STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Lane Nursing Home	210 E Park Lane Scott City, KS 67871

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 - Some	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** The facility identified a census of 35 residents, including five residents with full code status, and six residents sampled for code status. Based on record review and interview, the facility failed to ensure staff provided cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) to Resident (R) 1, who desired resuscitative measures as indicated by his full code status. Around 09:00 PM on [DATE], Certified Nurse Aide (CNA) M saw R1's representative leave his room. At 09:50 PM, CNA M entered R1's room and noted the resident was purple and lacked a pulse. CNA M called on the radio he needed a nurse STAT (immediately) and then stepped out of R1's room and shut the door. CNA M was not aware R1 was a full code status. Licensed Nurse (LN) G entered R1's room at 09:55 PM, assessed him, and noted he was cool, cyanotic (blue due to lack of oxygen), and lacked vital signs. LN G knew R1's full code status but determined R1 was out [outside] of the window for CPR and decided starting resuscitative measures would do more damage than it would help. The facility's failure to initiate resuscitative measures for R1 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 pleural effusions (abnormal accumulation of fluid in the lungs), pneumothorax (accumulation of air and blood in the area around the lungs), hypoxemia (abnormal deficiency in the concentration of oxygen in arterial blood), heart failure (a condition with low heart output and the body becomes congested with fluid), and atrial flutter (a condition when the hearts upper chambers beat too quickly). The admission Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R1 required supervision or touch assistance from staff for hygiene, transfer, and ambulating 10 feet. R1 required partial to substantial assistance with dressing and bathing and was dependent on staff for putting on/taking off footwear. The MDS documented R1 required continuous oxygen. The MDS documented R1 was short of breath with exertion and when sitting at rest. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated [DATE] documented R1 was at risk for further cognitive decline, loss of motivation, poor safety awareness, and inability to express his needs due to a new environment, recent hospitalization, and the transition into long term care. (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Functional Abilities CAA, dated [DATE], documented R1 had the potential for further mobility decline, falls, skin breakdown, and further incontinence related to muscle weakness, difficulty walking, recurrent pleural effusions, pneumothorax, and hypoxia. R1's Care Plan documented R1 had an altered cardiovascular status and directed staff to monitor R1's vital signs, notify R1's physician of significant abnormalities, and monitor R1 for chest pain or pressure, shortness of breath, nausea/vomiting, and changes in color or warmth of R1's extremities. The care plan documented R1 was on continuous oxygen via nasal cannula at 2-3 liters (L) ([DATE]). R1's Care Plan documented R1 chose to be resuscitated if his breathing or heart stopped. The plan documented R1's wishes would be honored and CPR would be initiated if R1's heart or breathing ceased ([DATE]). R1's admission Orders, dated [DATE], documented a full code status for R1 signed by R1's primary care physician. The Health Status Note, dated [DATE] at 12:16 AM, documented LN G went to R1's room at approximately 09:50 PM in response to a call from CNA M. Upon entering R1's room, LN G saw R1 with his buttocks on the footstool and upper body lying back in the recliner; his arms were spread out and his legs were upright and bent at the knees. The note documented R1 appeared as though he was sitting on the footstool to either get up and go to the bathroom or was coming back. R1's oxygen was only halfway on, wrapped around his right ear and neck, but not in his nares. Upon assessment, R1 was cool to the touch and his lips were turning blue; he had no pulse, no heart sounds, no rise and fall of his chest, and his eyes were fixed and slightly rolled back. LN G noted she understood R1 was a full code, yet at the time R1 was found she, along with the other staff in the room, all decided the time to start CPR had expired and starting CPR at that time would have done more damage to the body than it would help. LN G documented she asked everyone in the room if they would like to perform CPR, including the other LN, and everyone declined. The four staff in the room lifted R1 into the recliner and LN G and LN H both reassessed R1 for pulses, listened for heart sounds and breath sounds, and watched for chest rise and fall with none detected. LN G documented the staff pronounced R1 deceased and called the time of death, at that time. LN G's notarized Witness Statement, dated [DATE], documented she was called to R1's room at approximately 09:50 PM. Upon assessment, R1 was cool to the touch, lips were turning blue, no pulse, no heart sounds, and no rise and fall of the chest. R1's skin color was a yellowish/orange color, and his eyes were fixed and slightly rolled back. LN G stated she checked to verify R1 was a full code and returned to R1's room with the understanding R1 was a full code. LN G noted she asked everyone in the room if they felt doing CPR at that time would be beneficial and everyone agreed the time to do CPR and for it to be productive had expired, and starting CPR at that time would do more damage to R1's body than it would help. LN G stated she asked everyone in the room on numerous occasions if they would like to perform CPR, including the other LN, with everyone declining. LN G noted staff lifted R1 into the recliner and LN G and LN H both listened for heart sounds, and breath sounds and looked for chest rise and fall with no signs detected. LN G notified the on-call provider and LN G received the okay to pronounce R1 as deceased as well as to release the body to the funeral home when the family was ready. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LN H's notarized Witness Statement, dated [DATE], documented she was present in the facility prior to the 10:00 PM to 06:00 AM shift on the evening of [DATE] and while she waited to get a report from LN G, she heard staff radio for a nurse to R1's room STAT at 09:50 PM. LN H documented she went to the nurse's station, logged into the EMR, and checked the code status for R1; R1 was a full code. LN H grabbed the radio to inform staff R1 was a full code and CPR needed to be started at approximately 09:58 PM and LN G responded back on the radio, We are way past that point. LN H noted she grabbed a stethoscope and took it to R1's room. LN H stated she arrived in R1's room at 10:00 PM, CPR had not been started, and the staff in the room were CNA M, CNA N, and LN G. LN H noted she handed LN G the stethoscope so she could assess R1, but CPR had still not been initiated. LN H stated she left R1's room at 10:05 PM. CNA M's notarized Witness Statement, dated [DATE], documented at approximately 09:50 PM, he knocked on R1's door and received no answer. CNA M opened the door and saw R1 lying across his footstool, slumped back; R1's head lay on his recliner, his arms hung down, and his eyes rolled back. CNA M noted he shook R1, called his name, and got no response so he checked R1's pulse on R1's wrist and neck and did not feel anything. CNA M documented he paged for LN G to come to R1's room STAT and LN G responded she was in another resident's room, so he paged again for LN G to come quickly. The statement documented CNA N entered R1's room and CNA M told her, I think he's dead, and told CNA N to go get LN G. Both LN G and LN H came into R1's room ten minutes later, and LN G came first. CNA M noted both LN G and LN H called out to R1 and checked R1's pulse.; R1's skin was discolored. CNA M, CNA N, LN G, and LN G moved R1 farther up into the chair so the nurses could assess R1 better. CNA M wrote the last time he saw R1 was between 08:30 PM and 09:00 PM when R1's daughter visited. CNA N's notarized Witness Statement, dated [DATE], documented R1 did not eat supper and stayed in his room. CNA N last saw R1 when he wanted his evening pills and CNA N saw R1's daughter leave at 09:00 PM. CNA N documented CNA M called on his walkie-talkie, I need a nurse to [R1's] room STAT. CNA N stated she ran to R1's room and saw the resident leaning over his chair. CNA M stated, I think he's dead. CNA N documented they went into R1's room and checked for a pulse, and there was nothing. They called again for LN G, and she never came. CNA N stated she ran to the east side of the facility and told LN G, Come on. We need you. CNA N stated she ran back to the west side, and LN H told her R1 was a full code, and said staff better be doing CPR. CNA N stated she told LN G R1 was a full code, and LN G said, We are past that point. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Facility Incident Report, dated [DATE], documented on [DATE] at approximately 09:50 AM, CNA M discovered R1 unresponsive during routine rounds. Attempts to stimulate R1 were unsuccessful. CNA M checked both for radial and carotid pulses and found none. CNA M called for immediate nurse assistance using the walkie-talkie and CNA N arrived shortly after and also found no signs of life. Another call was made via walkie-talkie. LN G, who had been providing care to another resident on another unit at the opposite end of the building, did not immediately hear the call as a STAT emergency. CNA N located LN G around 09:53 PM and requested her attention from the opposite end of the hallway, and CNA N returned to R1's room while awaiting LN G's arrival. LN G arrived at 09:55 PM. Upon assessment, LN G noted R1 was cool to the touch, with cyanotic lips, no pulse, no respirations, fixed eyes, and other signs. Oxygen tubing was displaced from R1's nares. LN H, the oncoming nurse, heard the call prior to assuming her shift and announced over the walkie-talkie R1 was a full code at 09:57 PM. LN H arrived at R1's room at 10:00 PM, reiterated the code status, and stated CPR should be initiated. LN G responded she believed resuscitation would not be beneficial based on R1's condition and that too much time had passed. No CPR was initiated. LN G called the on-call provider, and an order was given to release the body. Next of kin and appropriate staff were notified per protocol. The cause of death was determined to be cardiac arrest secondary to acute myocardial infarction. All staff directly involved held current Basic Life Support (BLS) certification and CNA M and CNA N had participated in the facility-wide CPR drill conducted on [DATE]. On [DATE] at 02:00 PM, CNA M stated he went to do the last rounds and knew R1's daughter had just left, not long ago. CNA M stated he knocked on R1's door and there was no answer, so he opened R1's door and peeked in. CNA M stated that R1 was sitting on a stool and leaned back into his recliner with his arms spread wide and his eyes rolled into the back of his head. He was purplish. CNA M stated he checked a radial pulse and a carotid pulse and did not feel anything. So he got on the radio and called for the nurse STAT to R1's room but the nurse responded she was in another resident's room. CNA M said he called on the radio again that he needed a nurse now. CNA M stated he stepped out of R1's room and shut the door. He said he did not know R1 was a full code. On [DATE] at 02:30 PM, CNA M stated she last saw R1 at 08:57 PM when he called to ask for his potassium, and she went and asked the medication aide if he could have it; the medication aide said R1 had already had all of his pills and she went back into R1's room to tell him. CNA N stated when she heard CNA M call on the radio for a nurse STAT, she went to R1's room and saw R1 sitting on his stool and lying back in his recliner with his arms wide open. CNA N stated that R1's lips were purple, and she checked his pulse, and he did not have any. CNA N stated CNA M told her to run and get LN G and so she did. CNA N stated she did not know R1's code status. On [DATE] at 03:00 PM, Administrative Nurse D stated she is the CPR instructor at the facility, and she makes sure staff are trained for CPR. Administrative Nurse D stated she expected staff to perform CPR when finding a resident who is a full code unresponsive. Administrative Nurse D stated LN G now understood that she could not just call the time of death on a full code unless unmistakable signs of death were obvious. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's undated CPR Policy, documented that if an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally a staff member who is trained in CPR/BLS shall initiate CPR unless: it is known that a do not resuscitate order that strictly prohibits CPR and or external defibrillation exists for that individual or there are irreversible signs of death (e.g. rigor mortis). 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 person to arrive on the scene is not CPR/BLS trained, that person will call 911 and follow the 911 operator's instructions until a CPR/BLS trained staff member arrives. The facility identified and implemented immediate corrective actions, which were completed on [DATE] and included: All nursing staff re-educated regarding CPR and full code status, and mock codes were performed on all shifts. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at a J scope and severity.