STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT MISSION	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(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 represent the findings of Focused Infection Control survey and abbreviated complaint survey #KS00179242 and KS00178127.

On 04/04/23 at 03:30 PM the facility received a copy of the "Immediate Jeopardy [IJ] Template" was was informed of the IJ for Resident (R)1.

On 03/26/23 between 11:30 and 11:45 AM, Certified Nurse Aide (CNA) M and CNA O prepared to transfer R1 with a full body lift. At that time, R1's representatives entered the room and identified R1 appeared unresponsive. R1's representatives called for Licensed Nurse (LN) G. LN G, a certified cardiopulmonary resuscitation (CPR) instructor, assessed R1 and determined R1 had no pulse (cardiac arrest) and directed the CNA staff who were present to start CPR. CNA M and CNA O, who both had online CPR training but no hands-on skills assessment, started CPR. CNA O called 911 and CNA M began compressions while LN G left the room to look for the automated external defibrillator (AED-device which evaluates heart rhythms and delivers a shock if needed in cardiac emergencies). R1's representative became concerned with CNA M's ability to perform appropriate compressions and began delivering the CPR herself. LN G, unable to locate the AED, called 911 to make sure they were on the way, and then called facility administrative staff to alert them to the situation. During this time, LN H entered R1's room and assumed responsibility for the CPR. Emergency Medical Services (EMS) arrived shortly after and took over care of R1. R1 was pronounced dead in the facility at 12:13 PM. LN G never returned to

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

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F 000	Continued From page 1	F 000		

R1's room until after the death was declared. The facility LN staff failed to possess the skills and knowledge necessary to ensure R1 received adequate resuscitative measures when the CPR certified LN left the room and delegated the rescue effort to unlicensed, untrained staff. This placed R1 in immediate jeopardy.

On 03/26/23 the facility completed the following corrective actions:
The facility conducted an audit of code status for each resident.
The facility immediately began providing re-education to all relevant staff on cardiopulmonary resuscitation (CPR) which included verifying code status using the medical record, ensuring a certified staff member was available for each shift, maintaining equipment and supplies necessary for CPR/BLS
The facility provided training to Licensed Nurses and relevant staff on delivering basic life support per standards of practice, including starting chest compressions, maintaining a patent airway, and delivering air/oxygen.
The facility immediately conducted an audit of staff scheduled to ensure the availability of a CPR certified staff member for all shifts. Daily staffing sheets were updated to include an asterisk to identify the CPR certified staff members. The facility educated the staffing coordinator on the process for identifying certified staff members.
The facility conducted an audit of certified staff members to ensure certificates were current and met the requirements for a hands-on skills assessment.

The corrective actions were completed prior to the start of the survey therefore the deficient practice was cited as past noncompliance.

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F 000	Continued From page 2 The 2567 was sent electronically on 04/18/23.	F 000		