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	06/04/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide an environment free from accidents when staff failed to use a gait belt during a transfer for Resident (R) 1, which resulted in a fractured right femur (thigh bone). Additionally, the facility failed to place an appropriate wheelchair cushion for R2, and instead used a bed pillow which caused the resident to slide out of her wheelchair during a van transport, resulting in bilateral hematomas to her knees. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm (tumor) of the middle third of the esophagus, hypertension (elevated blood pressure), gastro-esophageal reflux disease (GERD-backflow of stomach contents to the esophagus), and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). R1's Entry Minimum Data Set (MDS) dated 12/09/25 documented R1 admitted to the facility on [DATE]. R1's Discharge Return Anticipated MDS dated 12/19/25 documented R1 discharged to the hospital on [DATE]. R1's Care and Activities of Daily Living Preferences Care Plan dated 12/11/26 lacked direction on how facility staff should transfer R1. R1's Orders tab documented a physician's order dated 12/10/25 for morphine (opioid medication - narcotic pain medication used to treat moderate to severe pain), 0.25 milliliters (ml) by mouth every four hours, for pain. R1's Health Status Note dated 12/19/25 at 11:51 PM documented R1 stated she was in pain at the beginning of the shift and requested morphine, which she received. R1 was asked if nursing staff could assess her right knee, to which R1 stated it was very painful and would like it assessed later. R1 rated her pain at a 10 out of 10, indicating severe pain. At 09:45 PM, a hospice nurse appeared and stated that R1's family asked hospice to come and check on R1. A physician's order was received to do a two-view X-ray and increase R1's morphine to 0.5 milliliters as needed (PRN) every hour. R1's family received an update and requested that R1 be sent to the emergency room for evaluation. R1 left the facility at 10:33 PM. R1's EMR lacked evidence the facility contacted hospice or the physician related to R1's report of new onset severe right knee pain at a 10/10. R1's SBAR Note dated 12/20/25 at 02:49 AM documented R1 had a change in condition and experienced right knee swelling and pain. R1's progress notes lacked documentation related to anything that occurred to have caused knee pain. The facility report dated 12/22/25 documented on 12/19/25, after dinner, CNA M transferred R1 from her wheelchair to her bed. Upon completion of the transfer, R1 laid in bed and reported feeling a pop in her right knee. R1 began complaining of significant pain. The facility report documented that CNA M immediately notified Licensed Nurse (LN) G, and LN G administered pain medication as ordered. LN G asked R1 if he could do a physical assessment of her right knee, to which R1 refused, stating she was in too much pain and asked not to be touched. R1 lifted her hand to prevent LN G from touching her. The facility report documented that a hospice nurse arrived to assess R1. The hospice nurse obtained verbal orders from the physician for an immediate two-view X-ray of the right knee and an increase in her morphine dose and frequency. R1 and her family requested that she go out to the emergency room for further evaluation. R1 admitted to the hospital with a fractured right femur. CNA M was immediately (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 0689 Level of Harm - Actual harm Residents Affected - Few	suspended and later terminated when the conclusions of the incident revealed CNA M failed to follow appropriate policies or procedures, which resulted in harm. CNA M admitted he had not used a gait belt. The facility's immediate corrective actions and interventions were to administer R1 pain medications (12/19/25); hospice assessment and support provided for R1 (12/19/25); R1 was sent to acute level of care (12/19/25); the facility contacted law enforcement to report this event and received case number 2025-2530; Staff were in-serviced on transfers with gait belts, reviewing Kardex (a nursing tool that gives a brief overview of the care needs of each resident), resident rights, and preventions of Abuse, Neglect and Exploitation. CNA M's notarized Witness Statement dated 12/19/25 documented he was assigned to care for R1 from 02:00 PM to 10:00 PM. CNA M documented R1 requested to get back into her bed around 06:10 PM. CNA M requested R1 hold on so he could check the Kardex to see how she transferred. The Kardex did not specify how R1 was transferred. CNA M went back to R1's room and prepared to transfer her. CNA M placed R1's wheelchair next to the right side of the bed, with the chair facing the head of the bed. CNA M then gently lifted R1, pivoted her and placed R1 on the bed. CNA M documented R1 yelled out as soon as he placed her on the bed. R1 stated she was in pain. R1 asked CNA M to see the nurse. CNA M asked CNA N for help getting R1 properly positioned in bed and then documented he did not enter R1's room the remainder of his shift. On 06/04/26 at 01:32 PM, CNA O stated in order to verify how a resident transferred, she looked at the plan of care (POC). If the resident was a one-person assist stand and pivot, CNA O stated she would put the gait belt on and then assist the resident with a transfer and talk to the resident while she transferred. If there was no clear indication on how a resident transferred, CNA O stated she would ask her nurse. CNA O revealed she would never attempt to transfer a resident without a gait belt. On 06/04/26 at 02:55 PM, Administrative Nurse D stated she expected nursing staff to use a gait belt when transferring a resident. On 06/04/25 at 02:59 PM, Administrative Staff A stated, when it was revealed CNA M transferred R1 without a gait belt, the facility did all staff in-service on transfers and other things to ensure this did not happen again. The facility's Safe Lifting and Movements of Residents policy, approved in December of 2024, directed that resident safety, dignity, comfort, and medical condition would be incorporated into goals and decisions regarding the safe lifting and moving of residents. The policy directed that staff would be responsible for direct resident care and would be trained in the use of manual (gait/transfer belts, slide boards) and mechanical lifting devices. - R2's Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), morbid obesity (excessive body fat), myocardial infarction (heart attack), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral (the large triangular bone/area between the two hip bones) region, unspecified stage, and pressure ulcer of the right buttocks, stage three (full thickness pressure injury extending through the skin into the tissue below), and muscle weakness. R2's Five Day Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R2 was dependent on staff with toileting transfers and putting on and taking off footwear. R2 required substantial to maximal assistant with sit to lying, lying to sitting, sit to stand, chair/bed to chair, and tub/shower transfers. R2's Functional Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 04/16/26 documented R2 had significant functional abilities deficits related to acute respiratory failure associated with recent COVID-19, wounds requiring colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) diversion, infection of a cardiac implant, acute cystitis (infection of the bladder), and a diagnosis of MS. R2's Skin Integrity Care Plan, initiated 04/17/26, noted she needed a pressure reduction cushion to protect the skin while up in her chair. R2's plan of care also directed staff to ensure R2 wore appropriate non-slip footwear for all transfers and when mobilizing in the wheelchair. R2's Health Status Note dated 04/29/26 at 05:02 PM documented R2 was picked up (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	by an outside transportation vendor and taken to her scheduled appointment. R2 was secured into the transport van. The note documented the wheelchair was secured appropriately with the floor straps and R2 was also seat belted in. The outside transport driver reported R2 slid under the seatbelt, out of her wheelchair onto the floor. The outside transport driver was instructed to leave R2 where she was and notify 911, who reportedly arrived on the scene and transported R2 to the emergency room. R2's Health Status Note dated 04/30/26 at 03:01 AM documented R2 returned to the facility at 08:00 PM with no acute fracture or dislocation. R2 complained of pain at six out of 10, and staff administered R2's as needed pain medication. R2's Physician Progress Note dated 04/30/26 at 03:02 PM documented R2 had a fall out of her wheelchair during transportation to an appointment the previous day. Emergency Medical Services (EMS) assisted R2 off the floor, and she was sent to the hospital. The workup was unremarkable. R2 had diffused pain rated at a five out of 10 and would like to have Voltaren gel (a topical nonsteroidal anti-inflammatory drug used to reduce pain and inflammation in joints) available. R2's Skin and Wound Note dated 05/22/26 at 01:51 AM documented on 05/13/26, R2 had two new blood-filled blisters to her bilateral lower extremities, with maroon color hyperpigmentation (skin that becomes darker that the surrounding skin due to excess melanin production) surrounding skin color representing hemosiderin (indication of iron accumulation in tissues, often reflecting prior bleeding, red blood cell breakdown, or underlying vascular or systemic disorders staining) which facility staff state had been present since admission. Facility staff reported R2 had undergone a fall close to two weeks ago during a transfer to the emergency department and she developed what looked like hematomas (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma), and they have not developed into blisters. R2's progress notes lacked descriptions of the areas of her bilateral knees from 04/29/26 to 05/22/26. The facility's fall investigation dated 04/29/26 at 01:25 PM documented R2 had slid out of her wheelchair during transportation to a provider's appointment. The transportation driver was instructed to leave R2 sitting on the transportation floor and to not to move R2, but to contact EMS to assist R2 up from the floor of the transportation van. Upon further investigation of R2's fall, it was noted that she was sitting on a head (bed) pillow and had a lift sheet under her, which caused her to slide out of her wheelchair. The facility's intervention to this event was verbal education with facility staff to not place a head pillow on the seat of the wheelchair but to ask/obtain an appropriately fitting wheelchair cushion from the charge nurse or nurse management. During an interview on 06/04/26 at 02:48 PM, Administrative Nurse E stated that R2's areas to her knees happened when she fell in the transportation van. During an interview on 06/04/26 at 02:55 PM, Administrative Nurse D stated the fall happened due to the pillow that the staff used (in R2's wheelchair as a seat cushion). Administrative Nurse D stated she expected staff to get a wheelchair cushion for R2's wheelchair. During an interview on 06/04/26 at 02:56 PM, Administrative Staff A stated she completed training with staff to ensure that the correct wheelchair cushion was in place. The facility's Skilled Fall Policy, approved in May of 2025, directed staff that the purpose of the Fall Program was to develop, implement, observe, and evaluate an interdisciplinary approach and manage strategies and interventions that foster resident independence and quality of life. The Fall Program promotes safety and education of both staff and residents. The policy further documented that falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital, or a nursing home. After each fall, an occurrence report would be completed, root cause would be determined, and interventions would be implemented.