Laundry Person GG had gone into R1's room around 09:30 AM and R1 needed LN G. CNA M told Environmental Service's Director HH, LN G had still not gone into R1's room. CNA M told Environmental Service's Director HH, she had seen R1's call light going off, but said she was not going to gown up to go back in R1's room for R1 to just tell her she needed LN G.

Food Service Director JJ's Notarized Witness Statement documented R1 did not have a breakfast menu filled out for the morning on [DATE] which indicated R1 did not receive breakfast.

The Facility Incident Report, dated [DATE], documented on [DATE] at 11:27 AM, LN G called to inform Administrative Nurse D to inform her R1 had passed. LN G stated R1 was unresponsive and cold to the touch and had no pulse. LN G reported she had last seen R1 around 08:00 AM and R1 was sitting upright in bed and in kind of a panic state because R1 could not find her call light and was having trouble breathing. LN G stated R1's vital signs were normal and R1's call light was attached to her bed. LN G assisted R1 in calling her sister which helped R1 calm. At 09:30 AM, Laundry Person GG went into R1's room to see if R1 had any laundry that needed to be done. R1 told Laundry Person GG she wanted to see LN G. Laundry Person GG went and told LN G to inform her of R1's request. LN G continued with medication pass and other duties. At 11:20 AM, LN G noticed R1's call light was going off on the computer. LN G stated she went into R1's room and found R1 lifeless. R1's family, physician, and Administrative Nurse D were notified. During the investigation, call light information was pulled which resulted in LN G and CNA M being suspended pending investigation. LN G was terminated on [DATE]. CNA M returned to work on [DATE]. All staff were in-serviced on [DATE] on Abuse and Neglect, Advanced Directives, and call lights.

On [DATE] at 10:00 AM, Laundry Person GG stated he had entered R1's room around 09:30 AM and R1 asked him to go and get LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed to see her, and LN G stated okay she would get to her. Laundry Person GG stated he heard later that R1 had died .

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:30 AM, CNA M stated she and LN G had been the only nursing staff on duty on [DATE]. CNA M stated she had told LN G she was going to go get showers started about 06:30 AM and LN G stated she would watch the floor and call lights. CNA M stated after showers were done, she went to the COVID rooms to start getting those residents up for the day. CNA M stated when she is gowned up and in Covid rooms she does not take her pager out of her pocket to look at it so she did not know R1's call light was going off until after she got out of the Covid rooms. CNA M stated with all of the COVID residents one nurse and one CNA were not enough staff to take care of the residents. CNA M stated she had not seen R1 at all that morning and was never in R1's room. On ,d+[DATE]/ 25 at 11:00 AM, Administrative Nurse D stated she would have expected staff to answer R1's call light before almost two hours had passed and expected LN G to start CPR on R1 right away after finding her unresponsive and pulseless and get EMS on its way to the facility. Administrative Nurse D stated LN G did not have the right to certify the time of death for R1. Administrative Nurse D stated there were other staff at work the day of the incident that could have answered R1's call light besides LN G and CNA M. Administrative Nurse D verified R1's call light had not been answered in one hour and forty-five minutes. Administrative Nurse D stated the last CPR in-service training was in November of 2023 and all staff were re-educated regarding CPR after the incident. Administrative Nurse D stated LN G could not understand why the facility terminated her employment because, in LN G's opinion, she had done nothing wrong. On [DATE] at 02:00 PM, Administrative Staff A stated one nurse and one CNA were enough staff to take care of seventeen to eighteen residents, and on the day of the incident one of the housekeeping staff and social services/activities staff were on duty and both were also CNA's. The facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated February 2018, documented Personnel have completed training on the initiation of CPR and basic life support for victims of cardiac arrest. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms. Cardiac arrest occurs soon after symptoms appear. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. If an individual or resident is found unresponsive and not breathing normally and licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or There are obvious signs of death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression/ventilation rate of 30:2. When the AED arrives assess for need and follow AED protocol as indicated. Continue with CPR/BLS until emergency medical personnel arrive. The facility's Abuse Policy, revised [DATE], documented all allegations of abuse including physical, mental, emotional, verbal, and/or sexual abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source and any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly shall be investigated by facility management. The administrator will ensure that any further potential abuse or mistreatment is prevented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Few	The facility failed to provide sufficient nurse staffing with the appropriate competencies and skill sets to assure residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for R1 which resulted in R1's needs not being met and ultimately R1's death. The facility completed the following corrective actions prior to this surveyor entering the facility: The facility submitted education regarding CPR, Advance Directives, Abuse and Neglect, and answering call lights that were completed on [DATE] and Call Light audits were implemented This deficient practice was Past Non-Compliance (PNC) as all corrections were completed prior to the surveyor entering the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0726

Level of Harm - Actual harm

Residents Affected - Few

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43204

The facility identified a census of 18 residents. Based on record review, observation, and interview, the facility failed to provide competent nurse staffing, who were unable to recognize Resident (R)1 required cardiopulmonary resuscitation (CPR - emergency lifesaving procedure performed when the heart stops beating) which resulted in R1's needs not being met and ultimately R1's death. On [DATE] at 07:39 AM, Licensed Nurse (LN) G went to R1's room to pass medications. R1's vital signs were blood pressure , d+[DATE] mm/Hg, heart rate 81 bpm, respirations 24 per minute, and SAO2 92% on oxygen at 4 L per nasal cannula. At 09:30 AM, Laundry Person GG went to R1's room and R1 asked him to get LN G. Laundry Person GG went directly to LN G and told LN G R1 needed her. LN G continued to pass medications and answer phone calls. R1 placed her call light on at 09:42 AM and the call light alarmed for one hour and forty-five minutes with no one answering her call light. At 11:00 AM, Environmental Services Director HH, heard Certified Nurse Aide (CNA) M state, that she had seen R1's call light going off, but CNA M was not gowning up to go into the room just to be told R1 needed LN G. At 11:27 AM, LN G looked at the call light directory and saw that R1's light was on. LN G went to R1's room and found her pale, cold to the touch, and pulseless. LN G failed to initiate CPR and pronounced R1 dead at 11:27 AM. This deficient practice placed R1 at risk for grave psychosocial outcomes including fear, anxiety, and neglect due to staff not responding to R1's needs.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of non-ST elevation (NSTEMI) myocardial infarction (a type of heart attack that occurs when a coronary artery is partially blocked), cardiomyopathy (heart disease), hypertension, (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (rapid, irregular heartbeat), and bradycardia (low heart rate, less than 60 beats per minute).

The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R1 required substantial staff assistance with bathing, dressing, transfer, and bed mobility. The MDS documented R1 required moderate staff assistance for personal hygiene, oral hygiene, and toileting hygiene.

The Functional Abilities Care Area Assessment (CAA), dated [DATE], documented R1 was admitted to the facility for physical therapy and occupational therapy for weight bearing and strengthening.

R1's Care Plan, which was not initiated until after R1's death, directed staff R1 required two staff assistance with bed mobility, R1 required two staff assistance and a full lift for transfer, R1 used a bed pan when not incontinent, and required one staff assistance for dressing and showering. The care plan documented R1 required oxygen therapy and directed staff to monitor R1 for signs and symptoms of respiratory distress: respirations, pulse oximetry (the amount of oxygen in the blood), increased heart rate, restlessness, diaphoresis (heavy sweating), headaches, lethargy, confusion, atelectasis (complete or partial collapse of a lung), hemoptysis (coughing up blood), cough, and skin color and report these signs to R1's doctor as needed. R1 required oxygen at 4 Liters (L) per nasal cannula.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Actual harm Residents Affected - Few	R1's EMR, dated [DATE] (date of admission) documented R1 was a full code. The Notes tab in R1's EMR revealed the following: The Nursing Progress Note, dated [DATE] at 11:35 AM, documented LN G went to assess R1. R1's call light was on and Laundry Person GG had stated R1 had requested a nurse. R1 had no signs of life. R1 had no visible breathing, no palpable pulse, and no audible heartbeat. LN G called R1's time of death at 11:26 AM. LN G notified R1's primary care provider, Administrative Nurse D, and R1's family. R1's primary care provider gave a verbal order to release R1's body to the funeral home. The Nursing Progress Note, dated [DATE] at 12:25 PM, documented R1 had previously been assessed by LN G at 07:39 AM. R1 was alert, oriented, and sat up at a forty-five-degree angle in her bed. R1's vital signs were normal, blood pressure ,d+[DATE] mm/Hg (millimeters of mercury), pulse 81 beats per minute, temperature of 96.6 degrees F, pulse 24 beats per minute, and pulse oximetry of 92%. R1 had been breathless which caused her to feel panicked. LN G attempted to call R1's family and coached R1 through some deep breathing to help R1 calm herself. When LN G assessed R1 again at 11:26 AM, R1 was cold to the touch, with no visible signs of life including no breathing, no palpable pulse, and no audible heartbeat. The [DATE] Working Schedule, documented LN G and Certified Nurse's Aide (CNA) M were the only two nursing staff scheduled for the [DATE] day shift to take care of 18 residents, with three of those residents being two staff assist. The list of staff certified in CPR documented LN G and CNA M were certified in CPR. The Call Light Audit Report documented R1 had put her call light on at 09:42 AM and it alarmed until 11:23 AM, one hour and forty-five minutes, and no one answered R1's call light. LN G's Notarized Witness Statement, dated [DATE], documented LN G arrived on shift at 06:00 AM. At 07:39 AM, LN G entered R1's room to administer her medications. R1 was alert and sat up in bed. R1's vital signs were within normal limits. R1 was in a panicked state because she could not find her call light or reach her table, and she felt breathless. LN G repositioned R1's bedside table and call light so R1 could reach the items, assisted R1 in calling her family, helped R1 take deep breaths to calm her down, and administered R1's morning medications. R1 stated she was good and needed no further assistance. LN G continued to pass medications to other residents and answer facility phone calls. At 09:31 AM, Laundry Person GG came to LN G and told LN G R1 was requesting a nurse. LN G continued to pass medications and answer facility phone calls. At 11:20 AM, LN G went to the nurse's station and noticed R1's call light was going off on the call light directory. CNA M stated, Oh, she still needs a nurse. At 11:26 AM, LN G went to assess R1 and found her cold to the touch, with no palpable pulse, no breathing, and no audible heartbeat. Based on the temperature of the body being cold to the touch, LN G assessed in her medical opinion life resuscitation was impossible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Actual harm Residents Affected - Few	CNA M's Notarized Witness Statement, dated [DATE], documented at 06:30 AM CNA M told LN G she was going to start showers and LN G stated she would watch the floor and answer call lights. CNA M stated when she was walking down the hall, she heard Laundry Person GG tell LN G R1 wanted her. CNA M stated she went to assist residents with COVID-19 (highly contagious respiratory virus) get up for the day. CNA M stated when she came out at about 11:15 AM and noted her pager identified R1's call light was going off. CNA M went to LN G and asked her if LN G wanted CNA M to get the call light and told LN G R1 had wanted her earlier and CNA M didn't know if LN G had been in there yet. LN G stated she would go and see what R1 needed. CNA M stated she did not know her pager was going off because she did not look at it when she was in the COVID rooms. Laundry Person GG's Notarized Witness Statement, dated [DATE], documented Laundry Person GG was in R1's room at 09:30 AM and R1 told him she needed to see LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed her. Environmental Service's Director HH's Notarized Witness Statement, dated [DATE], documented Environmental Service Director went to the nurse's station at 11:00 AM and CNA M told her Laundry Person GG had gone into R1's room around 09:30 AM and R1 needed LN G. CNA M told Environmental Service's Director HH, LN G had still not gone into R1's room. CNA M told Environmental Service's Director HH, she had seen R1's call light going off, but said she was not going to gown up to go back in R1's room for R1 to just tell her she needed LN G. Food Service Director JJ's Notarized Witness Statement, documented R1 did not have a breakfast menu filled out for the morning on [DATE] which indicated R1 did not receive breakfast. The Facility Incident Report, dated [DATE], documented on [DATE] at 11:27 AM, LN G called to inform Administrative Nurse D to inform her R1 had passed. LN G stated R1 was unresponsive and cold to the touch and had no pulse. LN G reported she had last seen R1 around 08:00 AM and R1 was sitting upright in bed and in kind of a panic state because R1 could not find her call light and was having trouble breathing. LN G stated R1's vital signs were normal and R1's call light was attached to her bed. LN G assisted R1 in calling her sister which helped R1 calm. At 09:30 AM, Laundry Person GG went into R1's room to see if R1 had any laundry that needed to be done. R1 told Laundry Person GG she wanted to see LN G. Laundry Person GG went and told LN G to inform her of R1's request. LN G continued with medication pass and other duties. At 11:20 AM, LN G noticed R1's call light was going off on the computer. LN G stated she went into R1's room and found R1 lifeless. R1's family, physician, and Administrative Nurse D were notified. During the investigation, call light information was pulled which resulted in LN G and CNA M being suspended pending investigation. LN G was terminated on [DATE]. CNA M returned to work on [DATE]. All staff were in-serviced on [DATE] on Abuse and Neglect, Advanced Directives, and call lights. On [DATE] at 10:00 AM, Laundry Person GG stated he had entered R1's room around 09:30 AM and R1 asked him to go and get LN G. Laundry Person GG stated he went directly to LN G and told her R1 needed to see her, and LN G stated okay she would get to her. Laundry Person GG stated he heard later that R1 had died . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:30 AM, CNA M stated she and LN G had been the only nursing staff on duty on [DATE]. CNA M stated she had told LN G she was going to go get showers started about 06:30 AM and LN G stated she would watch the floor and call lights. CNA M stated after showers were done, she went to the COVID rooms to start getting those residents up for the day. CNA M stated when she is gowned up and in Covid rooms she does not take her pager out of her pocket to look at it so she did not know R1's call light was going off until after she got out of the Covid rooms. CNA M stated with all of the COVID residents one nurse and one CNA were not enough staff to take care of the residents. CNA M stated she had not seen R1 at all that morning and was never in R1's room. On ,d+[DATE]/ 25 at 11:00 AM, Administrative Nurse D stated she would have expected staff to answer R1's call light before almost two hours had passed and expected LN G to start CPR on R1 right away after finding her unresponsive and pulseless and get EMS on its way to the facility. Administrative Nurse D stated LN G did not have the right to certify the time of death for R1. Administrative Nurse D stated there were other staff at work the day of the incident that could have answered R1's call light besides LN G and CNA M. Administrative Nurse D verified that R1's call light had not been answered in one hour and forty-five minutes. Administrative Nurse D stated the last CPR in-service training was in November of 2023 and all staff were re-educated regarding CPR after the incident. Administrative Nurse D stated LN G could not understand why the facility terminated her employment because, in LN G's opinion, she had done nothing wrong. On [DATE] at 02:00 PM, Administrative Staff A stated one nurse and one CNA were enough staff to take care of seventeen to eighteen residents, and on the day of the incident one of the housekeeping staff and social services/activities staff were on duty and both were also CNA's. The facility's Emergency Procedure-Cardiopulmonary Resuscitation Policy, dated February 2018, documented Personnel have completed training on the initiation of CPR and basic life support for victims of cardiac arrest. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms. Cardiac arrest occurs soon after symptoms appear. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest. If an individual or resident is found unresponsive and not breathing normally and licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual, or There are obvious signs of death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression/ventilation rate of 30:2. When the AED arrives assess for need and follow AED protocol as indicated. Continue with CPR/BLS until emergency medical personnel arrive. The facility's Abuse Policy, revised [DATE], documented all allegations of abuse including physical, mental, emotional, verbal, and/or sexual abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source and any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly shall be investigated by facility management. The administrator will ensure that any further potential abuse or mistreatment is prevented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Advena Living of Clay Center		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Liberty Clay Center, KS 67432	

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F 0726 Level of Harm - Actual harm Residents Affected - Few	The facility failed to provide sufficient nurse staffing with the appropriate competencies and skill sets to assure residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for R1 which resulted in R1's needs not being met and ultimately R1's death. The facility completed the following corrective actions prior to this surveyor entering the facility: The facility submitted education regarding CPR, Advance Directives, Abuse and Neglect, and answering call lights that were completed on [DATE] and Call Light audits were implemented This deficient practice was Past Non-Compliance (PNC) as all corrections were completed prior to the surveyor entering the building.