STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigations KS00191954, KS00191893, and KS00191068. The 2567 was sent electronically on 12/10/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1	F 550		

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 147 residents. The sample included 29 residents with two residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 75's right to be treated with respect, and dignity when her clothing protector was not removed after the meal was finished. The facility also failed to ensure a dignified dining experience for R13 when staff stood over him instead of sitting beside him. This deficient practice placed these residents at risk for negative psychosocial outcomes and decreased dignity.

Findings included:

- R75's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational ion (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 550	Continued From page 2	F 550		

09/18/24 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition.

R75's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/26/24 documented she was cognitively impaired.

R75's "Care Plan" dated 09/12/24 documented she required substantial to maximum assistance with meals. The plan of care documented she was dependent on staff assistance with all other activities of daily living. The plan of care dated 09/24/24 documented it was very important to R75 to receive snacks between meals.

On 12/02/24 at 10:32 AM R75 sat in her high-back wheelchair in the dining room asleep. R75 had a clothing protector attached around her neck that had fallen off her left shoulder and arm. R75 was not positioned at a dining room table and there were no drinks or food on any dining room tables.

On 12/04/24 at 12: 25 PM, Certified Nurse Aide (CNA) N stated no resident should have a clothing protector on if they are not eating or drinking. CNA N stated having a clothing protector left on would be a dignity concern.

On 12/04/24 at 12:35 PM, Licensed Nurse (LN) H stated R75 should not have a clothing protector left on after the meal had ended.

On 12/04/24 at 02: 21 PM, Administrative Nurse D stated she expected all the clothing protectors removed after each meal.

The facility's "Quality of Life-Dignity" policy last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 550	Continued From page 3	F 550		

revised on 02/20 documented each resident would be cared for in a manner that promotes and enhances his or her sense of well-being level of satisfaction with life, feeling of self-worth, and self-esteem. Residents would be always treated with dignity and respect. The facility's culture was one that supports and encourages humanization and individuation for residents and honors resident choices, preferences, values, and beliefs.

The facility failed to ensure R75's right to be treated with respect, and dignity when her clothing protector was not removed after the meal was finished. This deficient practice placed R75 at risk for negative psychosocial outcomes and decreased dignity.
- The "Diagnoses" tab of R13's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), intellectual disabilities, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), sleep apnea (a disorder of sleep characterized by periods without respirations), adult failure to thrive (includes not doing well, feeling poorly, weight

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	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 550	Continued From page 4	F 550		

loss, and poor self-care that could be seen in elderly individuals), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Modification of Significant Change Minimum Data Set (MDS)" dated 11/15/24, documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R13 had an impairment on both sides of his body. The MDS documented R13 was dependent on staff for activities of daily living (ADLs).

R13's " Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/15/24 documented that R13 had impaired cognitive function or impaired thought processes related to developmental delays.

R13's "Communication CAA" dated 11/15/24 documented R13 had a diagnosis of cerebral palsy and had impairment with communication.

R13's "Care Plan" dated 12/02/24 documented R13 suffered from a self-care deficit related to a decline in his prior level of independence resulting in the need for continued medical care related to cerebral palsy, intellectual disabilities, low vision, schizoaffective disorder, epilepsy, and adult failure to thrive. R13's plan of care documented R13 was dependent on staff for oral hygiene, personal hygiene, and eating.

On 12/01/24 at 08:32 AM R13 sat in the dining area in his wheelchair, awaiting his breakfast, Certified Nurse's Aide (CNA) M walked by R13, grabbed his juice glass, and gave him a drink while standing over R13, and then walked away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 550	Continued From page 5 CNA M did not speak to R13 during the observation. On 12/04/24 at 12:33 PM, Licensed Nurse (LN) G stated if a staff member was helping a resident eat or drink, the staff member should be at eye level with the resident and engaging with the resident. On 12/04/24 at 12:48 PM, Certified Nurse's Aide (CNA) M stated staff should sit next to the resident, and never just walk by the resident to give them a drink or a bite to eat. On 12/04/24 at 02:21 PM Administrative Nurse D stated staff should be engaging with residents when helping a resident eat or drink. She stated staff members should never stand over a resident while they assist the resident with eating. The facility's "Quality of Life-Dignity" policy revised on 02/2020 documented that each resident should be cared for in a manner that promotes and enhances his or her sense of well-being level of satisfaction with life, feeling of self-worth, and self-esteem. Residents would be always treated with dignity and respect. The facility's culture was one that supports and encourages humanization and individuation for residents and honors resident choices, preferences, values, and beliefs. The facility failed to ensure R13's dignity when staff stood over R13 to give him a drink of his juice and did not interact. This deficient practice placed R13 at risk for impaired dignity and decreased psychosocial well-being.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 6 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 7	F 580		

representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 147 residents. The sample included 29 residents with one reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R)13's guardian of changes related to the addition of psychotropic (alters mood or thoughts) medications. This deficient practice placed R13 at risk for uninformed care choices or inability to consent or decline treatment.

Findings included:

- The "Diagnoses" tab of R13's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), intellectual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 580	Continued From page 8	F 580		

disabilities, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), sleep apnea (a disorder of sleep characterized by periods without respirations), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Modification of Significant Change Minimum Data Set (MDS)" dated 11/15/24, documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R13 had an impairment on both sides of his body. The MDS documented R13 was dependent on staff for activities of daily living (ADLs).

R13's " Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/15/24 documented R13 had impaired cognitive function or impaired thought processes related to developmental delays.

R13's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 11/15/24 documented R13 had a diagnosis of cerebral palsy and antisocial personality, and R13 had been prescribed antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications. R13's CAA documented he would be monitored for behaviors and treated to help decrease his anxiety and depression. R13's CAA documented he received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 9	F 580		

psychotropic medication and was at risk for adverse side effects.

R13's "Care Plan" dated 12/02/24 documented R13 used Ativan (antianxiety medication) and nursing was to monitor and administer R13's antianxiety medication as ordered by the physician. The plan directed nurses to monitor for side effects and effectiveness of the medication every shift. R13's plan of care documented nursing was to monitor the resident for safety and monitor for increased risk of confusion, loss of balance, and cognitive impairment.

R13's EMR under "Orders" documented the following physician's order:
Lorazepam gel (Ativan) one milligram (mg) per one milliliter(ml) every eight hours as needed for agitation or anxiety apply 0.5mg topically every eight hours as needed (PRN) agitation dated 11/24/24. The order lacked a stop date.

R13's clinical record lacked evidence of guardian notification for the new Ativan gel order.

On 12/01/24 at 08:32 AM R13 sat in the dining area in his wheelchair, awaiting his breakfast.

On 12/04/24 at 09:24 AM R13's guardian stated the nursing staff had called her about care plans and falls. R13's guardian stated she had never been called or informed about adding any medication, or medication changes.

On 12/04/24 at 12:33 PM Licensed Nurse (LN) G stated it was the nurses' duty to call guardians and resident representatives and inform them of any medication changes. LN G stated when the guardian or representative was called, staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 10 documented the communication in the progress nursing note section of the EMR. On 12/04/24 at 03:21 PM Administrative Nurse D stated it the charge nurse should call the resident's guardian with any changes. Administrative Nurse D stated the unit nurse managers run a report of all new orders daily, and unit managers could also follow up with a guardian or representative on any medication change or change of condition. The facility did provide a policy for notification of changes. The facility failed to notify R13's guardian of changes related to the addition of psychotropic medications. This deficient practice placed R13 at risk for uninformed care choices or inability to consent or decline treatment.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents reviewed for comprehensive assessments and timing. Based on observation, record review, and interviews, the facility failed to ensure the significant change "Minimum Data Set (MDS)" for Resident (R) 16 was accurately coded as required by the "Resident Assessment Instrument (RAI) Manual." This placed R16 at risk for an inaccurate care plan and unmet care needs.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 11	F 641		

Findings included:

- R16 ' s Electronic Medical Record (EMR) recorded diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), and gastrostomy (the introduction of a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall).

R16 ' s "Significant Change MDS" dated 09/24/24 documented a Brief Interview for Mental Status (BIMS) score of eight which indicated a moderately impaired cognition. R16 was on a physician-prescribed weight gain regimen. R16 ' s MDS section K0520 Nutritional Approaches lacked documentation of a feeding tube (administration of nutritionally balanced liquefied foods or nutrients through a tube) and the percent of calories and amount of fluids provided per the feeding tube.

R16 ' s "Nutritional Care Area Assessment (CAA)" dated 10/01/24 documented R16 was currently on enteral feedings and water flushes. R16 was at risk for dehydration. The registered dietician would monitor her intake and nursing staff would provide feeding.

R16 ' s "Tube Feeding CAA" was not triggered.

R16 ' s "Care Plan" last revised on 09/18/24 directed staff that R16 was dependent on staff for tube feeding and water flushes. The staff was directed to see physician orders for current feeding orders.

R16 ' s "Order Summary Report" in the EMR documented a physician ' s order dated 07/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 641	Continued From page 12 for Nepro (therapeutic nutrition designed to help meet the specific nutrition needs of people on dialysis) nutritional supplement oral liquid 237 milliliters (ml) via feeding tube twice daily. On 12/03/24 at 11:45 AM R16 wheeled herself out to the dining room for lunch. R16 stated she was able to eat regular meals but did have the enteral feeding to supplement her meals due to a recent weight loss and her being on dialysis (a procedure where impurities or wastes are removed from the blood) therapy. On 12/04/24 at 02:04 PM Administrative Nurse F stated it appeared the dietician did not mark R16 ' s MDS for the enteral feeding when they completed the nutritional and tube feeding parts of the MDS. Administrative Nurse F stated that R16 was on enteral feeding and that she would do a modification to the MDS to ensure it was marked correctly. On 12/04/24 at 02:21 PM Administrative Nurse D stated she did not complete any part of the MDS but would expect the MDS staff that completed them to make sure they would be coded correctly. The facility did not provide a policy regarding the MDS as requested. The facility failed to ensure R16 ' s significant change MDS section K050 Nutritional Approaches was accurately coded as required by the RAI Manual. This placed R16 at risk for an inaccurate care plan and unmet care needs.	F 641		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 13	F 676		

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 147 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 14	F 676		

The sample included 29 residents with Resident (R) 93 reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure staff provided appropriate and safe assistance with activities of daily living (ADL) to R93 during a transfer which resulted in bruises to both R93's arms. This deficient practice placed R93 at risk of decreased ADL ability, pain, and psychosocial distress.

Findings included:

- R93's Electronic Medical Record (EMR) documented diagnoses of repeated falls, hypertension (HTN-elevated blood pressure), blindness in one eye, and dementia (a progressive mental disorder characterized by failing memory and confusion).

R93's "Significant Change Minimum Data Set (MDS)" dated 06/28/24 documented she had a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R93 required substantial to maximal assistance of staff for bed-to-chair (or wheelchair) transfers. R93 had a history of one fall without injury and one fall with injury since her prior assessment. R93 was on hospice services.

R93's "Quarterly MDS" dated 06/28/24 documented she had a BIMS score of 13 which indicated intact cognition. R93 was dependent on staff for bed-to-chair transfers. R93 had not had any falls since the prior assessment. R93 was on hospice services.

R93's "Functional Abilities Care Area Assessment (CAA) dated 07/01/24 documented she suffered from a self-care deficit related to a decline in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 15	F 676		

prior level of independence resulting in the need for continued medical care. She was on hospice services, and further decline was anticipated due to a cognitive communication deficit.

R93's "Care Plan" initiated on 03/28/24 and last revised on 11/20/24 directed staff that R93 was dependent on two staff, using a Hoyer lift (full body mechanical lift) for chair-to-bed or bed-to-chair transfers. Prior to the 11/20/24 revision, the care plan directed R93 required substantial to maximal assistance but did not indicate the use of a gair belt or how many staff were required.

A "Progress Note" in R93 ' s EMR dated 11/19/24 at 03:40 PM documented that on 11/19/24 the hospice nurse contacted Administrative Nurse D to report that a hospice aide reported that Certified Nurse Aide (CNA) P transferred R93 in a rough manner. The hospice nurse stated that R93 had a purple mark in the shape of a thumb on each arm. Administrative Nurse D and the nurse manager went to talk to R93 and assess her. R93 reported that CNA P transferred her on 11/17/24 to her chair. R93 wanted the pads in the chair smoothed out but CNA P did not smooth them out and CNA P used R93 ' s upper arms to transfer her to the chair. R93 had a bruise in the shape of a thumb on each of her upper arms which was purple in color. R93 ' s provider was notified and stated she would assess the resident the following day.

A "Progress Note" dated 11/21/24 at 11:58 AM from R93 ' s provider documented the resident was seen that day per request of Administrative Nurse D. R93 was seen in her room and said a staff member was trying to get her to transfer to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 16	F 676		

her wheelchair but the resident was concerned because the wheelchair was full of bed pads. The resident said she told the aide she did not want to move with all the pads in the wheelchair. R93 thought the staff looked frustrated and "mashed" her arms. R93 said she and the aide had not had any prior animosity and she was not sure why the CNA did that. R93 said the aide just seemed determined to make her do what CNA P wanted. R93 denied pain. Assessment of R93 revealed her bilateral upper extremity bicep areas (upper arm area) had nearly symmetric single ecchymotic (bruising) lesions in the shape of a thumbprint present, without edema. The nurse manager and Administrative Nurse D were notified and were reviewing the episode with plans to make changes for a safe transfer for R93.

The facility report documented an incident with R93 and CNA P that occurred on 11/17/24. Administrative Nurse D was notified by the hospice nurse, that the hospice aide had reported that facility CNA P had transferred R93 in a rough manner. CNA P used R93 ' s upper arms to transfer her to the chair. R93 had a bruise in the shape of a thumb on each of her upper arms which was purple in color. CNA P reported that R93 refused to be transferred with the gait belt. CNA P attempted to transfer R93 with the help of another CNA and R93 became stiff, arched her back, and was unwilling to grab the wheelchair per direction from the aides to assist with the transfer. CNA P held R93 ' s arms to keep her from falling as she transferred R93 to her wheelchair. Licensed Nurse (LN) J was asked how the resident transferred and said she had not transferred R93 recently. LN J went to try to transfer R93 and she again arched her back and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 17	F 676		

would not cooperate with the transfer. R93 was downgraded to a Hoyer lift for transfer and a referral was sent for therapy. CNA P was counseled on always using a gait belt and if the resident refused to use the gait belt the transfer was to be stopped and notify the charge nurse. CNA P grabbed R93 by the arm to prevent her from falling. R93 was care planned to be a partial moderate assist with transfers, revealing she needed assistance from staff during the transfer. CNA P attempted to use the gait belt and R93 refused to allow the aide to place the belt around her. R93 insisted on transferring without the gait belt. CNA P did get another staff to help to ensure R93 was safe. CNA P was unaware that if a resident refused to use the gait belt to transfer, the transfer should be downgraded to a Hoyer lift to ensure the resident's safety. CNA P was educated regarding the proper use of the gait belt during transfers and demonstrated competency with partial moderate assist transfers.

On 12/02/24 at 01:08 PM, R93 sat in her wheelchair in her room and said that CNA P was trying to transfer her on 11/17/24 and would not straighten the pads in her wheelchair. R93 said that CNA P grabbed her upper arms to transfer her to her wheelchair from her bed and left bruises on her arms.

On 12/04/24 at 12:58 PM, CNA P stated R93 was upset that the pads in her wheelchair were not flat, so she transferred R93 from her wheelchair back to her bed but R93 did not want to sit back in the wheelchair, so she went to get another aide to help her. CNA P stated R93 did not want the gait belt on her to transfer so CNA P grabbed R93 by her upper arms to prevent her from falling while transferred to her wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 676	Continued From page 18	F 676		

On 12/04/24 at 01:00 PM LN I stated she could not say, without looking at the care plan, how R93 transferred but thought R93 was a Hoyer transfer.

On 12/04/24 at 02:21 PM Administrative Nurse D stated she had thought R93 had been a one-person assist using a gait belt prior to the incident on 11/17/24 but would have to look at the care plan to verify that information. Administrative Nurse D stated that R93 was a two-person Hoyer lift for transfers now. Administrative Nurse D stated an investigation was done regarding the incident with R93 and CNA P, which resulted in a suspension until the investigation was completed. Administrative Nurse D stated CNA P was reeducated regarding proper transfer technique.

The "Activities of Daily Living (ADLs), Supporting" policy documented that residents would be provided with the care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Interventions to improve or minimize a resident's functional abilities would be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.

The facility failed to ensure staff provided appropriate and safe ADL assistance to R93 during a transfer which resulted in bruises to both R93's arms. This deficient practice placed R93 at risk of decreased ADL ability, pain, and psychosocial distress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 19	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with seven residents reviewed for treatment and services to prevent and/or heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 22's heels were offloaded either by boots or a pillow and further failed to ensure R13 was provided a pressure-reducing cushion for his wheelchair. This placed R22 and R13 at increased risk for pressure ulcer development and delayed healing. Findings Included: - R22's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 20	F 686		

sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, cognitive communication deficit, muscle weakness, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and dysphagia (swallowing difficulty).

The "Admission Minimum Data Set" (MDS) dated 11/05/24 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R22 had an impairment on one side of his lower body. The MDS documented R22 was dependent on staff for lower body dressing and putting on and taking off footwear, oral hygiene, and toileting. The MDS documented R22 was at risk for pressure ulcers and had a Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) over a bony prominence, and had an unhealed pressure ulcer on admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 21	F 686		

R22's "Pressure Ulcer/ Injury Care Area Assessment " dated 11/05/24 documented R22 was admitted with a right lateral foot deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and a surgical wound on 10/25/24. R22 required assistance with bed mobility.

R22's "Care Plan" revised 11/12/24 documented R22 was admitted with a right lateral foot DTI and surgical wound. Staff were to ensure adequate and proper repositioning every two hours, and as needed (PRN). Staff were to monitor skin condition with care, for color or texture changes, redness, edema, and incontinence-associated skin damage and report findings to the charge nurse. R22 was to use a pressure-reducing device in his chair and wheelchair.

R22's EMR under "Orders" documented the following physicians' orders:
Reposition the resident every two hours. Always keep heels offloaded every shift dated 10/31/24.

R22's medical record lacked documentation R22 refused offloading.

On 12/03/24 at 12:10 PM, R22 lay on his bed. R22's heel rested directly on the mattress. R22's heels were not offloaded.

On 12/03/24 at 12:30 PM R22 laid on his bed visiting with his family. R22's heels were directly on the mattress. R22's heels were not offloaded.

On 12/04/24 at 12:31 PM, R22 stated he was unaware his heels were supposed to be off the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 22	F 686		

mattress. He stated he had boots, and sometimes the staff put the boots on him. R22 stated staff would put a pillow under his legs, which was usually at night. R22 stated he was not able to take his boots off or remove the pillow from under his legs.

On 12/04/24 at 12:48 PM, CNA M stated he did have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), but he usually referred to the daily report sheet. CNA M stated he carried the daily report sheet and could refer to the sheet if he was unsure what each resident needed for care. CNA M stated it was not on the daily report to float R22's heels.

On 12/04/24 at 12:33 PM, Licensed Nurse (LN) G said ensuring boots are on the resident or offloading their heels would be the charge nurses' responsibility. LN G stated she did not think R22 could take his boots off on his own or remove a pillow if his heels were offloaded.

On 12/04/24 at 02:21 PM Administrative Nurse D stated applying boots to a resident or ensuring heels were offloaded would be on the nurse's task, but the charge nurse could delegate that duty to the CNA if the nurse was busy. Administrative Nurse D stated the staff all work together to ensure all tasks are completed.

The facility's "Pressure Ulcers/Skin Breakdown" policy revised on 04/18 documented that the nursing staff and practitioner would access and document an individual significant risk factors for developing pressure ulcers. The medical provider will help identify medical interventions related to wound management. A medical provider will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 23	F 686		

order pertinent treatments, including pressure reduction surfaces, wound cleansing, and or dressings.

The facility failed to ensure R22's heels were offloaded either by boots or a pillow. This placed R22 at increased risk for pressure ulcer development and delayed healing.

- The "Diagnoses" tab of R13's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), intellectual disabilities, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), sleep apnea (a disorder of sleep characterized by periods without respirations), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Modification of Significant Change Minimum Data Set (MDS)" dated 11/15/24, documented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 24	F 686		

Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R13 had an impairment on both sides of his body. The MDS documented R13 was dependent on staff for activities of daily living (ADLs). The MDS documented R13 was at risk for pressure ulcers and had one or more Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) or higher.

R13's "Pressure Ulcer/ Injury Care Area Assessment" dated 11/15/24 documented R13 was incontinent of bowel and bladder and required assistance with toileting and toileting hygiene. R13 would be assisted every two hours and as needed (PRN).

R13's "Care Plan" dated 08/27/24 documented that staff were to ensure adequate and proper repositioning every two hours and PRN. Staff were to avoid massaging over bony prominences and may use lotions and moisturizers to prevent skin from drying out. Staff were to monitor skin condition with care, for color or texture changes, redness, edema, and incontinence-associated skin damage and report findings to the charge nurse Staff were to provide supplements as ordered for wound healing. R13 was to have a pressure-reducing device in his chair and or wheelchair and a pressure-reducing mattress.

On 12/01/24 at 08:32 AM R13 sat in the dining area in his wheelchair. R13 had a blue and white blanket in his chair. R13 did not have a cushion in place.

On 12/02/24 at 08:21 AM, R13 sat in the dining area in his wheelchair, R13 had a blue and white

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 25	F 686		

blanket in his chair. R13 did not have a cushion in place.

On 12/03/24 at 08:17 AM, R13 sat in the dining area in his wheelchair. R13 did not have a cushion in place.

On 12/04/24 at 11:43 AM Therapy Director GG stated therapy staff worked with R13 on positioning. She stated the therapy staff should have noticed that R13 did not have a cushion in his wheelchair. She stated nursing and therapy were responsible for ensuring the resident's care plan was followed.

On 12/04/24 at 12:23 PM, Licensed Nurse (LN) G stated all staff have access to each resident's care plans. LN G stated she was unaware that R13 did not have a cushion in his wheelchair. She stated that it was the Certified Nurse Aide's (CNA) responsibility to help the resident into their wheelchair, but ultimately the nurse in charge was responsible for ensuring each resident had what they needed to stay safe.

On 12/04/24 at 12:48 PM, CNA M stated he did have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), but he usually referred to the daily report sheet. CNA M stated he carried the daily report sheet and could refer to the sheet if he was unsure what each resident needed for care. CNA M stated he could not remember the last time there was a cushion in R13's wheelchair.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated the CNAs would be the first check to ensure the cushion was in place; the charge nurse would be the second check, and the unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 686	Continued From page 26 manager should have been notified the resident's cushion was not in place. The facility's "Pressure Ulcers/Skin Breakdown" policy revised on 04/18 documented that the nursing staff and practitioner would access and document an individual significant risk factors for developing pressure ulcers. The medical provider will help identify medical interventions related to wound management. A medical provider will order pertinent treatments, including pressure reduction surfaces, wound cleansing, and or dressings. The facility failed to ensure R13 had a cushion in his wheelchair. This placed R13 at increased risk for pressure ulcer development.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 147 residents. The sample included 29 with 11 residents reviewed for accidents. Based on record review, interviews, and observations, the facility failed to ensure a safe environment free from accident hazards for Residents (R)5 and R32. The facility additionally failed to implement care-planned fall interventions for R13 and R27. This deficient	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 27	F 689		

practice placed the residents at risk for preventable falls and injuries.

Findings Included:

- The "Medical Diagnosis" section within R5's Electronic Medical Records (EMR) included diagnoses of cognitive communication deficit, transient ischemic cerebral attack (TIA-temporary episode of inadequate blood supply to the brain), weakness, history of falls, chronic kidney disease, and abnormalities with mobility.

R5's "Quarterly Minimum Data Set (MDS)" completed 09/24/24 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted she required partial to moderate assistance with transfers, bed mobility, toileting, bathing, personal hygiene, and oral hygiene. The MDS noted she required substantial to maximal assistance with lower body dressing and putting on her footwear. The MDS noted she had no falls since her admission.

R5's "Fall Care Area Assessment (CAA)" completed 07/08/24 indicated she had a history of falls before her admission and was at risk related to her medical diagnoses. The CAA noted she could make her needs known to staff.

R5's "Functional Abilities CAA" completed 07/08/24 indicated she required assistance with her activities of daily living (ADLs) and transfers. The plan instructed staff to anticipate her needs when indicated. The CAA noted she could make her needs known to staff.

R5's "Care Plan" initiated 07/01/24 indicated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 28	F 689		

was at risk for falls related to her history of falls and medication side effects. The plan indicated she required partial to moderate assistance with transfers, dressing, bed mobility, personal hygiene, toileting, and bathing. The plan noted she had one fall since her admission to the facility on 10/04/24 related to her self-ambulating in her room without calling for staff assistance. The plan indicated she was placed on occupational therapy to improve mobility functions and continued her physical therapy program. The plan indicated she was on a functional maintenance program related to ambulation and ADLs. The plan did not include documentation related to moving her bed to a high position when not in use.

On 12/02/24 at 11:30 AM staff propelled R5 to the dining room area in the "Memory Care Unit." Upon moving R5 out of her room, the staff stated "Let's put her bed in the high position so she can't get back in it." Staff then placed R5's bed in the highest position.

On 12/03/24 at 08:23 AM R5's bed was in the highest position. R5 sat at the dining room table.

On 12/04/24 at 07:11 AM R5 slept in her bed. Her bed was in the medium to low position.

On 12/04/24 at 10:00 AM R5's empty bed was placed in the high position.

On 12/04/24 at 10:20 AM Certified Nurses Aide (CNA) LL stated R5 was impulsive and often attempted to stand or transfer herself without staff assistance. She stated staff had to closely watch R5 while she was in her room and provided frequent checks for ADLs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 29	F 689		

On 12/04/24 at 11:01 AM Certified Medication Aide (CMA) RR stated staff had to closely watch R5 due to her impulsive behavior to self-transfer and attempt to ambulate without staff assistance. She stated staff should ensure her room was free of clutter and provide frequent toileting. She stated that R5 has had only one fall attempting to ambulate in her room.

On 12/04/24 at 02:22 PM Administrative Nurse D stated R5's bed should not be left in the high position due to her risk of falling and cognitive impairment. She stated staff were to leave it in the low position and assist her into and out of bed.

The facility's "Falls-Clinical Protocol" revised 05/2022 indicated the facility will assess each resident's functional abilities and identify pertinent interventions to prevent subsequent falls. The policy noted the facility will provide ongoing monitoring and assessment of individuals at risk for falls.

The facility failed to ensure R5's care environment was free from accident hazards when staff intentionally placed the bed in a high position to try to prevent R5 from getting in bed herself. This placed R5 at risk for preventable accidents and injuries.
- R32's Electronic Medical Record (EMR) recorded diagnoses of hypertension (HTN- an elevated blood pressure), and absence of the left and right leg above the knee.

R32's "Significant Change Minimum Data Set (MDS)" dated 09/14/24 documented R32 had a Brief Interview for Mental Status (BIMS) score of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 30	F 689		

11 which indicated a moderately impaired cognition. R32 required partial assistance for rolling left and right, substantial to maximal assistance for sitting to lying, and was dependent on staff for transfers. R32 had not had any falls since the prior assessment.

R32's "Cognition Care Area Assessment (CAA)" dated 09/19/24 documented he had a BIMS score of 11 and had mild cognitive impairment. Staff would assist and anticipate the resident's needs. R32 needed assistance with activities of daily living (ADLs), transfers, hygiene, dressing, and bathing. Staff would provide assistance every two hours and as needed.

R32's "Care Plan" last revised on 11/05/24, directed staff that R32 was at risk for falls secondary to being dependent with transfers. Staff were directed that R32 had a visual reminder in his room to use the call light for assistance prior to getting up and to re-educate staff to keep his bedside table close for him to reach things. Staff were to ensure the call light was within reach while in his room unsupervised. Staff were to encourage R32 to use his call light to alert staff for assistance. Staff were directed to respond promptly. Staff were directed to ensure a safe environment with an even floor, free from spills and or clutter, and have personal items within reach. The care plan lacked staff guidance for bed height placement.

R32's "Fall Risk Evaluation" dated 12/02/24 documented a fall risk score of seven. If the total score was 10 or greater, the resident should be considered at high risk for potential falls.

On 12/02/24 at 08:00 AM R32 was lying in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 31	F 689		

The bed height was noted to be in a high position.

On 12/02/24 at 12:15 PM, R32 was noted in his bed. The bed height was noted to be in a high position.

On 12/04/24 at 12:55 PM Certified Nurse Aide (CNA) O stated no resident's bed should ever be in a high position unless care was being provided or that was the resident's personal preference. CNA O stated a resident's care plan should document a high bed level preference but would not expect a resident who was a fall risk to have their bed in a high level.

On 12/04/24 at 01:00 PM Licensed Nurse (LN) I stated a resident's bed should not ever be in a high position unless a care was being provided. LN I stated R32 was at risk for falls so his bed should not be left in a high position by staff.

On 12/04/24 at 02:21 PM Administrative Nurse D stated she expected her staff to ensure R32's bed was never left at high height due to the risk of falls. Administrative Nurse D stated that R32 was dependent on staff for transfers and the only time his bed would need to be in a high position was when staff were providing care to him.

The "Falls - Clinical Protocol" policy revised in May 2022 documented that on admission the nurse would complete a Fall Risk Assessment. The nurse would identify individuals with a history of falls and risk factors for falling. The staff would document in the medical record a history of one or more recent falls. Chart high-risk status and interventions on the care plan. Ensure that the resident has therapy on admission as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 32	F 689		

The facility failed to ensure R32's bed was maintained at a safe height for fall prevention. This placed R32 at risk for fall-related injuries.
- The "Diagnoses" tab of R13's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), intellectual disabilities, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), sleep apnea (a disorder of sleep characterized by periods without respirations), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Modification of Significant Change Minimum Data Set (MDS)" dated 11/15/24, documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R13 had an impairment on both sides of his body. The MDS documented R13 was dependent on staff for activities of daily living (ADLs). The MDS documented R13 had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 689	Continued From page 33	F 689		

falls since admission.

The "Falls Care Area Assessment " dated 11/15/24 documented R13 was at risk for falls due to cerebral palsy, an antisocial personality, immobility, epilepsy, and the need for assistance.

R13's "Care Plan" revised 08/24/24 documented R13 was at risk for falls related to poor vision, epilepsy, and the need for assistance with ambulation and transfers. R13's plan of care documented that staff should encourage the use of non-skid footwear during ambulation and transfers. R13's plan of care dated 09/18/24 documented that staff were to ensure R13 had adequate lighting during waking hours, and they could leave the bathroom light or night light on during hours of sleep. Staff were also to ensure R13's call light was within his reach while he was in his room unsupervised, and staff should promptly respond to his call light. R13's plan of care dated 11/18/24 documented that a Dycem (non-slip mat used for stabilization and grip to prevent slipping) was added to his wheelchair; R13 continued occupational therapy (OT) services for seating and positioning. The plan documented a hospice medication review for scheduled pain medication, and a perimeter mattress was to be applied to R13's bed.

R13's EMR under "Event Note" dated 08/16/24 documented R13 was found on his side, on the floor mat in the fetal position by physical therapy (PT). R13 was unable to verbalize how he fell. The possible root cause was that R13 was impulsive, and had a mental diagnosis. R13 appeared combative, was in a new environment, or could be hungry or thirsty. Staff notified the physician of the fall and placed a scoop mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 34	F 689		

Staff checked and changed R13 due to incontinence. The lighting was appropriate, and R13 was offered fluids and snacks.

R13's EMR under "Interdisciplinary Team Note" dated 09/19/24 documented a fall on 09/18/24. The root cause was R13 slid out of his wheelchair and the immediate intervention was a Dycem was added to his wheelchair. OT was to evaluate the cushion for his wheelchair.

R13's EMR under "Interdisciplinary Team Note" dated 11/18/24 documented a fall on 11/18/24. The root cause of the fall was R13 was having behaviors; he was spitting out his medication and hitting his head on the table. The nurse aide was in the room when R13 put himself on the floor. The immediate intervention was a request for a medication review from R13's provider.

On 12/01/24 at 08:32 AM R13 sat in the dining area in his wheelchair, R13 had a blue and white blanket in his chair. R13 did not have a cushion or a Dycem in place.

On 12/02/24 at 08:21 AM, R13 sat in the dining area in his wheelchair, R13 had a blue and white blanket in his chair. R13 did not have a cushion or a Dycem in place.

On 12/03/24 at 08:17 AM, R13 sat in the dining area in his wheelchair. R13 did not have a cushion or a Dycem in place.

On 12/04/24 at 11:43 AM Therapy Director GG stated therapy staff worked with R13 on positioning. She stated the therapy staff should have noticed R13 did not have a Dycem in his wheelchair. She stated nursing and therapy were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 35	F 689		

responsible for ensuring the resident's care plan was followed.

On 12/04/24 at 12:23 PM, Licensed Nurse (LN) G stated all staff have access to each resident's care plans. She that it was the Certified Nurse Aide's (CNA) responsibility to help the resident into their wheelchair, but ultimately the nurse in charge was responsible for ensuring each resident had what they needed to stay safe.

On 12/04/24 at 12:48 PM, CNA M stated he did have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), but he usually referred to the daily report sheet. CNA M stated he carried the daily report sheet and could refer to the sheet if he was unsure what each resident needed for care.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated the CNAs would be the first check to ensure the resident Dycem was in place; the charge nurse would be the second check, and the unit manager should have been notified the resident's Dycem was not in place.

The facility's "Falls" policy revised on 05/22 documented that on admission the nurse would complete the fall risk assessment. The nurse would identify individuals with a history of falls and risk factors for falling. Nurses would chart high-risk status and interventions on the care plan and ensure that they have therapy on admission as appropriate.

The facility failed to ensure R13's Dycem was placed in his wheelchair to prevent falls. This deficient practice placed R13 at risk for continued falls and related injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 36	F 689		

- R27's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of obesity (excessive body fat), acute respiratory failure (a serious condition that occurs when the lungs are unable to provide the body with enough oxygen or remove enough carbon dioxide), Down's syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), sleep apnea (a disorder of sleep characterized by periods without respirations), hypotension (low blood pressure), dysphagia (swallowing difficulty), aphasia (condition with disordered or absent language function), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The " Admission Minimum Data Set" (MDS) for R27 dated 09/24/24 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R27 needed substantial to maximum assistance from staff for eating and was dependent on staff for dressing her upper and lower body and for all hygiene. The MDS documented R27 was dependent on staff for chair-to-bed transfers. The MDS documented R27 had not had a fall since admission.

R27's "Cognitive Loss/ Dementia Care Area Assessment " dated 09/24/24 documented R27 would maintain the current level of cognitive function through the review date. Staff were to engage in simple, structured activities that avoid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 37	F 689		

overly demanding tasks. The CAA documented R27 had impaired cognitive function or impaired thought processes related to developmental delays.

R27's "Communication Care Area Assessment " dated 09/24/24 documented R27 was primarily nonverbal. At times, R27 would make verbal noises but nothing discernible. R27 did maintain eye contact when being spoken to, and staff were to meet R27's needs.

R27's "Care Plan" revised 09/27/24 documented R27 was at risk for falls. R27's plan of care documented that staff were to ensure R27's call light was within her reach, and staff could leave the bathroom light on or night light on during hours of sleep. Staff should respond promptly to R27's call light. R27's plan of care dated 09/29/24 documented that R27 would have a fall mat on the floor next to her bed. R27's plan of care documented she would have a defined perimeter mattress and would be the first one up for dinner.

R27's EMR under "Progress Note" dated 11/18/24 documented that R27's roommate informed staff that R27 was sitting on the side of her bed. When the Certified Nursing Aide (CNA) entered R27's room, the CNA observed R27 sitting upright on the floor next to her bed. Staff assisted R27 to the laying position and placed her sling under her. Staff transferred R27 to her bed with a Hoyer (total body mechanical lift) and noted an abrasion down the left side of R27's back. The nursing staff notified the unit manager and physician.

R27's EMR under "Interdisciplinary Team Note "dated 11/22/24 documented the root cause of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 38	F 689		

the fall from 11/18/24 was R27 was sitting on the side of her bed, and the immediate intervention was to place a defined perimeter mattress on R27's bed and a fall mat.

On 12/02/24 at 01:14 PM R27 laid on her bed awake, with a stuffed animal beside her. R27 did not have a fall mat in place beside her bed.

On 12/03/24 at 01:17 PM, R27 lay on her bed with her eyes shut. R27 did not have a floor mat in place beside her bed.

On 12/04/24 at 12:23 PM, Licensed Nurse (LN) G stated all staff had access to each resident's care plan. She said that it was the CNA's responsibility to help the resident into their wheelchair or bed, but ultimately the nurse in charge was responsible for ensuring each resident had what they needed to stay safe.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated the CNAs would be the first check to ensure the resident's fall mat was in place; the charge nurse should also be following up to ensure what was in the care plan was being followed through.

The facility's "Falls" policy revised on 05/22 documented that on admission the nurse would complete the fall risk assessment. The nurse would identify individuals with a history of falls and risk factors for falling. Nurses would chart high-risk status and interventions on the care plan and ensure that they have therapy on admission as appropriate.

The facility failed to ensure that R27's fall mat was placed beside her bed per her plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 689	Continued From page 39 This deficient practice placed R27 at risk for fall-related injuries.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with two residents reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 52's physician-ordered supplemental oxygen supply was turned on. The facility failed to ensure R109's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) was stored appropriately when not in use. This placed R52 and R109 at risk of respiratory complications and possible infection. Findings included: - R52's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (a condition where your blood does not have enough oxygen), dysphagia (swallowing difficulty), aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 695	Continued From page 40	F 695		

vomit), dementia (a progressive mental disorder characterized by failing memory and confusion), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with hypoxia (inadequate supply of oxygen).

R52's "Significant Change Minimum Data Set (MDS)" dated 09/14/24 documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. R52 had impairment on both sides of his lower extremity and used a wheelchair for mobility. R52 required substantial assistance with bathing, lower body dressing, and transfers. R52 required oxygen therapy. R52 was on hospice services.

R52's "Functional Abilities Care Area Assessment (CAA)" dated 09/23/24 documented R52 suffered from self-care deficit secondary to assistance required in activities of daily living (ADLs), impaired balance and transition during transfers, and functional impairment in activity related to COPD and dementia.

R52's "Care Plan" last revised on 06/26/24 directed staff of R52's supplemental oxygen as needed. The plan directed staff may titrate to keep oxygen saturation (percentage of oxygen in the blood) level above 90 percent (%).

R52's "Order Summary" under the "Orders" tab of the EMR documented a physician's order dated 09/11/24 for continuous oxygen at one liter (L) per nasal cannula (NC). May titrate to keep oxygen saturation above 91%.

A nurse "Progress Note" dated 11/20/24 at 08:51

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 41	F 695		

AM for R52 documented an order was received from the provider for a chest X-ray.

A nurse "Progress Note: dated 11/21/24 at 08:07 AM for R52 documented the chest x-ray results were received and noted right basilar airspace opacities (findings that indicate something is in the space where air should be in the lungs) that was concerning for developing pneumonia. R52's provider had reviewed the results and ordered Amoxicillin (a medication used to treat bacterial infections) twice daily for seven days for pneumonia (an infection of the lungs).

R52's "Orders Summary" under the "Orders" tab of the EMR documented a physician's order dated 11/21/24 for Amoxicillin to be given two times daily by mouth for pneumonia.

On 12/02/24 at 07:47 AM, R52 sat in his wheelchair in his room, his NC was on and connected to his oxygen concentrator (a machine that provides supplemental oxygen) but the concentrator was not turned on. R52 was having some slight trouble getting his breath. Staff were notified that R52's concentrator was not on.

On 12/04/24 at 12:55 PM, Certified Nurse Aide (CNA) O stated R52 was on continuous oxygen and should either have a portable oxygen tank with him or his NC should be connected to his concentrator in his room and be on at all times.

On 12/04/24 at 01:00 PM Licensed Nurse (LN) I stated a resident who was on continuous oxygen should have the concentrator with them or always have a portable oxygen tank with them. LN I stated the aides should be making sure the concentrator was on when they did rounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 695	Continued From page 42	F 695		

On 12/04/24 at 02:21 PM Administrative Nurse D stated she would expect nursing staff to check residents when getting them up or during rounds to ensure that their oxygen was on. Administrative Nurse D stated that R52 had gone to the hospital back in September and had been treated for pneumonia last month, so he was more vulnerable to respiratory issues.

The "Oxygen Administration" policy was revised in October 2010 and documented to verify that there was a physician's order for the procedure. Review the physician's order or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Oxygen therapy was administered by way of an oxygen mask or an NC.

The facility failed to ensure R52's physician-ordered supplemental oxygen supply was turned on. This placed R52 at risk of respiratory complications and possible infection.
- R109's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of the need for assistance with personal care, cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and sleep apnea (a disorder of sleep characterized by periods without respirations).

The "Quarterly MDS" dated 11/07/24 documented R109 had moderately impaired cognition. The MDS documented that R109 used a CPAP during the observation period.

R109's "Functional Abilities (Self-Care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 695	Continued From page 43	F 695		

Mobility) Care Area Assessment" (CAA) dated 01/22/24 documented she required staff assistance related to her CVA.

R109's "Care Plan" dated 03/24/24 documented staff would clean her CPAP mask cushion and nose with soap and water and then hang it to dry.

R109's EMR under the "Orders" tab revealed the following physician orders:
Clean CPAP mask and tubing daily with soap and water and hang to air dry dated 05/09/24.

On 12/03/24 at 04:14 PM, R109 sat out at the dining room table. In her room, R109's CPAP mask and tubing laid directly on her CPAP machine on the bedside table next to the bed.

On 12/04/24 at 12:25 PM, Certified Nurse Aide (CNA) N stated she would clean R109's CPAP in the morning after she assisted R109 out of bed. CNA N stated she would clean the CPAP mask with a disinfectant wipe and then store the mask in a plastic bag.

On 12/04/24 at 12:35 PM, Licensed Nurse (LN) H stated she would clean R80's CPAP mask every morning with soap and water and then hang it to dry. LN H stated the CPAP mask should never be placed directly on the bedside table or the CPAP machine.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated she expected the nurse on the unit to clean the CPAP mask with soap and water. Administrative Nurse D stated that the mask was to hung to air dry. Administrative Nurse D stated the CPAP mask should never be stored directly on the bedside table or top of the CPAP machine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 695	Continued From page 44 The facility was unable to provide a policy related to the storage of respiratory equipment. The facility failed to ensure R109's CPAP mask was stored in a sanitary manner. This placed R109 at increased risk for respiratory infection and complications.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with three residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 80's access site for complications at least daily and document the arteriovenous (AV-a surgically created connection between an artery and a vein used for hemodialysis) fistula for the thrill (palpable vibration) and bruit (an audible vascular sound associated with turbulent blood flow usually heard with a stethoscope that may occasionally also be palpated as a thrill) every day. This deficient practice placed R80 at risk of adverse outcomes and physical complications related to dialysis.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 45	F 698		

Findings included:

- R80's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), a need for assistance with personal care, and cognitive communication deficit.

The "Admission Minimum Data Set" (MDS) dated 05/04/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R80 received dialysis during the observation period.

The "Quarterly MDS" dated 05/13/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R80 received dialysis during the observation period.

R80's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 05/13/24 documented he required staff assistance with toileting and personal hygiene.

R80's "Care Plan" dated 09/24/24 documented that staff would monitor, document, and notify the physician of any signs or symptoms of infection of his access site. The plan of care documented nursing staff would check and change his dressing daily at the access site.

R80's EMR under the "Orders" tab revealed the following physician orders:
Dialysis on Monday, Wednesday, and Friday for end-stage renal disease. Arteriovenous fistula

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 698	Continued From page 46	F 698		

(AVF- is an abnormal connection between an artery and a vein) located on the left upper extremity dated 09/22/24.

A review of R80's EMR under the "Assessment" tab revealed "Pre/Post Dialysis Evaluation" reviewed from 09/11/24 through 11/29/24. The assessments documented assessment for signs of infection of his AVF and bruit and thrill on the days he received dialysis (three days weekly).

R80's clinical record lacked evidence of daily assessment of R80's AVF and monitoring of thrill and bruit.

On 12/03/24 at 03:15 PM, R80 sat in a recliner in his room with his lower extremities elevated as he watched the news on the TV.

On 12/04/24 at 12:25 PM, Certified Nurse Aide (CNA) N stated she would help R80 get dressed and ready for dialysis.

On 12/04/24 at 12:35 PM, Licensed Nurse (LN) H stated she would assess his access site every Monday, Wednesday, and Friday when received dialysis. LN H stated his AVF should be assessed at least daily and that would usually be documented on the "Treatment Administration Record" (TAR).

On 12/04/24 at 02:21 PM, Administrative Nurse D stated she expected the nursing staff to assess R80's bruit and thrill every shift. Administrative Nurse D stated the nursing staff did not change the resident's dialysis access site dressing. Administrative Nurse D stated the nursing staff should monitor for any bleeding or any signs of infection. Administrative Nurse D stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 47 assessment of the access site would be documented on the resident's TAR. The facility's "Dialysis" policy last revised 09/2010 documented the staff would check thrills/bruit of grafts and fistulas, documented in EMR. When to remove the dressing from the access site placed on from the dialysis center. Monitor for signs and symptoms of infection including, but not limited to, fever, redness, tenderness, and bleeding at the fistula site. The facility failed to monitor R80's dialysis access site for the thrill, bruit, and signs of infection, bleeding, and the status of the dressing in place. This deficient practice placed R80 at risk of potential adverse outcomes and physical complications related to dialysis.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with two residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 699	Continued From page 48	F 699		

trauma-based triggers related to Resident (R) 75's and R107 posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R75 and R107 at risk for decreased psychosocial well-being and ineffective treatment.

Findings included:

- R75's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational ion (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS) dated 09/18/24 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition.

R75's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/26/24 documented she was cognitively impaired.

R75's EMR under the "Assessments" tab revealed "Activities/Social history and Initial Assessment" dated 09/16/24 under the "Trauma Informed Care" section documented she had a history of trauma, and the intervention would be the staff would recognize her specific triggers and avoid re-traumatization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 699	Continued From page 49	F 699		

R75's "Care Plan" dated 09/27/24 documented staff would recognize her specific triggers to avoid re-traumatization. The plan of care lacked individualized interventions that identified ways to decrease exposure to triggers that could re-traumatize her.

On 12/02/24 at 10:32 AM R75 sat in her high-back wheelchair in the dining room asleep. R75 had a clothing protector attached around her neck that had fallen off her left shoulder and arm. R75 was not positioned at a dining room table and there were no drinks or food on any dining room tables.

On 12/04/24 at 12: 25 PM, Certified Nurse Aide (CNA) N stated she was not aware R75 had experienced trauma in her past. CNA N stated she was not aware of what triggers might retraumatize R75.

On 12/04/24 at 12:35 PM, Licensed Nurse (LN) H stated she was not aware R75 had experienced trauma in her past. LN H stated she did not know what triggers could retraumatize R75.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated each resident was assessed for trauma-informed care at the time of admission to the facility, after changes in the psychosocial well-being of the resident and with every MDS. Administrative Nurse D stated if a resident had a history of past trauma personalized interventions should be listed on the resident plan of care to prevent the resident from being re-traumatized.

The facility's "Trauma Informed Care" policy last revised 03/2019 documented the facility would guide staff in appropriate and compassionate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 699	Continued From page 50	F 699		

care specific to individuals who have experienced trauma. The facility supported a culture of emotional well-being and physical safety for staff, residents, and visitors. Trauma-informed care was culturally sensitive and person-centered. Caregivers are taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers. As part of the comprehensive assessment, identify the history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Utilize trained and qualified staff members who have established a rapport with the resident to assess him or her for previous trauma. Interact with all residents and visitors in a manner that is welcoming and kind, without being intrusive. Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.).

The facility failed to identify trauma-based triggers related to R75's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R75 at risk for decreased psychosocial well-being and ineffective treatment.

- R107's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of cognitive communication deficit, need for assistance with personal care, intellectual disability, PTSD, and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought).

The "Admission Minimum Data Set" (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 699	Continued From page 51	F 699		

08/12/24 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R107 had a diagnosis of PTSD.

The "Quarterly MDS" dated 11/06/24 documented a BIMS score of 11 which indicated moderately impaired cognition. The MDS documented that R107 had a diagnosis of PTSD.

R107's "Psychosocial Well-Being Care Area Assessment" (CAA) dated 08/20/24 documented she was having adjustment issues to admission affecting her desire to do things.

R107's "Care Plan" dated 08/12/24 documented staff would engage her in simple, structured activities that avoided overly demanding tasks. The plan of care lacked individualized triggered -specific interventions that identified ways to decrease exposure to triggers that could re-traumatize her.

R107's EMR lacked evidence of a "Trauma Informed Care Assessment". The facility was unable to provide evidence a trauma-based care assessment was completed for R107 who had a diagnosis of PTSD.

On 12/03/24 at 01:47 PM R107 sat in her wheelchair as she rolled herself up the hallway from her room to the dining room area.

On 12/04/24 at 12:50 PM, Certified Nurse Aide (CNA) O stated she was not aware of any resident who had a diagnosis of PTSD.

On 12/04/24 at 12:57 PM, agency Licensed Nurse (LN) I said she was not aware of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 699	Continued From page 52	F 699		

resident that had a diagnosis of PTSD.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated each resident was assessed for trauma-informed care at the time of admission to the facility, after changes in the psychosocial well-being of the resident and with every MDS. Administrative Nurse D stated if a resident had a history of past trauma personalized interventions should be listed on the resident plan of care to prevent the resident from being re-traumatized. Administrative Nurse D stated she was not sure why R107 was not assessed for trauma-based care at the time of her admission or at the time of her quarterly MDS.

The facility's "Trauma Informed Care" policy last revised 03/2019 documented the facility would guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. The facility supported a culture of emotional well-being and physical safety for staff, residents, and visitors. Trauma-informed care was culturally sensitive and person-centered. Caregivers are taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers. As part of the comprehensive assessment, identify the history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Utilize trained and qualified staff members who have established a rapport with the resident to assess him or her for previous trauma. Interact with all residents and visitors in a manner that is welcoming and kind, without being intrusive. Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 699	Continued From page 53 The facility failed to identify trauma-based triggers related to R107's diagnosis of PTSD and implement individualized interventions to prevent re-traumatization. These deficient practices placed R107 at risk for decreased psychosocial well-being and ineffective treatment.	F 699		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with two reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record review, and observations, the facility failed to provide dementia-related behavioral services for Resident (R)30 to promote her highest practicable level of well-being. This deficient practice placed R30 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The "Medical Diagnosis" section within R30's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), history of seizures (violent involuntary series of contractions of a group of muscles), epilepsy (brain disorder characterized	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 744	Continued From page 54	F 744		

by repeated seizures), and insomnia (difficulty sleeping).

R30's "Significant Change Minimum Data Set (MDS)" completed 10/30/24 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS noted that verbal and physical behaviors were observed for one to three days during the assessment. The MDS noted her behaviors interfered with her care and put her at risk for injuries. The MDS noted her behaviors put others at risk for physical injury and intruded on the privacy of others. The MDS noted she rejected care one to three days during the assessment. The MDS indicated she had no upper or lower extremity impairments. The MDS noted she required substantial to maximal assistance with bed mobility, toileting, dressing, personal hygiene, and transfers. The MDS noted she required supervision or touch assistance while ambulating.

R30's "Cognitive Loss Care Area Assessment (CAA)" completed 10/29/24 indicated she had impaired cognitive function and thought processes related to her medical diagnoses. The CAA instructed staff to identify themselves during each interaction, reduce distractions, and use consistent simple sentences. The CAA instructed staff to provide cues and report changes in cognitive function.

R30's "Functional Abilities CAA" completed 10/29/24 indicated she required assistance with her activities of daily living (ADLs), transfers, and ambulation.

R30's "Behavioral CAA" completed on 10/29/24 indicated she received herbal supplementation for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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(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
F 744	Continued From page 55	F 744		

her continued behaviors. The CAA noted she would be assisted and monitored during her behaviors. The CAA noted she had verbal and physical behaviors that were disruptive to her and other resident's treatment and care environment.

R30's "Care Plan" 07/01/24 indicated she had a self-care deficit related to her decline of independence and medical diagnoses. The plan noted the level of ADL assistance needed was determined by her cognitive functioning from day to day. The plan noted most days she required set-up to partial assistance with personal hygiene, dressing, toileting, transfers, bed mobility, and personal hygiene. The plan noted her level of needed assistance would increase with confusion or behavioral episodes. The plan noted she had a communication deficit related to her cognitive decline and impaired thought processes. The plan instructed staff to keep her routine consistent and provide cues to reorient her. The plan instructed staff to supervise her as needed for confusion.

R30's "Care Plan" indicated she had aggressive behaviors towards others and would refuse care at times. The plan noted she would scream out if staff did not provide one-to-one care for her. The plan instructed staff to anticipate her needs and administer her medications as ordered (07/01/24). The plan instructed staff to intervene during behaviors to protect the rights and safety of others (07/01/24). The plan noted to remove R30 from situations if she became combative or agitated (08/09/24). The plan instructed staff to monitor her behavior episodes and attempt to determine the underlying causes 08/09/24). The plan instructed staff to explain treatment and procedures prior to completing them on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 744	Continued From page 56	F 744		

(08/09/24). The plan indicated staff will assist her with developing coping methods to prevent behaviors (08/09/24). The plan instructed staff to provide one-to-one care during behaviors until she calmed down (08/12/24). The plan indicated she started cannabidiol (CBD - herbal supplementation used for anxiety and agitation) during behavioral episodes (09/20/24). The plan instructed staff to provide one-to-one walk and pray with her to help diffuse behaviors (09/20/24). The plan instructed staff to allow her time to process requests and speak in short sentences (11/20/24). The plan instructed staff to be at eye level when talking with R30 (11/20/24). The plan lacked potential triggers or causes for her behaviors toward others and individualized non-pharmacological interventions to prevent repeated behaviors around meal services. The plan lacked techniques related to redirecting R30 during confusion and agitation.

R30's EMR under "Progress Notes" on 08/06/24 indicated she had an altercation with another resident in the dining room. The note indicated R30 became verbally aggressive towards other residents resulting in her arm being grabbed by the resident. The note indicated staff separated the residents and R30 was able to calm down. The note indicated she was given her CBD gummy and provided one-to-one supervision for the evening.

R30's EMR under "Progress Notes" on 08/13/24 indicated she attempted to enter another resident's room and became aggressive with both staff and the resident in the room. The note indicated that R30 was started on her CBD gummy supplement and provided one-to-one supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 744	Continued From page 57	F 744		

R30's EMR under "Progress Notes" on 10/06/24 indicated she had become verbally aggressive during dinner and began yelling at other residents. The note indicated she struck another resident at the dinner table.

R30's EMR under "Progress Notes" on 10/29/24 indicated she had an altercation with a resident upon being touched by the other resident. The note indicated no injuries were found. The note identified impulsive behaviors as the root cause.

On 12/04/24 at 10:20 AM R30 walked around the circular hallway within the memory care unit. R30's representative assisted her around the circular hallway. R30 reported she enjoyed her walks around the unit with staff. She stated it kept her moving and happy.

On 12/04/24 at 11:01 AM Certified Medication Aide (CMA) RR stated R30's behaviors have improved within the last two months. She stated that R30 would have good and bad days depending on her cognition. She stated that R30 could become physically aggressive with staff and other residents around mealtime or when she sat close to them. She stated the facility put her on CBD gummies recently for anxiety and her behaviors. She stated staff would have to provide one-on-one time with her at times to calm her down and prevent outbursts. She stated that R30's behaviors would be unpredictable and often no real triggers would be known. She stated that R30 liked to take walks and listen to music.

On 12/04/24 at 11:25 AM Administrative Nurse E stated that R30 liked to take walks and have one-to-one time with staff. She stated that R30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 744	Continued From page 58	F 744		

liked to recite the "Lord's Prayer" and "Hail Mary" prayers. She stated staff were expected to take their time explaining things to her and be patient. She stated that R30's behaviors would come and go. She stated that R30's representative visits her frequently to help keep her routine consistent. She stated medication changes were made to improve R30's behaviors and she's taking the CBD supplements.

On 12/05/24 at 02:20 PM Administrative Nurse D stated staff were expected to monitor R30 during activities and mealtimes. She stated staff should remain close and intervene if she became confused or agitated. She stated staff were to offer her walks and talk with her if she became upset or agitated. She was not sure if the care plan identified potential triggers or causative factors for R30's behaviors.

The facility's "Behavioral Health Services" policy revised 02/2019 indicated all residents will be provided behavioral health services as needed to attain or maintain the highest practicable level of psychical, mental, and psychosocial well-being. The policy noted the facility will provide service and treatment to include individualized interventions and supervision.

The facility was unable to provide a policy related to dementia care as requested on 11/04/24.

The facility failed to provide dementia-related behavioral services for R30 to promote her highest practicable level of well-being. This deficient practice placed R30 at risk for decreased quality of life, isolation, and impaired dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 756	Continued From page 59	F 756		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 756	Continued From page 60	F 756		

when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility identified a census of 147 residents. The sample included 29 residents with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) recommendations were acknowledged and/or acted upon for Resident (R) 75. This deficient practice placed R75 at risk for unnecessary medication use and possible adverse side effects.

Findings included:

- R75's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational ion (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS) dated 09/18/24 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R75 received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medication during the observation period.

R75's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 09/26/24 documented she was ordered an antianxiety medication for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 756	Continued From page 61	F 756		

anxiety.

R75's "Care Plan" dated 09/20/24 documented that nursing staff would assess R75's functional status prior to the initiation of drug use to serve as a baseline.

R75's EMR under the "Orders" tab revealed the following physician orders:
Ativan (antianxiety mediation) oral tablet 0.5 milligrams (mg) give one tablet by mouth as needed for anxiety or restlessness dated 10/10/24. The order lacked a stop date.
On 11/27/24 call durable power of attorney (DPOA) prior to administration of the as-needed Ativan medication.

R75's "Monthly Medication Review" (MMR) reviewed for September 2024 addressed the requirement for a rationale for continued availability and a specific future stop date for the antianxiety medication Ativan. The facility was unable to provide documentation the physician reviewed and addressed the CP's recommendations.

On 12/02/24 at 10:32 AM R75 sat in her high-back wheelchair in the dining room asleep. R75 had a clothing protector attached around her neck that had fallen off her left shoulder and arm. R75 was not positioned at a dining room table and there were no drinks or food on any dining room tables.

On 12/04/24 at 09:30 AM, Administrative Nurse D stated she was unable to find a physician response to the CP's September 2024 MRR. Administrative Nurse D stated the CP would print the MRRs and hand-deliver them to her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 756	Continued From page 62 Administrative Nurse D stated would divide the nursing portion of the MRRs out to each unit manager. Administrative Nurse D stated she expected the unit managers to address the nursing portion of the MRRs. Administrative Nurse D stated she would hand deliver the MRRs to each of the physicians. Administrative Nurse D stated once the physician had reviewed the MRRs, she would give them to the unit managers to make the changes if any new orders, and then they are given to medical records to be scanned into the resident's EMR. The facility's "Medication Regimen Review" policy last revised 05/2019 documented the consultant pharmacist reviewed the medication regimen of each resident at least monthly. The consultant pharmacist provided the director of nursing services and the medical director with a written, signed, and dated copy of all medication regimen reports. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. The facility failed to ensure CP recommendations had been addressed for R75's as-needed antianxiety medication Ativan which lacked a stop date. This deficit practice placed her at risk of adverse side effects of psychotropic medication and unnecessary medications.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 757	Continued From page 63 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 147 residents. The sample included 29 residents with six reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to follow instructions related to medication monitoring when staff administered Resident (R)303's anti-hypertensive (class of medication used to treat high blood pressure) medications outside the physician-ordered parameters. This deficient practice placed R303 at increased risk for unnecessary medication and side effects. Findings included: - The "Medical Diagnosis" section within R303's Electronic Medical Records (EMR) included diagnoses of acute respiratory failure, atherosclerotic heart disease (reduced blood flow	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 757	Continued From page 64	F 757		

due to blockages in the arteries within the heart), atrial fibrillation (rapid, irregular heartbeat), hypertension (high blood pressure), and chronic kidney disease.

R303's EMR revealed he was admitted on 11/07/24 and discharged on 11/15/24 to an acute care facility for emergency treatment.

R303 did not have a "Minimum Data Set (MDS) or "Care Area Assessment (CAA)" completed.

R303's "Care Plan" initiated 11/07/24 indicated he required supervision or touch assistance with dressing, meal set-up, personal hygiene, dressing, transfers, toileting, and bathing. The plan indicated he took medications with Black Box Warning (BBW- the highest safety-related warning that medications can be assigned by the Food and Drug Administration) and he was at risk for adverse interactions. The plan instructed staff to monitor and report changes related to his anti-hypertensive medications to his medical provider.

R303's EMR under "Physician Orders" revealed an order dated 11/08/24 for staff to administer 10 milligrams (mg) of amlodipine besylate (antihypertensive medication) by mouth once daily for hypertension. The order instructed staff to hold the medication if R303's systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg).

R303's EMR under "Physician Orders" revealed an order dated 11/08/24 for staff to administer 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 757	Continued From page 65	F 757		

mg of lisinopril (antihypertensive medication) by mouth once daily for hypertension. The order instructed staff to hold the medication if R303's SBP was less than 110 mmHg.

R303's EMR under "Physician Orders" revealed an order dated 11/08/24 for staff to administer five milligrams of terazosin (antihypertensive medication) by mouth once daily for hypertension. The order instructed staff to hold the medication if R303's SBP was less than 110 mmHg.

R303's EMR revealed he was admitted to an acute care facility on 11/15/24 related to low blood pressure.

A review of R303's November 2024 "Medication Administration Report" (MAR) revealed his morning blood pressure was taken before his medications were administered on 11/09/24. The MAR revealed his SBP was 99 mmHg. The MAR revealed his lisinopril, terazosin, and amlodipine were administered.

The EMR revealed his antihypertensive medications were held on 11/10/24, 11/12/24, and 11/14/24 due to low blood pressure.

An inspection of R303's medication punch cards revealed all three medications were punched out on 11/09/24.

On 12/04/24 at 11:01 AM Certified Medication Aide (CMA) R stated the MAR should flag documented blood pressures outside the parameters to prevent the medications from being given to residents with chronically low blood pressure. She stated that licensed staff were required to review the medication orders before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 757	Continued From page 66 administering all medications. She stated staff should check each resident's vital signs before administering antihypertensive medications. On 12/04/24 at 11:30 AM Administrative Nurse E stated the MAR would require a resident's blood pressure to be entered before medication administration. She stated staff were required to check the medication orders and parameters before giving the medications. On 12/04/24 at 12:20 PM Administrative Nurse D stated R303's antihypertensive medications should not have been given if his systolic pressure was 99 mmHg. She verified the medication had been administered. The facility's "Administering Medications" policy (undated) indicates the medication is to be administered in a safe and timely manner. The policy indicated staff were to administer medications in accordance with the prescriber's orders. The policy indicated that licensed staff will check to verify the correct residents, dosage amount, time, date, and route of the administration. The policy indicated staff would hold and notify the medical provider if the medications were outside the provided order parameters or not given. The facility administered R303's anti-hypertensive medication outside the physician-ordered parameters. This deficient practice placed R303 at increased risk for unnecessary medication and side effects.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 67 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 758	Continued From page 68	F 758		

rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 147 residents. The sample included 29 residents with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the as-needed (PRN) psychotropic (alters mood or thought) medication had a 14-day stop date or a specified duration with supporting physician documentation for Resident (R) 75's and R13's PRN psychotropic medications. This placed these residents at risk for unnecessary medication administration and possible adverse side effects.

Findings included:

- R75's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational ion (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory and confusion).

The "Admission Minimum Data Set" (MDS) dated 09/18/24 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R75 had received antianxiety (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 69	F 758		

class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medication during the observation period.

R75's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 09/26/24 documented she was ordered an antianxiety medication for anxiety.

R75's "Care Plan" dated 09/20/24 documented that nursing staff would assess R75's functional status prior to the initiation of drug use to serve as a baseline.

R75's EMR under the "Orders" tab revealed the following physician orders:
Ativan (antianxiety mediation) oral tablet 0.5 milligrams (mg) give one tablet by mouth as needed for anxiety or restlessness dated 10/10/24. The order lacked a stop date.
On 11/27/24 call durable power of attorney (DPOA) prior to administration of the as-needed Ativan medication.

R75's EMR lacked evidence of a physician documented rationale for the extended PRN Ativan which included a specified duration.

On 12/02/24 at 10:32 AM R75 sat in her high-back wheelchair in the dining room asleep. R75 had a clothing protector attached around her neck that had fallen off her left shoulder and arm. R75 was not positioned at a dining room table and there were no drinks or food on any dining room tables.

On 12/04/24 at 12:33 PM, Licensed Nurse (LN) G stated she was unsure how long a PRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 758	Continued From page 70	F 758		

antianxiety medication order could be active. LN G stated the physician puts all narcotic orders in electronically, and the order goes directly to the pharmacy. LN G stated the unit manager was responsible for reviewing all new orders and responsible to ensure all PRN psychotropic medication had a duration for use.

On 12/04/24 at 02:21 AM Administrative Nurse D stated the pharmacist reviews all orders entered electronically, and the unit nurse managers monitor every new order and was to ensure there was a duration. Administrative D stated the facility would have to review its process. She stated every psychotropic medication should have a 14-day stop date.

The facility's "Psychotropic Medication Use policy," revised in 2016, documented antipsychotic medications would be prescribed at the lowest possible dosage for the shortest t period and were subject to gradual dose reduction and re-review. Each resident's drug regimen must be free from unnecessary drugs.

The facility failed to ensure R75's PRN Ativan had a stop date, or a physician ordered specified duration for administration. This placed R75 at risk for unnecessary medication administration and possible adverse side effects.
- The "Diagnoses" tab of R13's Electronic Medical Record (EMR) documented diagnoses of schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), epilepsy (brain disorder characterized by repeated seizures), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 758	Continued From page 71	F 758		

diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), intellectual disabilities, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), sleep apnea (a disorder of sleep characterized by periods without respirations), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Modification of Significant Change Minimum Data Set (MDS)" dated 11/15/24, documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R13 had an impairment on both sides of his body. The MDS documented R13 was dependent on staff for activities of daily living (ADLs). The MDS documented R13 was taking anti-anxiety medication during the observation period.

R13's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 11/15/24 documented R13 had a diagnosis of cerebral palsy and antisocial personality, and R13 had been prescribed antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications. R13's CAA documented R13 would be monitored for behaviors and treated to help decrease his anxiety and depression. R13's CAA documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 758	Continued From page 72	F 758		

R13 received psychotropic medication and was at risk for adverse side effects.

R13's "Care Plan" dated 12/02/24 documented R13 used Ativan (antianxiety medication) and nursing was to monitor and administer R13's antianxiety medication as ordered by the physician. The plan directed nursing to monitor for side effects and the effectiveness of the medication every shift. R13's plan of care documented nursing was to monitor the resident for safety and monitor for increased risk of confusion, loss of balance, and cognitive impairment.

R13's EMR under "Orders" documented the following physician's order:
Lorazepam gel (Ativan) one milligram (mg) per one milliliter(ml) every eight hours as needed for agitation or anxiety apply 0.5mg topically every eight hours as needed (PRN) agitation dated 11/24/24. The order lacked a stop date.

On 12/01/24 at 08:32 AM R13 sat in the dining area in his wheelchair, awaiting his breakfast.

On 12/04/24 at 12:33 PM, Licensed Nurse (LN) G stated she was unsure how long a PRN antianxiety medication order could be active. LN G stated the physician puts all narcotic orders in electronically, and the order goes directly to the pharmacy. LN G stated the unit manager was responsible for reviewing all new orders and responsible to ensure all PRN psychotropic medication had a duration for use.

On 12/04/24 at 02:21 AM Administrative Nurse D stated the pharmacist reviews all orders entered electronically, and the unit nurse managers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 73 monitor every new order and was to ensure there was a duration. Administrative D stated the facility would have to review its process. She stated every psychotropic medication should have a 14-day stop date. The facility's "Psychotropic Medication Use policy," revised in 2016, documented antipsychotic medications would be prescribed at the lowest possible dosage for the shortest period and were subject to gradual dose reduction and re-review. Each resident's drug regimen must be free from unnecessary drugs. The facility failed to ensure R13 had a stop date for his PRN antianxiety medication. This deficient practice placed R13 at risk for unnecessary psychotropic medication administration.	F 758		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

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CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

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F 849	Continued From page 74	F 849		

requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 849	Continued From page 75	F 849		

care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 849	Continued From page 76	F 849		

agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 849	Continued From page 77 (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The sample included 29 residents with Resident (R) 93 reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure collaboration of care between R93's hospice provider and the facility. This placed R93 at risk of inadequate end-of-life care. Findings included: - R93's Electronic Medical Record (EMR) documented diagnoses of repeated falls, hypertension (HTN-elevated blood pressure), blindness in one eye, and dementia (a progressive mental disorder characterized by failing memory and confusion).	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 849	Continued From page 78	F 849		

R93's "Significant Change Minimum Data Set (MDS)" dated 06/28/24 documented she had a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R93 required substantial to maximal assistance of staff for bed-to-chair (or wheelchair) transfers. R93 had a history of one fall without injury and one fall with injury since her prior assessment. R93 was on hospice services.

R93's "Quarterly MDS" dated 06/28/24 documented she had a BIMS score of 13 which indicated intact cognition. R93 was dependent on staff for bed-to-chair transfers. R93 had not had any falls since the prior assessment. R93 was on hospice services.

R93's "Functional Abilities Care Area Assessment (CAA) dated 07/01/24 documented she suffered from a self-care deficit related to a decline in her prior level of independence resulting in the need for continued medical care. She was on hospice services, and further decline was anticipated due to a cognitive communication deficit.

R93's "Hospice Care Plan" initiated on 06/24/24 and revised on 09/30/24 directed staff to adjust the provisions of activities of daily living (ADLs) to compensate for the resident's changing abilities. The staff was directed to assess the resident's coping strategies and respect the resident's wishes. Staff was to encourage a support system of family and friends. Staff was to observe the resident closely for signs of pain, administer pain medication as ordered, and notify the physician immediately if there was breakthrough pain. The care plan lacked staff direction regarding how to collaborate with hospice, what supplies the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(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
F 849	Continued From page 79	F 849		

hospice service provided, or when hospice staff would make visits.

On 12/03/24 at 07:47 AM R93 sat in her wheelchair, at the dining room table, visiting with another resident while she waited for breakfast to be served.

On 12/03/24 at 12:55 PM Certified Nurse Aide (CNA) O stated a resident's care plan would let them know if a resident was on hospice. CNA O stated most of the supplies that the hospice provided were kept in the resident's room but as far as the care plan listing those items, she did not believe the care plan had that information on it. CNA O stated each resident was provided a binder by their hospice provider that listed when the hospice staff would visit each week.

On 12/03/24 at 01:00 PM Licensed Nurse (LN) I stated the hospice book for R93 should list what supplies were provided by hospice as well as when the hospice staff would make visits weekly. LN I stated she would expect R93's facility plan of care to reflect what hospice provided and how to contact them but could not verify for certain whether R93's "Care Plan" listed that or not.

On 12/04/24 at 02:21 PM Administrative Nurse D stated each resident that received hospice care had a hospice book provided by hospice that listed all the items, medications, and how often hospice staff would visit in it. Administrative Nurse D stated nursing staff knew to look in the hospice book if they had any questions about hospice. Administrative Nurse D stated that R93's "Care Plan" did not contain that hospice information as far as she was aware.

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	175410	A. BUILDING _____ B. WING _____	12/04/2024

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F 849	Continued From page 80 The "Hospice Program" policy revised in July 2017 documented: in general, it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided was appropriately based on the individual resident's needs. Communicating with the hospice provider to ensure the needs of the resident were addressed and met 24 hours per day. Collaborating with the hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services. Coordinated care plans for residents receiving hospice service would include the most recent hospice plan of care as well as the care and service provided by the facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure collaboration of care between R93's hospice provider and the facility. This placed R93 at risk of inadequate end-of-life care.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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F 880	Continued From page 81	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 82 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. The facility identified 41 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and four residents on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact). Based on record review, observations, and interviews, the facility failed to ensure Resident (R)109's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and the nasal cannulas for R45, R27, and R57 were stored in a sanitary manner when not in use and further failed to implement adequate hand hygiene and ensure the shared blood pressure cuff was sanitized after resident use. These deficient practices placed the residents at risk for infectious diseases. Findings included:	F 880		

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F 880	Continued From page 83	F 880		

- On 12/03/24 at 07:47 AM Certified Medication Aide (CMA) S obtained R93's blood pressure using a small blood pressure cuff. CMA S removed the small blood pressure cuff from the portable blood pressure machine and placed the cuff into the basket without sanitizing it. CMA S then removed the larger-sized blood pressure cuff from the basket, attached it to the blood pressure machine, and used it on R113 without performing hand hygiene first. CMA S did not sanitize the larger blood pressure cuff after use.

On 12/03/24 at 08:19 AM R45's nasal cannula laid over the back of R45's wheelchair while he was eating breakfast in the dining room.

On 12/03/24 at 11:57 AM R27's nasal cannula laid on the floor in the dining room, and a kitchen staff member passing trays to the resident's room stepped on the nasal cannula. R27's nasal cannula was then picked up and laid on the back of R27's wheelchair.

On 12/03/24 at 12:01 PM, R57's nasal cannula hung over the bed rail in her room, R57 did not have any type of container to place the nasal cannula in.

On 12/03/24 at 04:14 PM, R109 sat out at the dining room table. R109's CPAP mask and tubing were laid directly on her CPAP machine on the bedside table next to the bed.

On 12/04/24 at 11:10 R27's nasal cannula was hanging over the back of R27's wheelchair.

On 12/04/24 at 12:25 PM, Certified Nurse Aide (CNA) N stated she would clean R109's CPAP in

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F 880	Continued From page 84	F 880		

the morning after she assisted R109 out of bed. CNA N stated she would clean the CPAP mask with a disinfectant wipe and then store the mask in a plastic bag.

On 12/04/24 at 12:33 PM, Licensed Nurse (LN) G stated all staff were educated to place nasal cannulas not in use in a pull string bag. LN G stated ensuring the nasal cannula were stored appropriately was all nursing staff's responsibility.

On 12/04/24 at 12:35 PM, Licensed Nurse (LN) H stated she would clean the residents' CPAP masks every morning with soap and water and then hang them to dry. LN H stated the CPAP mask should never be placed on the bedside table or the CPAP machine.

On 12/04/24 at 02:21 PM, Administrative Nurse D stated she expected the nurse on the unit to clean the CPAP mask with soap and water. Administrative Nurse D stated that the mask was to hung to air dry. Administrative Nurse D stated the CPAP mask should never be stored directly on the bedside table or top of the CPAP machine. Administrative Nurse D stated nasal cannulas not in use are to be stored in a plastic bag, she stated that was everyone's responsibility. Administrative Nurse D stated she expected her staff to clean or sanitize the blood pressure cuffs, between residents.

The "Infection Prevention and Control" policy dated 2019 documented that the primary mission was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and

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F 880	Continued From page 85 infections. The facility failed to ensure R109's CPAP mask was stored in a sanitary manner, and nasal cannulas for R45, R27, and R 57 were stored in a sanitary manner and further failed to implement adequate hand hygiene ensuring shared blood pressure cuffs were sanitized after resident use. These deficient practices placed the residents at risk for infectious diseases.	F 880		
F 942 SS=E	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: The facility identified a census of 147 residents. Based on record review and interviews, the facility failed to ensure direct care staff had received the required resident rights. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 12/04/24 a review of the provided training for agency Certified Nurses Aid (CNA) MM, CNA NN, and CNA OO revealed the following: CNA MM's facility-provided credentialling file lacked evidence training was completed for resident rights training.	F 942		

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F 942	Continued From page 86 CNA NN's facility-provided credentialling file lacked evidence training was completed for resident rights training. CNA OO's facility-provided credentialling file lacked evidence training was completed for resident rights training. On 12/04/24 at 02:21 PM Administrative Nurse D stated she reviewed all the nursing staff information sent by the agency staffing company before a staff member worked. Administrative Nurse D stated upon the nursing staff reporting for the first shift she would go over dementia training, infection control, abuse, falls, and change in condition. Administrative Nurse D stated she assumed that the agency group made sure the nurse aides had the required training and education needed to work. The facility did not provide a policy regarding nurse aide required training as requested. The facility failed to ensure direct care staff had received resident rights training. This placed the residents at risk for impaired care and decreased quality of life.	F 942		