| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175499 | A. Building<br>B. Wing | 06/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Village at Mission | 7105 Mission Road<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure R1 received toileting assistance for Resident (R) 1 in accordance to her plan of care when staff left to sit in a soiled brief for over hours and failed to offer toileting assistance. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), malaise (vague uneasy feeling of body weakness, distress or discomfort), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and muscle weakness. R1's Admission/Five Day Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. R1 was impaired on her bilateral upper extremities and one side of her lower extremities. R1 was dependent on staff with toileting, shower/bathing herself, upper and lower body dressing, and putting on and taking off footwear. R1 required partial to moderate assistance with toilet transfers, tub/shower transfer, sit-to-lying, lying to sitting on the side of the bed, and sit-to-stand. The MDS documented R1 was frequently incontinent of urine and bowel. R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/12/2026 documented R1 had impaired cognitive function. R1's Urinary Incontinence and Indwelling Catheter CAA dated 06/12/2026 documented R1 was frequently incontinent, and R1 would have interventions in place to reduce risks associated with incontinence and the incidents of incontinence would be decreased. R1's Pressure Ulcer CAA dated 06/12/2026 documented R1 was at risk for pressure injury, with the goal that R1 would have interventions in place to promote clear and intact skin. R1's Incontinence Care Plan revised 06/16/2026 documented R1 would be assisted to the bathroom at regular intervals upon rising in the morning, before and after meals, at nighttime, and as needed (PRN). R1's plan of care directed staff to check her frequently for incontinence, approximately every two hours and as required for incontinence. R1's plan of care further directed staff to take R1 to the bathroom after each meal to promote a regular bowel elimination pattern. On 06/29/2026 at 10:54 AM, R1 laid on her back in her bed with her left knee up off the bed at roughly a 90 degree angle and her right leg crossed with her right foot resting on her left knee. There was a strong smell of urine and feces in the room at that time. R1's brief was saggy, discolored all over, with a brownish-yellow area on the right side of her brief at the peri area. R1 wore a hospital gown and had blankets piled to the right of her hip. The blankets were discolored in areas. R1 stated she needed a new brief. R1 revealed that she had been soiled for a while but could not locate a new brief. Her breakfast tray sat on the bedside table, Her trash had discarded gloves and a white cream substance. R1 stated that she would like help into the bathroom but the staff were very busy. On 06/29/2026 at 11:30 AM, R1 laid on her back in her bed, with her feet unmoved. R1 stated no one had been in to help her yet with a brief, but she would like to get clean bedding. R1's room still smelled of urine and feces. R1's breakfast tray still sat on the bedside table and her trash can had still not been emptied. R1 proceeded to straighten<br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her legs down onto the bed, while pulling her covers from the right side onto her stomach and the top of her thighs while talking. On 06/29/2026 at 12:06 PM, R1 laid in bed with her discolored blanket pulled across her lower stomach and upper thighs. R1 stated that no one had come to get her changed or ask if she needed anything. The breakfast tray remained on the bedside table, and the trash can had not been emptied. R1 stated she would like to be changed, or at least get the bedding changed. On 06/29/2026 at 12:10 PM, Certified Medication Aide (CMA) S entered R1's room to pass her noon-time medication. While R1 was taking her medications, Certified Nurses Aide (CNA) O entered R1's room with her lunch tray. CNA O observed the breakfast tray on the bedside table and moved it to a table in the room and then placed R1's lunch tray on the bedside table and moved the table closer to the left side of R1's bed. Neither CMA S or CNA O removed the trash, the breakfast tray, asked if the bedding needed to be changed, or asked if R1 needed to be changed or go to the toilet while in the room with R1. On 06/29/2026 at 12:30 PM, R1 laid in bed on her back with her covers onto her lower stomach and upper thighs. R1 stated that no one has asked if she needed to be changed or if she wanted her bedding changed. The breakfast tray was now gone from R1's room. On 06/29/2026 at 12:35 PM, an unidentified housekeeping staff was observed cleaning R1's room. The unidentified housekeeper continued to mop over R1's floor numerous times. R1 continued to lay in bed on her back with her covers pulled over her lower stomach and upper thighs, asking for briefs and R11 revealed that staff had not asked her if she needed to have her brief changed. On 06/29/2026 at 12:42 PM, Administrative Nurse E entered R1's room and could be heard asking if R1 liked the food. Administrative Nurse E exited R1's room and moved down the hall without finding staff to assist R1 with cares. On 06/29/2026 at 12:43 PM, Social Services X entered R1's room and exited while marking something on a clipboard and moved to another resident's room. Social Services X did not locate staff to assist R1 with cares or concerns. On 06/29/2026 at 12:50 PM, R1 laid in her soiled brief in her soiled bed. R1 laid on her back with her covers pulled up on her lower stomach and upper thighs. R1 revealed that no one had assisted or asked if R1 needed her brief or bedding changed. On 06/29/2026 at 01:00 PM, CMA R, CMA S, and CNA N were asked how to locate R1's toileting needs or cares. All three staff members got onto the computer at the nurses' station and proceeded to look up R1's toileting needs. CMA R read that R1 needed be assisted to the checked at regular intervals upon rising in the morning, before and after meals, at nighttime, and as needed. None of the staff could recall the last time someone had assisted R1. At that time the three staff members proceeded to ask who was assigned to care for R1. CNA N stated he had been assigned to that room. CNA N further stated that Administrative Staff A had told him to stay out of R1's room. On 06/29/2026 at 01:03 PM, Administrative Nurse E asked CNA N who he had informed on the team working that day that he could not go into that room. CNA N stated he had said something to the charge nurse, and he had not been back into R1's room since breakfast. On 06/29/2026 at 01:07 PM, Administrative Nurse E and CNA M entered R1's room and asked R1 if she needed assistance with getting her brief and bedding changed. R1 stated that she would like that. Administrative Nurse E and CNA M began to remove R1's bedding off of the side of the mattress and assisted R1 out of her gown, while simultaneously starting to the process of changing R1's brief. CNA M laid out wipes on a clean surface and started to provide peri care, wiping front to back. When R1's brief was opened, a stronger smell of urine could be smelled. When R1 was assisted to her side so that CNA M could begin cleansing R1's backside, a strong smell of feces could now be smelled as it mixed with the smell of urine. CNA M continued to wipe R1's backside, front to back. R1's buttocks were bright red in color. The bedding that lay under R1 had a dark yellow ring that surrounded R1's bottom, approximately one foot to a foot and a half in circumference. CNA M confirmed that it was dried urine on R1's bedding. On 06/29/2026 at 01:15 PM, Administrative Nurse E stated that R1 should not have been left like this and that CNA N should have notified someone that he could not provide care for R1. On 06/29/2026 at 02:53 PM, Administrative Staff A stated this was not acceptable and an investigation had been started to find out why R1 had not been assisted. The facility's Activities of Daily Living policy, approved 09/24/2025, directed that<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the facility would provide each resident with care, treatment, and services according to the resident's individualized care plan. The policy documented that based on the comprehensive assessment of each resident, the facility staff would ensure that the resident's ability to perform activities of daily living did not decline unless the resident's clinical condition circumstances made the decline unavoidable, including toileting, grooming, and bathing. The facility did not have a policy on incontinence, as requested on 06/29/2026. |