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. 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. (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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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.