STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265802	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Armour Oaks Senior Living Community	8100 Wornall Road Kansas City, MO 64114

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** Based on interview and record review, the facility failed to contact Emergency Medical Services (EMS), to initiate and provide continuous Cardiopulmonary Resuscitation (CPR) timely per facility policy for one sampled resident (Resident #1) out of three sampled residents, who was a full code status. The facility census was 31 residents. The Administrator and Director of Nursing (DON) were notified on [DATE] at 2:45 P.M., of the Immediate Jeopardy (IJ) Past Non-Compliance which occurred on [DATE]. On [DATE], the Administrator and DON became aware of the violation of the facility's CPR policy. The facility in-serviced the staff on the CPR policy and procedures, medical emergencies and ensured code status updates for all residents. The IJ was corrected on [DATE]. Review of the facility policy Residents' Rights Regarding Treatment and Advance Directives, dated 2022, showed:-It is the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.-Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.-Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. -The facility will use the process as provided by state law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes. Review of the facility policy medical Emergency Response, dated 2022, showed:-It is the policy of this facility to respond to medical emergencies for resident, staff and visitors.-The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid, and summon for assistance.-CPR will continue unless there is a do not resuscitate (DNR) order in place, there are obvious signs of clinical death (rigor mortis, dependent lividity, decapitation, transection or decomposition) or initiating CPR could cause injury or peril to the rescuer.-A nurse will assess the situation and determine the severity of the emergency, stay with the resident, and designate a staff member to announce a code blue if necessary, notify the physician and call 911 as needed. -If the resident experiences cardiac arrest, the facility must provide basic life support, including CPR, prior to the arrival of EMS and in accordance with the resident's advance directives, or in absence of advance directive or a DNR order, and if the resident does not show obvious signs of clinical death. -The facility will ensure CPR certified staff are available at all times. -This facility will not implement a No CPR policy. Review of the facility Policy and Procedure for CPR, dated 8/2020, showed:-Residents have the right to make decisions concerning their care, including the right to accept or refuse CPR. This decision will be indicated in the resident's advance directives.-While awaiting physician's order to withhold CPR, staff will document a resident's refusal of CPR, per the advance directives purple sheet. -This choice will be confirmed at least annually.-If a resident experiences a cardiac or respiratory arrest, the CPR-certified staff member will review the resident's chart to determine if they are a full code or DNR. Review of Resident #1's admission Record showed (continued on next page)

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	the resident:-admitted on [DATE].-The advanced directive was left blank, no indication of code status. Review of the resident's Hospice Record, dated [DATE], showed:-No DNR order.-Care plan showed DNR. Review of the resident's Progress Note, dated [DATE] at 7:42 P.M., showed the resident: -Was admitted for respite stay via non-emergency transport on a gurney.-The resident presented as nonverbal and responds only to painful stimuli during repositioning.-The resident remains at Full Code status. Review of the resident's Progress Note, dated [DATE] at 2:20 P.M., showed the resident:-Presented febrile with a temp of 102.0 Fahrenheit (F). (Normal temperature for adults is in the range of 97 F to 99 F.)-The nurse administered Tylenol 750 milligrams (mg) and notified Hospice (end of life care). -After being seen by Hospice, vitals taken again, all WNL (within normal limits) with temperature at 97.8 F. Review of the resident's Progress Note dated [DATE] at 9:24 A.M., showed: -Informed of resident declining condition - watery stool and draining feeding from his/her mouth.-At about 7:15 A.M., abnormal vital signs: blood pressure low, no #s; temperature 102 F; pulse 35; oxygen 99% with 3 Liters of oxygen. -Called Hospice immediately on [DATE] and was told one of their nurses would be at facility promptly.-The resident was found unresponsive at 8:31 A.M. -Tried to inform family, but unable to leave a message as mailbox was full. -Informed DON, then called 911, and staff started CPR on the floor until paramedics arrived and took over. -The resident was pronounced dead at 9:01 A.M. Review of the resident's Outside the Hospital Do-Not-Resuscitate Order, dated [DATE], showed it was signed by the physician on [DATE]. During an interview on [DATE] at 9:23 A.M., the DON said:-The situation happened a couple of weeks ago regarding Licensed Practical Nurse (LPN) A and the resident's code status.-The resident was admitted for respite care with Hospice services in place. -The resident was a Full Code upon admission with consideration of changing to DNR.-There was no durable power of attorney for the resident which delayed the change in code status for the resident.-The DON advised once the hard copy of the DNR was completed and in the facility, the code status could be changed in the electronic medical record for the resident.-The following morning, [DATE] at 8:34 A.M., LPN A sent a message to the DON stating the resident had passed. -At 8:45 A.M. the DON advised LPN A the resident remained a Full Code unless there was a DNR document from Hospice.-At 8:46 A.M. the DON advised if there was no DNR document then life saving measures were to be done until EMS were onsite.-At 8:46 A.M. the DON advised the Clinical Manager to assess the situation and initiate a code, call 911 and complete CPR until EMS arrived. -He/She expected all CPR certified staff to perform CPR on all residents without a DNR. -Only licensed staff are expected to be CPR certified. During an interview on [DATE] at 12:36 P.M., LPN A said:-The resident was admitted as a Hospice patient and a Full Code. -The resident passed away on [DATE] and on [DATE] the family and Hospice had changed the code to DNR.-The DON was aware of the code status change.-When the resident passed away on [DATE] at 8:31 A.M., he/she went by the new code status.-The DON told him/her no, he/she had to do CPR because the resident was a Full Code.-The resident's profile on the computer said the resident was a DNR. The DON made him/her start CPR on the resident.-When the fire department arrived, they took over CPR and requested a print out the resident's code status.-He/She delayed printing the resident's code status and was hiding in the medication room.-The Hospice nurse arrived at the facility with a hard copy of the DNR and advised the first responders to stop CPR.-The fire department stopped life saving measures and left the facility.-There was no official copy of the DNR in the facility until after the resident passed away.-He/She said it was not common practice to change a code status on the resident profile prior to receiving the hard copy of the DNR.-When there was no DNR in place CPR should be started immediately. During an interview on [DATE] at 10:43 A.M., LPN B said:-On [DATE], he/she was in the social worker's office in the basement of the facility when the DON texted a copy of the conversation with LPN A and asked him/her to go assess the situation.-He/She went to check on the resident and the resident did not have any signs of life.-He/She checked the chart to verify the code status and the resident was a Full Code.-He/She told LPN A he/she needed to start CPR.-LPN A said the resident was a DNR and no CPR was needed.-There was no DNR form located for the (continued on next page)

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