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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Mission	7105 Mission Road Prairie Village, KS 66208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 53 residents. The sample included nine residents reviewed for Advanced Directives (a legal document that provides instructions for medical care when a person is unable to communicate their wishes). Based on record review, observation, and interview, the facility failed to provide cardiopulmonary resuscitation (CPR) to Resident (R) 1, who elected a full code status. On [DATE] at 05:10 PM, R1's family member reported to the nurse R1 had died. Licensed Nurse (LN) G did not check R1's code status until prompted by a hospice nurse and LN I, approximately 45 minutes later, and then the LNs started resuscitative measures. The facility's failure to initiate CPR on a full-code resident placed R1 and all residents with full code status in immediate jeopardy.Findings included:- R1's Electronic Medical Record (EMR) documented R1 admitted [DATE], with diagnoses of atherosclerotic heart disease (also known as coronary artery disease, when coronary arteries become narrowed or blocked by plaque buildup), generalized anxiety disorder (a more severe form of anxiety disorder characterized by persistent excessive worry that interferes with daily functioning), arial fibrillation (and irregular heart beat characterized by fatigue, heart palpitations, dizziness and shortness of breath), and chronic kidney disease (a long term condition wherein the kidney's lose their ability to function, which can lead to serious health complications).R1's Significant Change Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS assessment recorded that R1 elected Hospice Services (specialized medical care for persons suffering from life-threatening illness, providing comfort and quality of life measures).R1's Care Plan, initiated on [DATE], recorded R1's Advanced Directive as a Full Code. The Care Plan noted the directive was also in the social service review, which directed staff to ensure the resident's wishes were honored in regard to any advanced directive. R1's Care Plan further instructed staff to review the advance directive at least quarterly and with any change in condition. The staff were to ask residents about any desired changes to current advanced directives or whether they wished to execute any.Review of the Profile Sheet in the EMR documented, R1 elected a Full Code (to receive resuscitative measures, CPR) status.The Physician Order Sheet (POS) dated [DATE] recorded R1 maintained Full Code status since [DATE].Review of a Physician Progress Note dated [DATE] at 11:07 PM documented R1's code status as a Full Code.A Nurses Progress Notes dated [DATE] at 05:34 PM recorded R1 was actively passing during the shift. A Hospice nurse visited, and R1 received a dose of Morphine (a narcotic pain reliever) at 04:55 PM. R1's family requested a hospice nurse visit and LN G called and left a voicemail. At 05:10 PM, R1's family member notified LN G that the resident may have passed. The nurses' notes recorded there were no audible heart sounds assessed with a stethoscope or respirations for R1. At 05:29 PM, the hospice nurse called and stated they were on route to the facility. The staff notified the residents' family, physicians, and the assistant director of nursing.A Nurses Progress Notes dated [DATE] at 06:16 PM (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed staff reviewed the EMR and identified R1 had Full Code status and informed LN G. LN G immediately returned to R1's room and initiated CPR with the hospice nurse, who had just arrived. Emergency Medical Services (EMS) arrived shortly after and care was transferred to EMS, who pronounced R1's death at 06:42 PM. The Nurses Notes timeline revealed between the notification of R1's presumed death at 05:10 PM to the initiation of CPR at approximately 06:16 PM, represents approximately 66 minutes lapsed before staff-initiated CPR on R1.The facility report documented R1's family member told the nurse R1 died at 05:29 PM (the [DATE] at 05:34 PM Nurses' Note documented R1 informed the nurse at 05:10 PM, a difference of 19 minutes. The report documented the LN assessed the resident as pulseless and not breathing. The LN failed to check R1's code status at that time. At 06:10 PM, the assistant director of nursing asked LN G to confirm the resident's code status and noted R1 was a full code. LN G and the Hospice nurse then initiated CPR (a 41-minute lapse in the staff initiation of CPR to R1). The facility immediately suspended LN I and LN G on [DATE] pending an investigation. On [DATE], the facility terminated LN G's employment. A witness statement dated [DATE] documented LN G was told in the report that R1 was actively passing. Staff checked on R1 throughout the shift and had a Hospice nurse and family present most of the day. At 04:45 PM, R1 had Cheyne-Stokes breathing (an abnormal pattern of breathing, characterized by periods of not breathing and deep, rapid breathing), R1's skin was cool to the touch, but not mottling (blotchy, red-purplish marbling of the skin near the end of life caused by slow blood circulation). At 05:10 PM staff called Consultant Nurse L. At 05:25 PM, R1's family notified LN G, he believed R1 passed. Consultant Nurse L arrived at 06:10 PM, noted R1 was a full code, and staff began CPR on R1.A witness statement for LN I, dated [DATE], documented at 05:25 PM, LN G asked LN I to call Consultant Nurse L, who reported R1 was a full code. At 05:41 PM, Administrative Nurse E questioned LN I on R1's code status and noted R1 was a full code. LN, I called EMS at 6:10 PM, and LN I and LN G began CPR on R1.During an interview on [DATE] at 10:55 AM, Administrative Nurse D, Administrative Nurse F, and Administrative Staff A stated R1's decline came about very quickly. On [DATE] at around midnight R1 started to decline, refused her medications, the hospice nurse was in, and the residents' family was also in throughout the day. Administrative Nurse D, Administrative Nurse F, and Administrator Staff A said after R1 died they did a follow-up with the family. The family reportedly did not have any inappropriate responses (regarding CPR) and were happy with R1's cares.On [DATE] at 10:55 AM, Administrative Nurse F stated the facility identified a problem with the nurse who did not immediately administer CPR to the resident was suspended pending investigation, self-cited the deficient practice, conducted staff education, and performed ongoing audits to ensure compliance and that no incidents like this could occur again.On [DATE] at 10:55 AM, Administrative Staff A stated all nursing assistants, nursing staff, activities staff, and facility transport staff were Basic Life Support (BLS) certified. Administrative Staff A stated newly hired staff completed electronic training before hire, and quarterly regarding resident code status: where to locate the status and who to contact in emergencies. On [DATE] at 01:24 PM, Administrative Nurse D stated R1 did not want to be a full code when hospice began ([DATE]). Administrative Nurse D expected nurses to check the code status of all residents at the time of a change in condition, regardless of Hospice status. Administrative Nurse D stated when the situation occurred, the resident's family was under the impression the resident was a DNR. Administrative Nurse D stated LN G assumed R1 was a DNR due to being on Hospice. Administrative Nurse D stated LN G was immediately suspended, and the investigation determined staff did not follow the facility policy. Administrative Nurse D stated the facility educated all staff immediately and reviewed all residents' code status, including hospice residents. The investigation identified one resident who wanted to change to a DNR status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrative Nurse D stated weekly audits were ongoing.The facility's Advanced Directive Policy, approved 12/2024, documented prior to admission to the facility, the social services director or designee will provide written information to the resident concerning his or her right to make decisions, concerning medical care, including the right to refuse or accept medical or surgical treatment and the right to formulate advanced directives. The policy recorded the plan of care for each resident will be consistent with his or her treatment preference and/or advanced directives.On [DATE] at 05:15 PM, Administrative Staff A was provided with a copy of the IJ Template and notified that beginning on [DATE], the facility's failure to perform CPR on R1 for almost an hour placed R1 in Immediate Jeopardy. The facility identified and immediately implemented corrective actions as follows:1. The two nurses involved LN I and LN G were immediately suspended on [DATE]. (LN G was terminated on [DATE]).2. DON or designee completed all licensed staff training on the advanced directive policy and how to identify a resident's code status in the EMR. (signature sheets on file)3. All licensed staff did not work until training was completed ([DATE]).4. DON or designee interviewed five nurses weekly, asking about the procedure when a patient was found unresponsive and how to identify code status.5. A mock review of checking the resident's status was scheduled weekly for four weeks and then monthly (audits on file).6. Patterns or trends would be reported to the Quality Assurance committee for further recommendations and follow-up.Due to the corrective actions completed prior to the onsite survey, the deficient practice was deemed past non-compliance at a scope and severity of J (isolated with actual harm).