STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 The following citations represent the findings of complaint investigation #KS 177081. This 2567 was electronically sent to the facility on 01/03/23.	F 000		
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 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 76 residents, with two residents sampled for cardiopulmonary resuscitation (CPR-an emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.). Based on record review and interview, the facility failed to ensure one Resident (R)1 received the care he chose in regards to CPR. Findings included: - Resident (R)1 admitted to the facility on 12/15/22 with diagnoses that included complex tachyarrthymias (abnormal heart rhythms with a rate of 100 or more beats per minute), pacemaker placement, and coronary artery disease ([CAD] abnormal condition that may affect the flow of oxygen to the heart). The admission "Minimum Data Set"(MDS), dated	F 678		

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
	175465	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 1	F 678		

11/20/22, revealed the resident had a brief interview for mental status (BIMS) score of seven, indicating he had severely impaired cognition. The resident was not on hospice services.

The MDS tracking assessment, dated 11/22/22, revealed the resident discharged to an acute hospital.

The MDS Entry Tracking record, dated 12/15/22, revealed the resident readmitted to the facility from an acute hospital.

Review of the facility's electronic health records revealed a Do not resuscitate (DNR or no code is a written legal order to withhold cardiopulmonary resuscitation [CPR], in respect of the wishes of a person in case their heart stopped or they stopped breathing) order, signed by the physician on 12/20/22.

Review of the clinical records revealed the following:

On 12/20/22 at 12:35 PM, the resident's durable power of attorney (DPOA) for healthcare and DNR signed by the resident and faxed to the resident's physician.

On 12/27/22 at 05:10 AM, staff entered the resident's room to administer his morning medication and assist the certified nurse's aide (CNA) with moving the resident up in the bed. Upon moving the resident, the resident jerked very quickly and began to have "Choppy breathing". The resident became unresponsive, and the nurse "initiated CPR due to code status believed to be a full code." The CNA called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 2	F 678		

Emergency Medical Services (EMS) and another nurse came down (from another unit) to assist with the code (CPR). When EMS arrived, they took over CPR. The nurse went to print off paperwork and saw the resident was DNR status. The nurse informed EMS. EMS wanted to see the copy, however, staff was unaware in the electronic charts the DNR form located, so she called the director of nursing (DON). The DON called the social worker, and the social worker called the nurse to find the DNR orders under the advanced directives tab. While on the phone, EMS stopped CPR. The physician notified by EMS and the time of death was at 05:45 AM.

On 12/29/22 at 09:45 AM, Administrative staff A reported the nurse went in to help with resident cares. During the time she was in the resident's room, the resident's heart stopped, and she immediately began CPR. The resident declined within the past few weeks, and the nurse was unaware that the resident's code status changed from CPR to DNR, so the nurse imitated CPR. The resident's door name plates on the door indicate a quick reference for code status. The white background on the resident's name should indicate if the resident was a DNR. The green background should reference if a resident was a Full code (to initiate CPR).

On 12/29/22 at 11:52 PM, Licensed Nurse (LN) G reported, while doing routine cares, she assisted the CNA to reposition the resident in the bed. When staff repositioned him, the resident jerked, and within "a few seconds", the resident was unresponsive. LN G "grabbed the crash cart" and her and another nurse from another unit, continued CPR until EMS started. She reported she performed CPR on the resident for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 3	F 678		

approximately "10 to 15 minutes" before EMS arrived and took over CPR. Once EMS responded, LN G left the room to print off the resident's records for transport to the hospital, however, once she looked at the electronic records, she knew at that time, the resident was a DNR. She then informed EMS of the DNR status. EMS continued CPR until they could review the signed DNR form, and LN G was unaware where the signed form was in the electronic records. She reported "I knew he was a full code, but it must have changed". She "did not think to look at the door) for a quick reference, but reported the background was white (to reference a DNR status).

The facility's policy for "Procedure: Advance Directive and Code status", dated 01/2022, revealed advance directives will be respected in accordance with state law and community policy.

The facility failed to honor this resident's wish,when the resident lacked the presence of vital signs (pulse and respiration), as the resident chose in regards to CPR, when staff initiated CPR on a resident that did not want cardiopulmonary resuscitation, and had a current DNR in his medical record.