STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

The following citations are the result of abbreviated survey and complaint investigation KS00181707 and KS00180914.

On 08/17/23 at 12:45 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the immediacy for Resident (R)1.

At 09:00 AM on 07/22/23 Certified Nurse Aide (CNA) M answered R1's call light and found R1 on the floor. CNA M informed Licensed Nurse (LN) G, who responded to R1's room, and noted R1 was unresponsive. LN G assessed R1's carotid artery (major blood vessel which supplies blood to the brain) and could not feel a pulse, so LN G obtained a stethoscope and assessed for lung sounds which were absent. Staff then notified 911 and verified R1 was a full code, but still did not initiate CPR. Eleven minutes later, at 09:11 AM, Emergency Medical Services (EMS) arrived onsite, and EMS initiated CPR shortly thereafter. The delay in resuscitative measures placed R1 and the fifteen other residents with full code status in immediate jeopardy.

On 07/28/23 the facility completed all corrective measures which included:
Community-wide staff educations on "Code Blue Policy" and procedure. Mock code drills were performed over three days on all shifts. With education provided during the drills to staff.
Medical Director was notified.
All staff were e re-educated on delivery of CPR specific to placement of resident and delivery of chest compressions.
Competency testing was completed by clinical

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
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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	Continued From page 1 staff. All corrective measures were completed prior to the onsite survey, therefore the citation was deemed past noncompliance and the scope and severity existed at a "K." The 2567 was sent electronically on 08/29/23	F 000		
F 678 SS=K	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 identified a census of 80 residents with three reviewed for code status. Based on record review and interview, the facility failed to ensure staff provided cardiopulmonary resuscitation (CPR) to Resident (R) 1, who desired resuscitative measures indicated by his full code status (code status determination for residents who wish to receive CPR). At 09:00 AM on 07/22/23 Certified Nurse Aide (CNA) M answered R1's call light and found R1 on the floor. CNA M informed Licensed Nurse (LN) G, who responded to R1's room, and noted R1 was unresponsive. LN G assessed R1's carotid artery (major blood vessel which supplies blood to the brain) and could not feel a pulse, so LN G obtained a stethoscope and assessed for lung sounds which were absent. Staff then notified 911 and verified R1 was a full code, but still did not initiate CPR. Eleven minutes later, at 09:11 AM,	F 678	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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) arrived onsite, and EMS initiated CPR shortly thereafter. The delay in resuscitative measures placed R1 and the fifteen other residents with full code status in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and gout (inflammation of the joints).

The "Quarterly Minimum Data Set (MDS)," dated 05/18/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of fourteen, which indicated intact cognition. The MDS documented R1 required extensive assistance of one to two staff for all activities of daily living (ADL) except eating.

The "Advance Directives Care Plan," dated 06/20/23, documented R1 was a full code and R1's preferences regarding full code status would be honored.

The "Facility Intake Assessment," dated 11/22/23, documented R1 was a full code.

The "Nurse's Note," dated 07/22/23, documented at 09:00 AM CNA M informed LN G that R1 was on the floor. R1 was unresponsive when LN G entered the room. R1 laid face down on the floor with his walker underneath his legs, his arm was crossed underneath of him, and red drainage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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		

coming from R1's head. R1's call light was attached to his recliner and turned on when staff found R1. CNA M and LN G removed the walker from underneath R1's legs, in order for staff to assess R1. LN G could not access R1's carotid artery or lung sounds in the position R1 was found in due to the walker underneath R1's legs and his dresser on his right side. LN G palpated (felt) R1's carotid artery and determined there was no pulse. LN G obtained a stethoscope, assessed and noted R1's lungs sounds were absent, and called 911 immediately. The facility receptionist notified staff EMS was on the way. R1's code status was verified. EMS arrived at 09:11 AM and began CPR. Staff notified R1's primary care physician via phone call regarding R1's transfer to the hospital emergency room at 09:30 AM.

The "Facility Incident Report," dated 07/28/23, documented CNA M notified LN G at 09:09 AM that CNA M went to answer R1's call light and found R1 lying prone (facing downward) in his room. LN G assessed R1's carotid artery and could not palpate a pulse. LN G assessed R1 for lung sounds which were absent. R1's code status was verified. 911 was called. EMS arrived at 09:15 AM and began CPR. The staff notified R1's representative, the on-call nurse, and R1 primary care physician. R1 transferred to the local hospital emergency room at 09:35 AM. The emergency department notified the facility of R1's death.

CNA M's "Witness Statement," dated 07/22/23, documented CNA M found R1 around 09:00 AM. CNA M stated she was answering R1's call light and found R1 face down on the floor, laying on his walker. CNA M stated she approached R1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 4	F 678		

called R1's name, R1 did not respond, and was not breathing. CNA M stated she immediately alerted LN G and continued to try and arouse R1.

LN G's "Witness Statement," dated 07/26/23, documented LN G saw R1 at 07:10 AM in the dining room. LN G sat down beside R1 to check R1's blood pressure and obtain a finger stick blood sugar. LN G stated this was the last time she saw R1 prior to his fall. The statement directed to see nurses notes for fall documentation.

On 08/17/23 at 10:00 AM, CNA M stated she found R1 unresponsive on the floor in his room. CNA M stated R1 was not breathing. CNA M stated she immediately notified LN G. LN G came into R1's room and they removed R1's walker from under him. LN G assessed R1 for pulse and breath sounds and there were none. CNA M stated she had not started CPR on R1 because she did not know his code status because the residents were all elderly and most were Do Not Resuscitate (DNR-advance directive for no CPR). CNA M stated she and LN G did not roll R1 over; EMS rolled R1 over and started CPR when they got to his room. CNA M stated she had been educated about code status and CPR since the incident.

On 08/17/23 at 10:55 AM, LN G stated she assessed R1 for carotid pulse and lungs sounds and they were absent. LN G stated she did not initiate CPR because she could not move R1 into a good position to give CPR. LN G stated she called 911 and the front desk to initiate code blue response, but no one came. EMS arrived and started CPR and transported R1 to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 5	F 678		

On 08/17/23 at 11:30 AM, Administrative Nurse D stated LN G and CNA N had never had anything like that happen before and they did not think about starting CPR; they were just in shock and did not think they could move R1 off of his stomach to start CPR. Administrative Nurse D stated LN G and CNA M were able to get R1's walker out from underneath him and when EMS got to the facility, EMS moved furniture to get R1 moved. Administrative Nurse D stated LN G did not think to call staff from other areas of the building to assist. Administrative Nurse D stated a plan of correction was started regarding code blues (cardiac or respiratory arrest situation) and code Blue mock drills were performed three times a week on every shift and were now done weekly. Administrative Nurse D stated all staff were in-serviced on CPR and the steps to follow when a code blue occurred.

On 08/17/23 at 11:45 AM, Administrative Staff A verified there were three Automated External Defibrillators (AED-used to deliver electrical shock in sudden cardiac arrest situation) in the building to be used for code blues.

The facility's "Cardiopulmonary Resuscitation and Code Blue Policy," revised January 2023, documented licensed staff are required to complete training on the cardiopulmonary resuscitation (CPR) and basic life support, including defibrillation for victims of sudden cardiac arrest. Training in BLS includes recognizing presentations of sudden cardiac arrest (SCA). The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse. Early delivery shock with a defibrillator plus CPR within 3-5 minutes of collapse can further increase changes of survival. If an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 6	F 678		

individual is found unresponsive and not breathing, staff member who is certified in CPR/BLS shall initiated CPR unless it is known that a DNR order that prohibits CPR and external defibrillation exists or there are obvious signs of irreversible death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. If an individual is found unresponsive, for no more than 10 seconds, assess for abnormal or absence of breathing. If sudden cardiac arrest is likely begin CPR. Instruct a staff member to activate the emergency response team (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status. Initiate basic life support BLS sequence of events (CAB) chest compressions, airway, breathing.

The facility failed to ensure staff immediately initiated CPR on R1, who was a full code. The delay in initiating resuscitative measures placed R1 and the fifteen other residents with full code status in immediate jeopardy.

On 07/28/23 the facility completed all corrective measures which included:
Community-wide staff educations on "Code Blue Policy" and procedure. Mock code drills were performed over three days on all shifts. With education provided during the drills to staff.
Medical Director was notified.
All staff were e re-educated on delivery of CPR specific to placement of resident and delivery of chest compressions.
Competency testing was completed by clinical staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 7 All corrective measures were completed prior to the onsite survey, therefore the citation was deemed past noncompliance and the scope and severity existed at a "K."	F 678		