STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT MISSION	**7105 MISSION ROAD , PRAIRIE VILLAGE, Kansas, 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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 3179026, 3179591, 3190472, 3167662, and 3179073. The census was 44. The sample included four residents.	F0000		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by:	F0755		

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 reverse for further 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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F0755 SS = D	Continued from page 1 Based on observation, record review, and interviews, the facility failed to maintain an effective controlled substance reconciliation system, which included notifying Administrative Nurse D of discrepancies in Resident (R) 1's liquid lorazepam (a controlled antianxiety medication- medication used to treat anxiety). Findings included: - R1's admitted to the facility on 07/08/2026. R1's Electronic Medical Record (EMR) documented diagnoses of encounter for palliative care (treatment designed to relieve or reduce the intensity of uncomfortable symptoms) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The "Admission Minimum Data Set (MDS)" dated 07/15/2026, documented R1 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. R1 had wandering behaviors for one to three days in the lookback period. R1 received antianxiety medications. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 07/16/2026, documented R1 had impaired cognitive function. The "Behavioral Symptoms CAA" dated 07/16/2026, documented the CAA triggered due to R1's physical/abusive behaviors towards staff and other residents, resistance to cares, wandering, yelling out, and cursing. R1's "Care Plan" dated 07/09/2026 and revised 08/26/2026, documented R1 had a potential for alterations with mood and behavior problems and received hospice services. The plan documented the following interventions: 07/09/2026- Staff administered R1's medications as ordered and monitored/documented for side effects and effectiveness. 08/26/2026- Staff gave R1 anti-anxiety medications ordered by a medical doctor and monitored/documented side effects and	F0755		

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F0755 SS = D	Continued from page 2 effectiveness. R1's EMR documented the following: An order with a start date of 07/09/2026 and discontinued date of 07/15/2026, for lorazepam oral concentrate 2 milligrams (mg)/milliliter (mL), give 0.25 mL every one hour as needed for anxiety, agitation, and restlessness. An order with a start date of 07/15/2026 and discontinued date of 07/29/2026, for lorazepam 0.25 mL every hour as needed for anxiety, agitation, and restlessness. An order with a start date of 08/02/2026 and discontinued date of 08/14/2026, for lorazepam 0.25 mL every hour as needed for anxiety, agitation, and restlessness. An order with a start date of 08/14/2026 and discontinued date of 08/23/2026, for lorazepam 0.25 mL every hour as needed for anxiety, agitation, and restlessness. An order with a start date of 08/23/2026 and discontinued date of 09/04/2026, for lorazepam 0.25 mL every hour as needed for anxiety, agitation, and restlessness. An order with a start date of 09/04/2026 and discontinued date of 09/07/2026, for lorazepam 0.25 mL every four hours as needed for anxiety. An order with a start date of 09/11/2026 for lorazepam one mg tablet every four hours as needed for terminal restlessness and anxiety. R1's "Individual Resident's Controlled Substance Record" documented the facility received 30 mL of lorazepam on 07/13/2026. Review of the record revealed R1 received 32 doses of 0.25 mL lorazepam between 07/12/2026 at 11:45 PM and 08/30/2026 at 09:00 PM. Review revealed on 08/02/2026, R1 had 24.5 mL of lorazepam left and two licensed nurses (LN) corrected the count from 24.50 mL to 22.0 mL. On 08/25/2026 at 11:00 PM, the record documented	F0755		

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F0755 SS = D	Continued from page 3 R1 had 20 mL of lorazepam before she received 0.25 mL of lorazepam with an amount remaining documented as 18 mL. The last documented lorazepam administration on the record was on 08/30/2026 at 09:00 PM with an amount remaining as 17.75 mL. Review of R1's "Treatment Administration Record (TAR)" for July and August 2026 revealed of the 32 administrations of lorazepam documented in the above controlled substance record, only six were documented in the TAR. R1's "Individual Resident Controlled Substance Record" documented the continuation of the lorazepam from the above controlled substance record with a remaining lorazepam amount as 17.75 mL at the start of the record. Review of the record revealed R1 received six doses of 0.25 mL lorazepam between 08/31/2026 at 02:45 AM and 09/06/2026 at 02:00 PM. On 09/07/2026, two LN corrected the lorazepam count from 16.25 mL to 15 mL. On 09/08/2026, multiple LN corrected the lorazepam count three times, from 15 mL to 16 mL, 16 mL to 15 mL, and 15 mL to 14.25 mL. R1 received 0.5 mL of lorazepam on 09/10/2026 at 08:00 PM with a remaining amount documented as 13.75 mL. Review of the Healthcare unit's "Shift Change Controlled Substance Inventory Count Sheet" from 09/01/2026 06:00 AM shift to 09/14/2026 06:00 AM shift, revealed there were eight out of 50 nurse signature spaces blank indicating the two-nurse count was not performed. On 09/10/2026 at 02:46 PM, R1 sat in her Broda chair in the activity area. On 09/10/2026 at 04:03 PM, Administrative Nurse D stated she did not know about the corrected dose on 08/02/2026 for R1's lorazepam. On 09/14/2026 at 11:46 AM, Consultant GG stated the facility investigated the lorazepam liquid bottle and identified the nurses had not ensured all of the medication was out of the dropper that was attached to the lid when they did the count, which caused inconsistency in the count. She stated the facility audited all of the lorazepam orders and there were no other discrepancies besides R1.	F0755		

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F0755 SS = D	Continued from page 4 On 09/14/2026 at 12:16 PM, LN G stated she prevented controlled substance discrepancies by counting with the off-going or oncoming nurse every shift. She stated if she found a discrepancy, she reported it to Administrative Nurse D and did not make a count correction without her permission. LN G stated when they counted the lorazepam liquid bottles, she removed the stopper inside the bottle to make sure it was empty to prevent a discrepancy. She stated she signed the inventory count sheet at each shift change. LN G stated when she gave an as needed (PRN) controlled medication, she assessed the resident for what they needed it for, then signed it off on the count sheet and in the EMR. On 09/14/2026 at 12:31 PM, Administrative Nurse D stated she expected nurses to notify her if the controlled substance count was off so she could investigate and adjust it. She stated the nurses completed count with each shift change and signed the narcotic inventory count sheets. Administrative Nurse D stated she expected the nurse to document in the resident's TAR and on their narcotic count sheet when they give a PRN narcotic medication. She stated she expected the nurses to notify her if the count was off and to not correct the count without her permission. The facility's "Controlled Substance Policy," dated December 2024, directed the on-coming LN or certified medication technician (CMT) and the off-going LN or CMT counted controlled substances every shift and signed the Narcotic Sign In and Out sheet that the count was completed. The policy directed staff reported any discrepancy in the inventory of a controlled substance to the Director of Nurses immediately. The Director of Nurses was responsible for investigating and making a reasonable effort to reconcile all reported discrepancies. The policy directed the LN or CMT signed the controlled substance medication out on the Controlled Substance Proof of Use form and documented in the Medication Administration Record immediately after administering the drug.	F0755		