STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD HILLSBORO, KS 67063**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

A complaint survey for KS180176 and KS180210 was conducted by Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 05/22/23 and 05/23/23.

On 05/23/23 at 11:20 AM, Administrative Staff A was provided a copy of the IJ template and notified of the facility failure to provide therapeutic and/or mechanically altered diets as ordered, and the failure to provide supervision/assistance for R1 while she ate, due to her dysphagia and risk for aspiration, which placed R1 in immediate jeopardy. Due to these failures, R1 subsequently choked/aspirated during a facility activity on 05/12/23, after staff noted she began making a "gurgling" sound and had difficulty breathing. The staff implemented a mouth sweep and suctioning of R1, which was unsuccessful. Staff then began CPR when R1 became unresponsive and ashen in color, and was noted with blue tinting to her lips and fingernails. The facility transferred R1 to a local hospital via Emergency Medical Services, where she subsequently died.

The facility identified and implemented the following corrective measures on 05/15/23 at 04:00 PM:

1. On 05/12/23 at 05:30 PM, the facility implemented an immediate intervention for a dietary team member to be present at all activities if food/drinks were served. Dietary Staff BB would review the activities calendar and prepare the food/drinks for activities. The facility updated the list of mechanically altered diets/fluids.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

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F 000	Continued From page 1 2. On 05/12/23 at 05:30 PM, the facility completed immediate education and review on the care plan policy with all nursing staff. 3. On 05/12/23 at 05:30 PM, the facility completed immediate education on abuse, neglect, and exploitation to all staff. 4. On 05/12/23 at 05:30 PM, the facility completed immediate education on diet/food consistency/thickened liquids to all nursing and dietary staff. 5. On 05/15/23 at 01:00 PM, the facility contacted the Medical Director to review the investigation, reporting summary, action plan, and the new dysphagia diet policy. 6. On 05/16/23 at 04:00 PM, the facility revised the "Dysphagia Care" policy and completed education to all nursing and dietary staff. The surveyor verified the implementation of the above corrective actions onsite on 05/23/23 at 03:30 PM. Due to the implemented corrective actions prior to the surveyor's arrival onsite, the deficient practice was deemed past-noncompliance and existed at a "J" scope and severity. This 2567 was electronically sent to the facility on 06/01/23.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 2 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility reported a census of 41 residents with six sampled, including three residents reviewed for physician ordered therapeutic/mechanically altered diets. Based on observation, record review, and interview, the facility failed to prevent neglect when they failed to provide Resident (R)1 with a therapeutic diet and 100% supervision during oral intake. R1 had dysphagia (swallowing difficulty) and was at risk for aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident) following a cerebrovascular accident (CVA - [stroke] sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). Due to these failures and lack of staff knowledge on providing the correct altered diet/fluids to residents, R1 attended a facility activity/party on 05/12/23, where she consumed hard shell candy pieces within reach of where staff placed her, and staff served her a cupcake and a non-thickened liquid. Although staff were in the area, they did not provide 100% supervision to the resident while eating and neglected to identify she had received non-thickened liquids	F 600	Past noncompliance: no plan of correction required.	

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	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

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F 600	Continued From page 3	F 600		

until the cup was empty and only ice remained. R1 choked/aspirated, made a "gurgling" sound, had difficulty breathing, mouth sweep and suctioning were unsuccessful, and R1 became unresponsive and ashen in color with blue tinting to her lips and fingernails. The staff initiated cardiopulmonary resuscitation (CPR - emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.) and called 911. Emergency Services took over and transferred her to the hospital where she later died. This deficient practice resulted in R1's death and placed five other residents who received a therapeutic diet/mechanically altered consistency diet in immediate jeopardy.

Findings included:

- The hospital "Progress Note" dated 04/30/23 for R1 revealed an assessment of dysphagia with aspiration.

The hospital "Admission Physician Orders" dated 05/03/23 for R1 included a diagnosis of post CVA.

The "Minimum Data Set (MDS)" tab revealed R1 entered the facility on 05/04/23.

The "Baseline Care Plan" dated 05/04/23 revealed R1 required one-person physical assistance support for eating and required a mechanical soft diet, meat with gravy, nectar thick liquids, ate in the dining room, used a weighted utensil/straw, and was at risk for swallowing and chewing problems.

The hospital "Discharge Instructions" dated 05/04/23 for R1 revealed a diet order of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 4	F 600		

mechanical soft, nectar thick liquids, gravy on meat, 100% supervision during meal per Speech Therapy, and included R1 would aspirate (inhaling liquid or food into the lungs) if the meat was dry.

The "Functional Abilities and Goals - Admission" assessment dated 05/04/23 revealed the resident required supervision or physical assistance for eating.

The "Orders" tab for R1 included a diet order dated 05/04/23 for mechanical soft, level 2 texture (food to avoid included but were not limited to dry or chewy cakes, cookies, and chewy candies and allowed food items included moist cakes or slurried cakes), nectar consistency, and lacked R1 required 100% supervision.

The "Admission Summary Progress Note" dated 05/04/23 at 04:07 PM revealed R1's diet was mechanical soft, meat with gravy, nectar thick liquids, one to one with meals, had weighted utensils and straw, medications to be crushed with applesauce, and she was alert with mild confusion.

The "Speech Therapy Evaluation and Plan of Treatment" dated 05/08/23 revealed R1 had a diagnosis of dysphagia following other cerebrovascular disease and had decreased safety during oral intake, with a history of dysphagia and aspiration.

The "BIMS [Brief Interview of Mental Status] Evaluation Progress Note" dated 05/10/23 at 04:22 PM revealed a score of three indicating severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 5	F 600		

The facility "Timeline of Events" for 05/12/23 revealed the following:
1. At 01:55 PM, Activity Staff Z was making cherry limeades for the activity party in the dining room. Consultant Therapy Staff GG brought R1 to the dining room in her wheelchair, and Certified Nurse Aide (CNA) M was assisting in the dining room area.

2. At 01:58 PM, CNA M and Activity Staff Z passed out drinks that Activity Staff Z made for the activity, all resident in the activity were served a cherry limeade in a plastic cup.

3. At 02:09 PM, Administrative Nurse D passed out cupcakes to the residents that wanted one and Activity Staff Z passed out straws.

4. At 02:24 PM, Administrative Nurse D checked on R1 who was vocalizing at that time.

5. At 02:25 PM, Administrative Nurse D went back to check on R1 and Certified Medication Aide (CMA) R helped R1 at that time.

6. At 02:26 PM, Administrative Nurse D and CMA R helped R1 who had increased mucus at that time.

7. At 02:29 PM, Administrative Nurse D and CMA R continued to assist R1 with napkins and mucus.

8. At 02:32 PM, Administrative Nurse D and CMA R continued to assist R1.

9. At 02:37 PM, CMA R and CMA S took R1 out of the dining room and to Licensed Nurse (LN) G to be assessed. Administrative Nurse D and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 6	F 600		

Dietary Staff BB stayed in the dining room.

10. At 02:38 PM, R1 was at the nurse's station.

11. At 02:40 PM, staff went to get the suction machine.

12. At 02:41 PM, staff arrived with the emergency suction machine cart.

13. At 02:43 PM, LN G and Consultant Therapy Staff II assisted R1 to the floor and attempted mouth sweeps on R1, with R1's head turned to the side.

14. At 02:44 PM, Consultant Therapy Staff II started CPR.

15. At 02:50 PM, Emergency Medical Services (EMS) arrived and took over CPR.

16. At 03:15 PM, EMS left the building with R1 after return of cardiac rhythm and pulse.

17. At 06:04 PM, staff contacted the hospital and hospital nurse explained the DPOA (Durable Power of Attorney) desired to cease treatment at the hospital and R1 expired.

The "Progress Note" dated 05/12/23 at 03:59 PM revealed a staff member brought R1 to the nurse stating she was at the facility activity/party when R1 was given thin liquids to drink and started choking, possibly aspirating. When the nurse began assessment, R1 was not responding and her color began to change to ashen, eventually blue in her lips and nail beds. The nurse attempted to suction R1 to remove any fluid without success and R1 went completely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 7	F 600		

unresponsive at that time. The staff helped lower R1 to the floor, the staff started CPR right away. R1 lacked a pulse and air exchange, CPR continued, and the staff notified 911. CPR continued until EMS arrived.

The facility "Witness Statement" dated 05/15/23 by CNA M revealed on 05/12/23 she had asked Activity Staff Z if there was anything she could do to help in the dining room and he had told her to pass out some drinks, so CMA M did. After passing out a couple of drinks and talking to a few residents, CMA M left the dining room to go to her assigned work area.

The facility "Witness Statement" dated 05/15/23 by Administrative Nurse D revealed on 05/12/23 she arrived (lacked what time) to the dining room to assist Activity Staff Z with the activity and asked what needed done. Most of the resident's had drinks at that time, Administrative Nurse D gave out a couple then passed out cupcakes, then assisted a resident to eat and drink. At some point Dietary Staff BB came out with the fruit and meat trays and started to serve the residents. Activity Staff Z asked R1 what she wanted and Dietary Staff BB said she was on a special diet and could not have the fruit, but she could get her a fruit cup, and Administrative Nurse D continued to serve the other residents. While on the south side of the dining room serving residents, Administrative Nurse D heard someone coughing with a moist/wet cough and saw that it was R1. Administrative Nurse D stated she went over to R1 and at some point, CMA R came over to help R1, too. R1 was coughing and talking and calmed down after a while, and Administrative Nurse D asked CMA R, if she was back to normal status and CMA R responded "maybe" but did not look

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 8	F 600		

too sure about it. Administrative Nurse D then told CMA R to take her to the nurse's station to be checked by the nurse while Administrative Nurse D stayed with the other residents. Then, CMA S came to the dining room and said the staff needed Administrative Nurse D immediately, and when arrived at the nurse's station, the staff there was trying to get R1 out of her wheelchair. The staff got R1 to the floor, she was unresponsive, 911 notified, and CPR started. CPR continued until EMS arrived and took over and they achieved a cardiac rhythm and transported her out via gurney.

The facility "Witness Statement" dated 05/15/23 by CMA R revealed on 05/12/23 she went to the dining room (lacked what time) to assist with the activity/party, noticed R1 "gurgling", and notified Administrative Nurse D who was present in the dining room. CMA R sat with R1 and talked to her asking if she could breathe at that time and R1 said she could. CMA R asked again a couple of minutes later if she could breathe again and R1 stated it was "tough." CMA R notified Administrative Nurse D, who instructed her to take R1 to the charge nurse on duty. R1 started changing colors and another staff went to get the emergency cart the proceeded to get her out of the chair. CMA R called 911 and the staff started CPR as another staff member went and got Administrative Nurse D.

The facility "Witness Statement" dated 05/15/23 by Dietary Staff BB revealed on 05/12/23 there was an activity/party which started at 02:00 PM and dietary was providing fruit, cookies, and meat/cheese trays, and was running behind. Dietary Staff BB entered the area at about 02:30 PM and at that time R1 had a cup and a cupcake

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

wrapper in front of her, and Administrative Nurse D and CMA S were helping out Activity Staff Z. Activity Staff Z asked R1 if she would like any fruit and Dietary Staff BB informed Activity Staff Z that R1 was not allowed that on her diet, but she could get her some canned fruit.

The facility "Witness Statement" dated 05/15/23 by CMA S revealed on 05/12/23 she was helping in the dining room when R1 started "gurgling" and after a while, Administrative Nurse D asked to take R1 down to the charge nurse on duty. When CMA S noticed R1 was changing color, she ran for the emergency cart and when returned staff were attempting to get R1 out of the wheelchair. Another staff called 911 and CMA S went to get Administrative Nurse D who was in the dining room. CMA S took EMS when they arrived to R1, and the staff were performing CPR.

The facility "Witness Statement" dated 05/15/23 by Consultant Therapy Staff II revealed on 05/12/23 around 02:30 PM, she walked out of the therapy room and heard "she's not breathing" so then handed her patient over to Consultant Therapy Staff GG and went to help. Consultant Therapy Staff II helped lower R1 to the floor, swept her mouth twice to see if anything was blocking her airway and CPR initiated. LN G used the suction machine, however, was unsuccessful. LN G used an "Ambu bag" (handheld device used to provide ventilation to patients her are not breathing) and could not get it sealed around R1's mouth. Consultant Therapy Staff II gave "mouth to mouth" several times. R1 had a sticky, light red fluid that came out and the staff turned her head to get the fluid out. During this time R1 was unresponsive and turning blue. EMS arrived and took over and stated R1 had a pulse after they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

gave her medication and CPR, then transported her to the hospital.

The facility "Witness Statement" dated 05/15/23 by LN G revealed on 05/12/23, staff brought R1 to the nurse's station. R1 had been at the facility activity/party where she was given thin liquids. R1 was not responding when assessment began, her skin color became ashen, then blue. LN G ran to get the suction machine to try and remove any fluids from R1's airway without success. CPR started, R1 had no pulse or air exchange, 911 notified, and CPR continued until EMS arrived.

The hospital records where R1 transferred to on 05/12/23 revealed she was unresponsive, cyanotic (bluish or purplish discoloration of the skin), and receiving treatment with a LMA (laryngeal mask airway - used as a temporary method to maintain an open airway), "bagging" (providing breathes with use of a device), and she had poor air movement with coarse breath sounds (crackling, bubbling sound that presents with excessive fluid in the lungs which could be caused by aspiration). At 03:33 PM, the family reported she had a DNR (do not resuscitate) and requested comfort measure. R1's time of death was at 03:55 PM.

On 05/22/23 at 10:05 AM, Administrative Staff A stated the facility "Timeline of Events" was done using the facility cameras.

On 05/22/23 at 10:50 AM Administrative Staff A stated R1 did receive a cupcake at the activity/party on 05/12/23 and her diet order included 100% supervision with meals.

On 05/22/23 at 11:01 AM Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 11	F 600		

stated she was "generally supervising" the dining room area on 05/12/23 and was in the vicinity of R1.

On 05/22/23 at 11:09 AM, CNA M stated she was in the dining room for the activity on 05/12/23 and Activity Staff Z asked her to help pass out drinks. CNA M stated she gave R1 a limeade from the table and that she had never provided cares to her before as R1 was in a different area of the facility than where she had been assigned to. CNA M stated she was not sure what kind of diet R1 was on. CNA M stated there were packages of what looked like hard shell candies on the table and that R1 had some in front of her, however, she did not know if R1 had opened them or not and had not observed R1 take a drink while there.

On 05/22/23 at 11:40 AM, Activity Staff Z stated he put the activity/event together and had left at 02:28 PM on 05/12/23. Activity Staff Z stated Administrative Staff A had brought cupcakes and hard-shell candies for the party and placed the candies on the tables where the residents would sit. Activity Staff Z stated he placed cupcakes on plates and Administrative Nurse D and CMA S passed them out. Activity Staff Z stated he recalled R1 sat in the dining room with the hard-shell candies in front of her and did not know if she opened them or not. Activity Staff Z stated he passed out a few drinks, mainly pouring them, and did not know if any of the residents in the dining room required thickened liquids, and he did not know R1's diet orders. Activity Staff Z stated he left at 02:28 PM and at that time heard Dietary Staff BB and Administrative Nurse D talking about R1's liquids were supposed to be thickened. R1 had already ate her cupcake and she had the hard candies and a drink in front of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	**200 WILLOW RD HILLSBORO, KS 67063**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

her.

On 05/22/23 at 01:19 PM, Consultant Therapy Staff HH stated R1 was an aspiration risk based on the swallow study done at the hospital, prior to admission to the facility. Consultant Therapy Staff HH stated R1 admitted to the facility on a dysphagia level two diet, ground meat, mechanical soft, nectar thick liquids, and 1:1 supervision and she did not change any of the admission diet orders for R1. Consultant Therapy Staff HH stated according to the dysphagia diet guidelines used by the facility, would need to double check, typically the cupcake would need to be slurried, cakes should be moist, sometimes the frosting could do that, and stated it was a fine line and depended on how moist or soft the cupcake, if R1 would be able to tolerate it. Consultant Therapy Staff HH stated she would not have recommended the hard-shell candies due to the outer candied shell could pose a risk if not chewed well.

On 05/22/23 at 02:26 PM, Dietary Staff BB stated she saw R1 in the dining room on 05/12/23 and she had a cup in front of her and did not see if it was empty or not, an empty cupcake wrapper, and a little box with hard-shell candies that was opened in front of R1. Dietary Staff BB stated R1 had a mechanical soft dysphagia level two diet, and as long as the cupcake had enough frosting and was a moist cake, then it would be appropriate for her. Dietary Staff BB stated she did not see the cupcakes and probably would not have given her the candies. Dietary Staff BB stated there were nursing staff present in the dining room, however not with R1 at the table. Dietary Staff BB stated Activity Staff Z was getting ready to give her some fresh fruit, but before she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

answered, she told Activity Staff Z she could get R1 a fruit cup. When she returned to the dining room, CMA S and CMA R checked on R1, debated on if they should call the nurse or take R1 to the nurse, and they decided to take the resident to the nurse. Dietary Staff BB stated the nursing staff would have to look at a resident's care plan to determine their diet and the dietary staff had a spreadsheet for the different diets due to lack of access to the care plans.

On 05/22/23 at 02:45 PM, Administrative Staff A stated she had put the hard-shell candies in a small purple box that had a butterfly on top, like fun size, as center pieces on the tables for the party around 01:00 PM, after lunch, when Activity Staff Z set up the tables and made the cupcakes.

On 05/22/23 at 03:51 PM, Administrative Nurse D stated she did not observe R1 take any drinks however she had a cup in front of her at the activity/party on 05/12/23, and it only had ice in it when she observed it. It was approximately a 12-ounce plastic cup, and there was evidence R1 ate the candies due to colors of the candies on the tablecloth where she touched it after putting them in her mouth, and the box was empty. Administrative Nurse D stated it was "okay" for R1 to have the candies since they "melt in your mouth." Administrative Nurse D stated R1's liquids were to be thickened, and thickened liquids would not have ice in them. Administrative Nurse D stated she did not know if R1 required supervision with oral intake, and when checking the care plan, Administrative Nurse D stated the care plan did not reveal she required supervision for meals. Administrative Nurse D stated 100% supervision at meals would indicate the resident should have "somebody sitting there with them"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

and the 100% supervision should have been included in her diet order. Administrative Nurse D stated staff should have provided supervision at the party when R1 had food and fluids. Prior to serving R1, the staff should have checked the care plan and orders.

On 05/22/23 at 06:43 PM, CMA R stated when she entered the dining room on 05/12/23, R 1 had a cupcake, a little box of hard-shell candies, and what she thought was fruit punch, and later staff passed out the cookies. CMA R stated she did not see R1 drink from the cup, but it only had ice in it when it was later observed. CMA R stated she did not see R1 eat the candies or the cookie, however the cookie did not have any bites gone from it when she removed R1 away from the table. CMA R, who had cared for R1 before, stated at the time she knew R1 was to have chopped ground meat moistened with gravy and thickened liquids. CMA R stated she said something to Administrative Nurse D, after noticing R1 having some problems, that it looked like there was regular (thin) liquids in R1's cup and had not noticed it before that time. CMA R stated she sat by R1 and asked her one last time about her breathing and R1 stated it was really hard to breathe, so she alerted Administrative Nurse D who told her to take R1 to the nurse. CMA R stated R1 required supervision, when she came out for meals, staff was always to be with her, and when CMA R got to the dining room on 05/12/23, no staff were with R1, at that time. CMA R stated Administrative Nurse D and CMA S were "meandering" around the residents in the area.

On 05/23/23 at 01:54 PM, third attempt made to contact LN G for interview, without success. Review of the facility video footage dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

05/12/23 from 01:45 PM until 02:37 PM with Administrative Staff A revealed the following:

At 01:48 PM, purple boxes sat on the tables in the area of the dining room for the activity/party.

At 01:55 PM, Consultant Therapy Staff GG brought R1 to the table via wheelchair for the activity/party, and the box of candies were in front of her on the table. R1's back was to the facility camera.

At 1:58 PM, CNA M provided R1 a cup of fluids from the table where Activity Staff Z was making the cherry limeades. R1 grabbed the cup and tilted her head back, which appeared that she took a drink from the cup.

At 01:59 PM, R1 appeared to take another drink, CNA M was at the table where the resident sat, then exited the area at 02:01 PM.

At 02:02 PM, Activity Staff Z and Administrative Nurse D entered the activity/party area, R1 lacked supervision by staff.

At 02:05 PM R1 moved her upper body forward and back, her back still to the facility camera.

At 02:08 PM, Administrative Nurse D gave R1 a cupcake.

At 02:13 PM, CMA R patted R1 on the back.

At 02:21 PM, Activity Staff Z and Dietary Staff BB appeared to be talking to each other in the area of the activity/party behind R1.

At 02:25 PM, Administrative Nurse D sat down by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

R1, CMA R rubbed R1's shoulders, then Administrative Nurse D got up from the table.

At 02:26 PM, Administrative Nurse D handed CMA R a napkin, who then bent over R1, however, R1's back was still to the facility camera, obstructing view of what CMA R did with the napkin.

At 02:27 PM, CMA R patted R1 on the shoulders while Administrative Nurse D was on the right side of R1.

At 02:30 PM, CMA R remained with R1.

At 02:31 PM, CMA R got another napkin and returned to R1, however unable to see what she did with the napkin.

At 02:33 PM, R1 made a motion with her hand, Administrative Nurse D checked on her and walked away.

At 02:34 PM, CMA R stood beside R1 and patted her on the back, rubbed her back/neck area with gentle pats.

At 02:35 PM, CMA R stood up again, and continued to rub R1's back.

At 02:36 PM, CMA R left R1 to throw something away and then returned to R1.

At 02:37 PM, CMA R leaned over R1, moved her away from the table and towards the exit doorway of the dining room, walked away, and CMA S moved R1 in her wheelchair out of the dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 600	Continued From page 17	F 600		

The facility "Level Two" ground food guideline, undated, revealed that food to avoid included dry or chewy cakes, cookies, and chewy candies and allowed food items included moist cakes or slurried cakes.

The facility policy "Thickened Liquids - Preparing and Serving" undated, revealed thickened liquids will be served when ordered by the resident's physician.

On 05/23/23 at 11:20 AM, Administrative Staff A was provided a copy of the IJ template and notified the facility failure to prevent neglect with the failure to provide therapeutic and/or mechanically altered diets as ordered, and failure to provide supervision/assistance for R1 while she ate, due to her dysphagia and risk for aspiration, placed R1 in immediate jeopardy Due to this failure, R1 subsequently choked/aspirated at the facility activity on 05/12/23, after staff noted she began making a "gurgling" sound and had difficulty breathing. The staff implemented a mouth sweep and suctioning of R1, which were unsuccessful, then began CPR when R1 became unresponsive and ashen in color, with blue tinting to her lips and fingernails. The facility emergency medical transferred R1 to a local hospital, where she subsequently died.

The facility identified and implemented the following corrective measure on 05/15/23 at 04:00 PM:

1. On 05/12/23 at 05:30 PM, the facility implemented an immediate intervention for a dietary team member to be present at all activities if food/drinks were served. Dietary Staff BB would review the activities calendar and prepare the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18 food/drinks for activities. The facility updated the list of mechanically altered diets/fluids. 2. On 05/12/23 at 05:30 PM, the facility completed immediate education and review on the care plan policy with all nursing staff. 3. On 05/12/23 at 05:30 PM, the facility completed immediate education on abuse, neglect, and exploitation to all staff. 4. On 05/12/23 at 05:30 PM, the facility completed immediate education on diet/food consistency/thickened liquids to all nursing and dietary staff. 5. On 05/15/23 at 01:00 PM, the facility contacted the Medical Director to review the investigation, reporting summary, action plan, and the new dysphagia diet policy. 6. On 05/16/23 at 04:00 PM, the facility revised the "Dysphagia Care" policy and completed education to all nursing and dietary staff. The surveyor verified the implementation of the above corrective actions onsite on 05/23/23 at 03:30 PM. Due to the implemented corrective actions prior to the surveyor's arrival onsite, the deficient practice was deemed past-noncompliance and existed at a "J" scope and severity.	F 600		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 19	F 678		

emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with six sampled, including three residents reviewed for Advance Directives (a written document which indicated the medical decisions for health care professionals when the person could not speak). Based on record review and interview, the facility failed to honor Advance Directives for one of the three residents sampled, Resident (R)1. R1 choked/aspirated, made a "gurgling" sound, had difficulty breathing, mouth sweep and suctioning were unsuccessful, and became unresponsive and ashen in color with blue tinting to her lips and fingernails, and lacked air exchange and a pulse. The staff initiated cardiopulmonary resuscitation (CPR - emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.) and called 911. The resident had an Advance Directive in place and a physician order for a DNR (do not resuscitate). Emergency Services took over CPR and transferred R1 to the hospital where she later died.

Findings included:

- The hospital "Admission Physician Orders" dated 05/03/23 for R1 included a diagnosis of post cerebrovascular accident (CVA - [stroke] sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and a physician ordered code status of DNR.
The hospital "Advance Directive Durable Power of Attorney for Health Care and Living Will" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 20	F 678		

05/03/23, located under the miscellaneous tab in the electronic medical record (EMR) revealed a living will section where R1 indicated she did not want life sustaining treatments (CPR, mechanical ventilator, kidney dialysis, feeding tube) if: unconscious, in a coma, or in a vegetative state and there was little chance of recovery, or if a breathing machine needed and to be in bed the rest of life, and if a condition present that would make her die very soon, even with life-sustaining treatments. The Advance Directive included R1's initials where she wanted her preferences, as expressed in this Living Will, to be followed strictly. The resident signed the Advance Directive along with two witnesses.

The "Minimum Data Set (MDS)" tab revealed R1 entered the facility on 05/04/23.

The "Baseline Care Plan" dated 05/04/23 revealed R1 had an Advance Directive status of DNR.

The "Orders" tab for R1 lacked a code status.

The EMR lacked an answer for R1's code status on the dashboard (area that can be clicked on to view code status information along with special instructions, diet, allergies, etc.) in the EMR.

The facility "Timeline of Events" for 05/12/23 revealed the following:

1. At 02:44 PM, Consultant Therapy Staff II started CPR.

2. At 02:50 PM, Emergency Medical Services (EMS) arrived and took over CPR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 21	F 678		

3. At 03:15 PM, EMS left the building with R1 after return of cardiac rhythm and pulse.

4. At 06:04 PM, staff contacted the hospital and hospital nurse explained the DPOA (Durable Power of Attorney) desired to cease treatment at the hospital and R1 expired.

The "Progress Note" dated 05/12/23 at 03:59 PM revealed a staff member brought R1 to the nurse stating she was at the facility activity/party when R1 was given thin liquids to drink and started choking, possibly aspirating. When the nurse began assessment, R1 was not responding and her color began to change to ashen, eventually blue in her lips and nail beds. The nurse attempted to suction R1 to remove any fluid without success and R1 went completely unresponsive at that time. The staff helped lower R1 to the floor, the staff started CPR right away. R1 lacked a pulse and air exchange, CPR continued, and the staff notified 911. CPR continued until EMS arrived.

The facility "Witness Statement" dated 05/15/23 by Administrative Nurse D revealed on 05/12/23 while on the south side of the dining room serving residents, she heard someone coughing with a moist/wet cough and saw that it was R1. Administrative Nurse D stated she went over to R1 and at some point, CMA R came over to help R1, too. R1 was coughing and talking and calmed down after a while, and Administrative Nurse D asked CMA R, if she was back to normal status and CMA R responded "maybe" but did not look too sure about it. Administrative Nurse D then told CMA R to take her to the nurse's station to be checked by the nurse while Administrative Nurse D stayed with the other residents. Then, CMA S

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 22	F 678		

came to the dining room and said the staff needed Administrative Nurse D immediately, and when arrived at the nurse's station, the staff there was trying to get R1 out of her wheelchair. The staff got R1 to the floor, she was unresponsive, 911 notified, and CPR started. CPR continued until EMS arrived and took over and they achieved a cardiac rhythm and transported her out via gurney.

The facility "Witness Statement" dated 05/15/23 by CMA R revealed on 05/12/23 she went to the dining room (lacked what time) to assist with the activity/party, noticed R1 "gurgling", and notified Administrative Nurse D who was present in the dining room. CMA R sat with R1 and talked to her asking if she could breathe at that time and R1 said she could. CMA R asked again a couple of minutes later if she could breathe again and R1 stated it was "tough." CMA R notified Administrative Nurse D, who instructed her to take R1 to the charge nurse on duty. R1 started changing colors and another staff went to get the emergency cart the proceeded to get her out of the chair. CMA R called 911 and the staff started CPR as another staff member went and got Administrative Nurse D.

The facility "Witness Statement" dated 05/15/23 by CMA S revealed on 05/12/23 she was helping in the dining room when R1 started "gurgling" and after a while, Administrative Nurse D asked to take R1 down to the charge nurse on duty. When CMA S noticed R1 was changing color, she ran for the emergency cart and when returned staff were attempting to get R1 out of the wheelchair. Another staff called 911 and CMA S went to get Administrative Nurse D who was in the dining room. CMA S took EMS when they arrived to R1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 23	F 678		

and the staff were performing CPR.

The facility "Witness Statement" dated 05/15/23 by Consultant Therapy Staff II revealed on 05/12/23 around 02:30 PM, she walked out of the therapy room and heard "she's not breathing" so then handed her patient over to Consultant Therapy Staff GG and went to help. Consultant Therapy Staff II helped lower R1 to the floor, swept her mouth twice to see if anything was blocking her airway and CPR initiated. LN G used the suction machine, however, was unsuccessful. LN G used an "Ambu bag" (handheld device used to provide ventilation to patients her are not breathing) and could not get it sealed around R1's mouth. Consultant Therapy Staff II gave "mouth to mouth" several times. R1 had a sticky, light red fluid that came out and the staff turned her head to get the fluid out. During this time R1 was unresponsive and turning blue. EMS arrived and took over and stated R1 had a pulse after they gave her medication and CPR, then transported her to the hospital.

The facility "Witness Statement" dated 05/15/23 by LN G revealed on 05/12/23, staff brought R1 to the nurse's station. R1 was not responding when assessment began, her skin color became ashen, then blue. LN G ran to get the suction machine to try and remove any fluids from R1's airway without success. CPR started, R1 had no pulse or air exchange, 911 notified, and CPR continued until EMS arrived.

The hospital records where R1 transferred to on 05/12/23 revealed she was unresponsive, cyanotic (bluish or purplish discoloration of the skin), and receiving treatment with a LMA (laryngeal mask airway - used as a temporary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 24	F 678		

method to maintain an open airway), "bagging" (providing breathes with use of a device), and she had poor air movement with coarse breath sounds (crackling, bubbling sound that presents with excessive fluid in the lungs which could be caused by aspiration). At 03:33 PM, the family reported she had a DNR (do not resuscitate) and requested comfort measure. R1's time of death was at 03:55 PM.

On 05/22/23 at 10:05 AM, Administrative Staff A stated the facility "Timeline of Events" was done using the facility cameras.

On 05/22/23 at 04:06 PM, Administrative Nurse D stated, after looking in R1's orders in the EMR, R1 did not have a DNR order. Administrative Nurse D stated in another state the hospital DNR could not be used and we would have to get our own order, and that is why she instructed the staff to initiate CPR to R1 on 05/12/23. Administrative Nurse D stated on admission the charge nurse should initiate the "red" DNR form with the doctor and verify the code status. Administrative D stated she was not aware if that had been done for R1 when admitted to the facility, and Social Service staff would follow up to see if the code status had been addressed.

On 05/23/23 at 10:57 AM Social Service Staff X stated Advance Directives such as DPOA (Durable Power of Attorney), Living Will, code status, were in the admission packet and she goes over that information if none present. Social Service Staff X stated she talked to R1's DPOA about advance directives and he informed her he signed "stuff" with the hospital, however, could not recall what he said he had signed. Social Service Staff X stated R1 was a full code until the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 25 charge nurse reviewed the paperwork to see if we had the correct forms and told the family she would be a full code until the facility looked at all of her paperwork. Social Service Staff X stated she did not "have the time to go through all of her stuff yet" and never had the DNR form signed and was going to go back and talk to the family to "get the form we wanted." The facility policy "Cardio-Pulmonary Resuscitation [CPR] Policy" dated 01/20/20, revealed the staff were to determine if resident had a pulse or respirations and determine the DNR status. Full code residents were identified on the kiosks and the individual resident dashboard in the electronic system. The face sheet would indicate a resident's code status. Personnel would provide basic life support, including CPR to a resident requiring emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. The facility failed to follow R1's Advance Directive and physician order for DNR, when she became unresponsive, quit breathing, and lacked a pulse, and the facility staff- initiated CPR.	F 678		
F 808 SS=J	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State	F 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 26	F 808	Past noncompliance: no plan of correction required.	

law.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with six sampled, including three residents reviewed for physician ordered therapeutic/mechanically altered diets. Based on observation, record review, and interview, the facility failed to provide Resident (R)1 with a therapeutic diet and 100% supervision during oral intake. R1 had dysphagia (swallowing difficulty) and was at risk for aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident) following a cerebrovascular accident (CVA - [stroke] sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). Due to these failures and lack of staff knowledge on providing the correct altered diet/fluids to residents, R1 attended a facility activity/party on 05/12/23, where she consumed hard shell candy pieces within reach of where staff placed her, and staff served her a cupcake and a non-thickened liquid. Although staff were in the area, they did not provide 100% supervision to the resident while eating and neglected to identify she had received non-thickened liquids until the cup was empty and only ice remained. R1 choked/aspirated, made a "gurgling" sound, had difficulty breathing, mouth sweep and suctioning were unsuccessful, and R1 became unresponsive and ashen in color with blue tinting to her lips and fingernails. The staff initiated cardiopulmonary resuscitation (CPR - emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.) and called 911. Emergency Services took over and transferred her to the hospital where she later died. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 808	Continued From page 27	F 808		

deficient practice resulted in R1's death and placed five other residents who received a therapeutic diet/mechanically altered consistency diet in immediate jeopardy.

Findings included:

- The hospital "Progress Note" dated 04/30/23 for R1 revealed an assessment of dysphagia with aspiration.

The hospital "Admission Physician Orders" dated 05/03/23 for R1 included a diagnosis of post CVA.

The "Minimum Data Set (MDS)" tab revealed R1 entered the facility on 05/04/23.

The "Baseline Care Plan" dated 05/04/23 revealed R1 required one-person physical assistance support for eating and required a mechanical soft diet, meat with gravy, nectar thick liquids, ate in the dining room, used a weighted utensil/straw, and was at risk for swallowing and chewing problems.

The hospital "Discharge Instructions" dated 05/04/23 for R1 revealed a diet order of mechanical soft, nectar thick liquids, gravy on meat, 100% supervision during meal per Speech Therapy, and included R1 would aspirate (inhaling liquid or food into the lungs) if the meat was dry.

The "Functional Abilities and Goals - Admission" assessment dated 05/04/23 revealed the resident required supervision or physical assistance for eating.

The "Orders" tab for R1 included a diet order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 28	F 808		

dated 05/04/23 for mechanical soft, level 2 texture (food to avoid included but were not limited to dry or chewy cakes, cookies, and chewy candies and allowed food items included moist cakes or slurried cakes), nectar consistency, and lacked R1 required 100% supervision.

The "Admission Summary Progress Note" dated 05/04/23 at 04:07 PM revealed R1's diet was mechanical soft, meat with gravy, nectar thick liquids, one to one with meals, had weighted utensils and straw, medications to be crushed with applesauce, and she was alert with mild confusion.

The "Speech Therapy Evaluation and Plan of Treatment" dated 05/08/23 revealed R1 had a diagnosis of dysphagia following other cerebrovascular disease and had decreased safety during oral intake, with a history of dysphagia and aspiration.

The "BIMS [Brief Interview of Mental Status] Evaluation Progress Note" dated 05/10/23 at 04:22 PM revealed a score of three indicating severe cognitive impairment.

The facility "Timeline of Events" for 05/12/23 revealed the following:

1. At 01:55 PM, Activity Staff Z was making cherry limeades for the activity party in the dining room. Consultant Therapy Staff GG brought R1 to the dining room in her wheelchair, and Certified Nurse Aide (CNA) M was assisting in the dining room area.

2. At 01:58 PM, CNA M and Activity Staff Z passed out drinks that Activity Staff Z made for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 29	F 808		

the activity, all resident in the activity were served a cherry limeade in a plastic cup.

3. At 02:09 PM, Administrative Nurse D passed out cupcakes to the residents that wanted one and Activity Staff Z passed out straws.

4. At 02:24 PM, Administrative Nurse D checked on R1 who was vocalizing at that time.

5. At 02:25 PM, Administrative Nurse D went back to check on R1 and Certified Medication Aide (CMA) R helped R1 at that time.

6. At 02:26 PM, Administrative Nurse D and CMA R helped R1 who had increased mucus at that time.

7. At 02:29 PM, Administrative Nurse D and CMA R continued to assist R1 with napkins and mucus.

8. At 02:32 PM, Administrative Nurse D and CMA R continued to assist R1.

9. At 02:37 PM, CMA R and CMA S took R1 out of the dining room and to Licensed Nurse (LN) G to be assessed. Administrative Nurse D and Dietary Staff BB stayed in the dining room.

10. At 02:38 PM, R1 was at the nurse's station.

11. At 02:40 PM, staff went to get the suction machine.

12. At 02:41 PM, staff arrived with the emergency suction machine cart.

13. At 02:43 PM, LN G and Consultant Therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 30	F 808		

Staff II assisted R1 to the floor and attempted mouth sweeps on R1, with R1's head turned to the side.

14. At 02:44 PM, Consultant Therapy Staff II started CPR.

15. At 02:50 PM, Emergency Medical Services (EMS) arrived and took over CPR.

16. At 03:15 PM, EMS left the building with R1 after return of cardiac rhythm and pulse.

17. At 06:04 PM, staff contacted the hospital and hospital nurse explained the DPOA (Durable Power of Attorney) desired to cease treatment at the hospital and R1 expired.

The "Progress Note" dated 05/12/23 at 03:59 PM revealed a staff member brought R1 to the nurse stating she was at the facility activity/party when R1 was given thin liquids to drink and started choking, possibly aspirating. When the nurse began assessment, R1 was not responding and her color began to change to ashen, eventually blue in her lips and nail beds. The nurse attempted to suction R1 to remove any fluid without success and R1 went completely unresponsive at that time. The staff helped lower R1 to the floor, the staff started CPR right away. R1 lacked a pulse and air exchange, CPR continued, and the staff notified 911. CPR continued until EMS arrived.

The facility "Witness Statement" dated 05/15/23 by CNA M revealed on 05/12/23 she had asked Activity Staff Z if there was anything she could do to help in the dining room and he had told her to pass out some drinks, so CMA M did. After

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 31	F 808		

passing out a couple of drinks and talking to a few residents, CMA M left the dining room to go to her assigned work area.

The facility "Witness Statement" dated 05/15/23 by Administrative Nurse D revealed on 05/12/23 she arrived (lacked what time) to the dining room to assist Activity Staff Z with the activity and asked what needed done. Most of the resident's had drinks at that time, Administrative Nurse D gave out a couple then passed out cupcakes, then assisted a resident to eat and drink. At some point Dietary Staff BB came out with the fruit and meat trays and started to serve the residents. Activity Staff Z asked R1 what she wanted and Dietary Staff BB said she was on a special diet and could not have the fruit, but she could get her a fruit cup, and Administrative Nurse D continued to serve the other residents. While on the south side of the dining room serving residents, Administrative Nurse D heard someone coughing with a moist/wet cough and saw that it was R1. Administrative Nurse D stated she went over to R1 and at some point, CMA R came over to help R1, too. R1 was coughing and talking and calmed down after a while, and Administrative Nurse D asked CMA R, if she was back to normal status and CMA R responded "maybe" but did not look too sure about it. Administrative Nurse D then told CMA R to take her to the nurse's station to be checked by the nurse while Administrative Nurse D stayed with the other residents. Then, CMA S came to the dining room and said the staff needed Administrative Nurse D immediately, and when arrived at the nurse's station, the staff there was trying to get R1 out of her wheelchair. The staff got R1 to the floor, she was unresponsive, 911 notified, and CPR started. CPR continued until EMS arrived and took over and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 32	F 808		

achieved a cardiac rhythm and transported her out via gurney.

The facility "Witness Statement" dated 05/15/23 by CMA R revealed on 05/12/23 she went to the dining room (lacked what time) to assist with the activity/party, noticed R1 "gurgling", and notified Administrative Nurse D who was present in the dining room. CMA R sat with R1 and talked to her asking if she could breathe at that time and R1 said she could. CMA R asked again a couple of minutes later if she could breathe again and R1 stated it was "tough." CMA R notified Administrative Nurse D, who instructed her to take R1 to the charge nurse on duty. R1 started changing colors and another staff went to get the emergency cart the proceeded to get her out of the chair. CMA R called 911 and the staff started CPR as another staff member went and got Administrative Nurse D.

The facility "Witness Statement" dated 05/15/23 by Dietary Staff BB revealed on 05/12/23 there was an activity/party which started at 02:00 PM and dietary was providing fruit, cookies, and meat/cheese trays, and was running behind. Dietary Staff BB entered the area at about 02:30 PM and at that time R1 had a cup and a cupcake wrapper in front of her, and Administrative Nurse D and CMA S were helping out Activity Staff Z. Activity Staff Z asked R1 if she would like any fruit and Dietary Staff BB informed Activity Staff Z that R1 was not allowed that on her diet, but she could get her some canned fruit.

The facility "Witness Statement" dated 05/15/23 by CMA S revealed on 05/12/23 she was helping in the dining room when R1 started "gurgling" and after a while, Administrative Nurse D asked to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 33	F 808		

take R1 down to the charge nurse on duty. When CMA S noticed R1 was changing color, she ran for the emergency cart and when returned staff were attempting to get R1 out of the wheelchair. Another staff called 911 and CMA S went to get Administrative Nurse D who was in the dining room. CMA S took EMS when they arrived to R1, and the staff were performing CPR.

The facility "Witness Statement" dated 05/15/23 by Consultant Therapy Staff II revealed on 05/12/23 around 02:30 PM, she walked out of the therapy room and heard "she's not breathing" so then handed her patient over to Consultant Therapy Staff GG and went to help. Consultant Therapy Staff II helped lower R1 to the floor, swept her mouth twice to see if anything was blocking her airway and CPR initiated. LN G used the suction machine, however, was unsuccessful. LN G used an "Ambu bag" (handheld device used to provide ventilation to patients her are not breathing) and could not get it sealed around R1's mouth. Consultant Therapy Staff II gave "mouth to mouth" several times. R1 had a sticky, light red fluid that came out and the staff turned her head to get the fluid out. During this time R1 was unresponsive and turning blue. EMS arrived and took over and stated R1 had a pulse after they gave her medication and CPR, then transported her to the hospital.

The facility "Witness Statement" dated 05/15/23 by LN G revealed on 05/12/23, staff brought R1 to the nurse's station. R1 had been at the facility activity/party where she was given thin liquids. R1 was not responding when assessment began, her skin color became ashen, then blue. LN G ran to get the suction machine to try and remove any fluids from R1's airway without success. CPR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 34	F 808		

started, R1 had no pulse or air exchange, 911 notified, and CPR continued until EMS arrived.

The hospital records where R1 transferred to on 05/12/23 revealed she was unresponsive, cyanotic (bluish or purplish discoloration of the skin), and receiving treatment with a LMA (laryngeal mask airway - used as a temporary method to maintain an open airway), "bagging" (providing breathes with use of a device), and she had poor air movement with coarse breath sounds (crackling, bubbling sound that presents with excessive fluid in the lungs which could be caused by aspiration). At 03:33 PM, the family reported she had a DNR (do not resuscitate) and requested comfort measure. R1's time of death was at 03:55 PM.

On 05/22/23 at 10:05 AM, Administrative Staff A stated the facility "Timeline of Events" was done using the facility cameras.

On 05/22/23 at 10:50 AM Administrative Staff A stated R1 did receive a cupcake at the activity/party on 05/12/23 and her diet order included 100% supervision with meals.

On 05/22/23 at 11:01 AM Administrative Nurse D stated she was "generally supervising" the dining room area on 05/12/23 and was in the vicinity of R1.

On 05/22/23 at 11:09 AM, CNA M stated she was in the dining room for the activity on 05/12/23 and Activity Staff Z asked her to help pass out drinks. CNA M stated she gave R1 a limeade from the table and that she had never provided cares to her before as R1 was in a different area of the facility than where she had been assigned to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 35	F 808		

CNA M stated she was not sure what kind of diet R1 was on. CNA M stated there were packages of what looked like hard shell candies on the table and that R1 had some in front of her, however, she did not know if R1 had opened them or not and had not observed R1 take a drink while there.

On 05/22/23 at 11:40 AM, Activity Staff Z stated he put the activity/event together and had left at 02:28 PM on 05/12/23. Activity Staff Z stated Administrative Staff A had brought cupcakes and hard-shell candies for the party and placed the candies on the tables where the residents would sit. Activity Staff Z stated he placed cupcakes on plates and Administrative Nurse D and CMA S passed them out. Activity Staff Z stated he recalled R1 sat in the dining room with the hard-shell candies in front of her and did not know if she opened them or not. Activity Staff Z stated he passed out a few drinks, mainly pouring them, and did not know if any of the residents in the dining room required thickened liquids, and he did not know R1's diet orders. Activity Staff Z stated he left at 02:28 PM and at that time heard Dietary Staff BB and Administrative Nurse D talking about R1's liquids were supposed to be thickened. R1 had already ate her cupcake and she had the hard candies and a drink in front of her.

On 05/22/23 at 01:19 PM, Consultant Therapy Staff HH stated R1 was an aspiration risk based on the swallow study done at the hospital, prior to admission to the facility. Consultant Therapy Staff HH stated R1 admitted to the facility on a dysphagia level two diet, ground meat, mechanical soft, nectar thick liquids, and 1:1 supervision and she did not change any of the admission diet orders for R1. Consultant Therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 36	F 808		

Staff HH stated according to the dysphagia diet guidelines used by the facility, would need to double check, typically the cupcake would need to be slurried, cakes should be moist, sometimes the frosting could do that, and stated it was a fine line and depended on how moist or soft the cupcake, if R1 would be able to tolerate it. Consultant Therapy Staff HH stated she would not have recommended the hard-shell candies due to the outer candied shell could pose a risk if not chewed well.

On 05/22/23 at 02:26 PM, Dietary Staff BB stated she saw R1 in the dining room on 05/12/23 and she had a cup in front of her and did not see if it was empty or not, an empty cupcake wrapper, and a little box with hard-shell candies that was opened in front of R1. Dietary Staff BB stated R1 had a mechanical soft dysphagia level two diet, and as long as the cupcake had enough frosting and was a moist cake, then it would be appropriate for her. Dietary Staff BB stated she did not see the cupcakes and probably would not have given her the candies. Dietary Staff BB stated there were nursing staff present in the dining room, however not with R1 at the table. Dietary Staff BB stated Activity Staff Z was getting ready to give her some fresh fruit, but before she answered, she told Activity Staff Z she could get R1 a fruit cup. When she returned to the dining room, CMA S and CMA R checked on R1, debated on if they should call the nurse or take R1 to the nurse, and they decided to take the resident to the nurse. Dietary Staff BB stated the nursing staff would have to look at a resident's care plan to determine their diet and the dietary staff had a spreadsheet for the different diets due to lack of access to the care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 37	F 808		

On 05/22/23 at 02:45 PM, Administrative Staff A stated she had put the hard-shell candies in a small purple box that had a butterfly on top, like fun size, as center pieces on the tables for the party around 01:00 PM, after lunch, when Activity Staff Z set up the tables and made the cupcakes.

On 05/22/23 at 03:51 PM, Administrative Nurse D stated she did not observe R1 take any drinks however she had a cup in front of her at the activity/party on 05/12/23, and it only had ice in it when she observed it. It was approximately a 12-ounce plastic cup, and there was evidence R1 ate the candies due to colors of the candies on the tablecloth where she touched it after putting them in her mouth, and the box was empty. Administrative Nurse D stated it was "okay" for R1 to have the candies since they "melt in your mouth." Administrative Nurse D stated R1's liquids were to be thickened, and thickened liquids would not have ice in them. Administrative Nurse D stated she did not know if R1 required supervision with oral intake, and when checking the care plan, Administrative Nurse D stated the care plan did not reveal she required supervision for meals. Administrative Nurse D stated 100% supervision at meals would indicate the resident should have "somebody sitting there with them" and the 100% supervision should have been included in her diet order. Administrative Nurse D stated staff should have provided supervision at the party when R1 had food and fluids. Prior to serving R1, the staff should have checked the care plan and orders.

On 05/22/23 at 06:43 PM, CMA R stated when she entered the dining room on 05/12/23, R 1 had a cupcake, a little box of hard-shell candies, and what she thought was fruit punch, and later staff

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	175387	A. BUILDING _____ B. WING _____	C 05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE HOMES	200 WILLOW RD HILLSBORO, KS 67063

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F 808	Continued From page 38	F 808		

passed out the cookies. CMA R stated she did not see R1 drink from the cup, but it only had ice in it when it was later observed. CMA R stated she did not see R1 eat the candies or the cookie, however the cookie did not have any bites gone from it when she removed R1 away from the table. CMA R, who had cared for R1 before, stated at the time she knew R1 was to have chopped ground meat moistened with gravy and thickened liquids. CMA R stated she said something to Administrative Nurse D, after noticing R1 having some problems, that it looked like there was regular (thin) liquids in R1's cup and had not noticed it before that time. CMA R stated she sat by R1 and asked her one last time about her breathing and R1 stated it was really hard to breathe, so she alerted Administrative Nurse D who told her to take R1 to the nurse. CMA R stated R1 required supervision, when she came out for meals, staff was always to be with her, and when CMA R got to the dining room on 05/12/23, no staff were with R1, at that time. CMA R stated Administrative Nurse D and CMA S were "meandering" around the residents in the area.

On 05/23/23 at 01:54 PM, third attempt made to contact LN G for interview, without success.

Review of the facility video footage dated 05/12/23 from 01:45 PM until 02:37 PM with Administrative Staff A revealed the following:
At 01:48 PM, purple boxes sat on the tables in the area of the dining room for the activity/party.

At 01:55 PM, Consultant Therapy Staff GG brought R1 to the table via wheelchair for the activity/party, and the box of candies were in front of her on the table. R1's back was to the facility camera.

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F 808	Continued From page 39	F 808		

At 1:58 PM, CNA M provided R1 a cup of fluids from the table where Activity Staff Z was making the cherry limeades. R1 grabbed the cup and tilted her head back, which appeared that she took a drink from the cup.

At 01:59 PM, R1 appeared to take another drink, CNA M was at the table where the resident sat, then exited the area at 02:01 PM.

At 02:02 PM, Activity Staff Z and Administrative Nurse D entered the activity/party area, R1 lacked supervision by staff.

At 02:05 PM R1 moved her upper body forward and back, her back still to the facility camera.

At 02:08 PM, Administrative Nurse D gave R1 a cupcake.

At 02:13 PM, CMA R patted R1 on the back.

At 02:21 PM, Activity Staff Z and Dietary Staff BB appeared to be talking to each other in the area of the activity/party behind R1.

At 02:25 PM, Administrative Nurse D sat down by R1, CMA R rubbed R1's shoulders, then Administrative Nurse D got up from the table.

At 02:26 PM, Administrative Nurse D handed CMA R a napkin, who then bent over R1, however, R1's back was still to the facility camera, obstructing view of what CMA R did with the napkin.

At 02:27 PM, CMA R patted R1 on the shoulders while Administrative Nurse D was on the right

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F 808	Continued From page 40	F 808		

side of R1.
At 02:30 PM, CMA R remained with R1.

At 02:31 PM, CMA R got another napkin and returned to R1, however unable to see what she did with the napkin.

At 02:33 PM, R1 made a motion with her hand, Administrative Nurse D checked on her and walked away.

At 02:34 PM, CMA R stood beside R1 and patted her on the back, rubbed her back/neck area with gentle pats.

At 02:35 PM, CMA R stood up again, and continued to rub R1's back.

At 02:36 PM, CMA R left R1 to throw something away and then returned to R1.

At 02:37 PM, CMA R leaned over R1, moved her away from the table and towards the exit doorway of the dining room, walked away, and CMA S moved R1 in her wheelchair out of the dining room.

The facility "Level Two" ground food guideline, undated, revealed that food to avoid included dry or chewy cakes, cookies, and chewy candies and allowed food items included moist cakes or slurried cakes.

The facility policy "Thickened Liquids - Preparing and Serving" undated, revealed thickened liquids will be served when ordered by the resident's physician.

On 05/23/23 at 11:20 AM, Administrative Staff A

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F 808	Continued From page 41	F 808		

was provided a copy of the IJ template and notified the facility failure to provide therapeutic and/or mechanically altered diets as ordered, and failure to provide supervision/assistance for R1 while she ate, due to her dysphagia and risk for aspiration, placed R1 in immediate jeopardy Due to this failure, R1 subsequently choked/aspirated at the facility activity on 05/12/23, after staff noted she began making a "gurgling" sound and had difficulty breathing. The staff implemented a mouth sweep and suctioning of R1, which were unsuccessful, then began CPR when R1 became unresponsive and ashen in color, with blue tinting to her lips and fingernails. The facility emergency medical transferred R1 to a local hospital, where she subsequently died.

The facility identified and implemented the following corrective measure on 05/15/23 at 04:00 PM:

1. On 05/12/23 at 05:30 PM, the facility implemented an immediate intervention for a dietary team member to be present at all activities if food/drinks were served. Dietary Staff BB would review the activities calendar and prepare the food/drinks for activities. The facility updated the list of mechanically altered diets/fluids.

2. On 05/12/23 at 05:30 PM, the facility completed immediate education and review on the care plan policy with all nursing staff.

3. On 05/12/23 at 05:30 PM, the facility completed immediate education on abuse, neglect, and exploitation to all staff.

4. On 05/12/23 at 05:30 PM, the facility completed immediate education on diet/food

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F 808	Continued From page 42	F 808		

consistency/thickened liquids to all nursing and dietary staff.

5. On 05/15/23 at 01:00 PM, the facility contacted the Medical Director to review the investigation, reporting summary, action plan, and the new dysphagia diet policy.

6. On 05/16/23 at 04:00 PM, the facility revised the "Dysphagia Care" policy and completed education to all nursing and dietary staff.

The surveyor verified the implementation of the above corrective actions onsite on 05/23/23 at 03:30 PM.

Due to the implemented corrective actions prior to the surveyor's arrival onsite, the deficient practice was deemed past-noncompliance and existed at a "J" scope and severity.