STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175410	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	**6700 E 45TH STREET NORTH , BEL AIRE, Kansas, 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
F0000	INITIAL COMMENTS A complaint survey was conducted at Catholic Care Center on 05/05/26 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference number(s) 2797084, 2976470, 2985405, and 2997071 were investigated. The facility census on the first day of the survey was 05/05/26. The sample size included 153 residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) 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.	F0580		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = D	Continued from page 1 (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 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: Based on record review and interview, the facility failed to notify Resident (R) 1's responsible party of a medication error that may have affected R1's physical health and may have required medical intervention. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cerebral infarction (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), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), chronic pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Admission Minimum Data Set (MDS)," dated 03/31/26, documented R1 had a Brief Interview for Mental Status score of nine, which indicated	F0580		

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F0580 SS = D	Continued from page 2 moderately impaired cognition. The MDS documented R1 required moderate assistance from staff for toileting, bathing, dressing, personal hygiene, bed mobility, and transfers. The MDS documented R1 received an anticoagulant (a class of medications used to prevent the blood from clotting) and antiplatelet (a class of medication used to reduce the ability of blood platelets to stick together reducing the risk of harmful blood clots from forming) medications during the lookback period. The “Cognitive Loss/Dementia Care Area Assessment (CAA),” dated 03/25/26, documented R1 had impaired cognitive function and impaired thought processes. R1 would be able to maintain her ability to communicate her basic needs and remain oriented to person, place, situation, and time. The “Functional Abilities CAA,” dated 03/25/26, documented R1 had impaired balance and transition during transfers and functional impairment in activity. The CAA documented R1 had weakness and decreased safety awareness. R1’s “Care Plan,” initiated 03/20/26, documented R1 had impaired cognitive function and the care plan directed staff to ask R1 yes or no questions to determine her care needs, cue, orient, and supervise R1 as needed, and keep R1’s routine consistent and provide consistent care givers. The care plan documented R1 was at risk for adverse medication interactions and R1 would no have adverse reactions to her medication regimen. R1’s “April 2026 Medication Administration Record (MAR)” documented R1 was scheduled to take atorvastatin (a cholesterol-lowering medication), fluorometholone ophthalmic suspension (an eye drop used to treat swelling, redness, and itching), apixaban (an anticoagulant medication), and oxybutynin (a medication used to treat an overactive bladder). R2’s “April 2026 MAR” documented R2 was scheduled to take atorvastatin, doxazosin (a medication used to treat high blood pressure), mirtazapine (a medication used to treat major depressive disorder with a side effect of drowsiness), ropinirole (a medication used to treat moderate to severe restless leg syndrome with common side effects of nausea, dizziness, and	F0580		

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F0580 SS = D	Continued from page 3 sudden sleepiness), amiodarone (a medication used to treat life-threatening heart rhythm problems with common side effects of difficulty breathing, coughing, or chest tightness), lacosamide (a medication used to treat seizures with common side effects of dizziness, nausea, headache, and tremors), and Humalog (a fast acting insulin used to manage blood sugars). The “Progress Note,” dated 04/23/26 at 06:43 AM, documented LN G walked into R1’s room, asked R1 if her name was [R2’s name], and R1 said, “Yes.” LN G administered all of R2’s nighttime medications to R1. R1’s heart rate prior to medication administration was 115 beats per minute. R1’s blood sugar was checked and was over 300 milligrams per deciliter (mg/dL). Once staff determined that R1 was given the incorrect medication, an assessment was done. Initial vital signs were blood pressure 106/46 millimeters of mercury (mm/Hg), heart rate 111 beats per minute, oxygen percentage 85%, respirations 22 breaths per minute, and temperature of 97.9 degrees Fahrenheit (F). The primary care physician was notified. R1's EMR lacked evidence of family notification of the medication error. R1 was unavailable for observation. On 05/05/26 at 01:30 PM, Administrative Nurse D stated LN G had been an agency nurse and should have followed the facility’s policy of medication administration and the five rights. Administrative Nurse D verified LN G did not notify R1’s responsible party of the medication error. The facility's "Change in a Resident’s Condition or Status Policy" documented the facility shall promptly notify the resident, his or her Attending Physician, and responsible party of changes in the resident’s medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).	F0580		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	"Past Noncompliance - no plan of correction required"	

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F0760 SS = D	Continued from page 4 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure Resident (R) 1 remained free of significant medication errors when on 04/22/26, Licensed Nurse (LN) G prepared medications administered the wrong medications and five units of regular insulin (a vital hormone produced by the pancreas that regulates blood sugar levels by enabling cells to use glucose for energy) to R1. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cerebral infarction (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), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), chronic pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Admission Minimum Data Set (MDS)," dated 03/31/26, documented R1 had a Brief Interview for Mental Status score of nine, which indicated moderately impaired cognition. The MDS documented R1 required moderate assistance from staff for toileting, bathing, dressing, personal hygiene, bed mobility, and transfers. The MDS documented R1 received an anticoagulant (a class of medications used to prevent the blood from clotting) and antiplatelet (a class of medication used to reduce the ability of blood platelets to stick together reducing the risk of harmful blood clots from forming) medications during the lookback period. The "Cognitive Loss/Dementia Care Area Assessment CAA)," dated 03/25/26, documented R1 had impaired cognitive function and impaired thought processes. R1 would be able to maintain her ability to communicate her basic needs and remain oriented to person, place, situation, and time. The "Functional Abilities CAA," dated 03/25/26, documented R1 had impaired balance and transition during transfers and functional impairment in	F0760		

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F0760 SS = D	Continued from page 5 activity. The CAA documented R1 had weakness and decreased safety awareness. R1's "Care Plan," initiated 03/20/26, documented R1 had impaired cognitive function and the care plan directed staff to ask R1 yes or no questions to determine her care needs, cue, orient, and supervise R1 as needed, and keep R1's routine consistent and provide consistent care givers. The care plan documented R1 was at risk for adverse medication interactions and R1 would no have adverse reactions to her medication regimen. Review of R1's "Vital Signs" for April 2026 documented R1's oxygen percentage ranged from 92% to 99%. R1's "April 2026 Medication Administration Record (MAR)" documented R1 was scheduled to take atorvastatin (a cholesterol-lowering medication), fluorometholone ophthalmic suspension (an eye drop used to treat swelling, redness, and itching), apixaban (an anticoagulant medication), and oxybutynin (a medication used to treat an overactive bladder). R2's "April 2026 MAR" documented R2 was scheduled to take atorvastatin, doxazosin (a medication used to treat high blood pressure), mirtazapine (a medication used to treat major depressive disorder with a side effect of drowsiness), ropinirole (a medication used to treat moderate to severe restless leg syndrome with common side effects of nausea, dizziness, and sudden sleepiness), amiodarone (a medication used to treat life-threatening heart rhythm problems with common side effects of difficulty breathing, coughing, or chest tightness), lacosamide (a medication used to treat seizures with common side effects of dizziness, nausea, headache, and tremors), and Humalog (a fast acting insulin used to manage blood sugars). The "Progress Note," dated 04/23/26 at 06:43 AM, documented LN G walked into R1's room, asked R1 if her name was [R2's name], and R1 said, "Yes." LN G administered all of R2's nighttime medications to R1. R1's heart rate prior to medication administration was 115 beats per minute. R1's blood sugar was checked and was over 300 milligrams per deciliter (mg/dL). Once staff determined that R1 was	F0760		

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F0760 SS = D	Continued from page 6 given the incorrect medication, an assessment was done. Initial vital signs were blood pressure 106/46 millimeters of mercury (mm/Hg), heart rate 111 beats per minute, oxygen percentage 85%, respirations 22 breaths per minute, and temperature of 97.9 degrees Fahrenheit (F). The primary care physician was notified. The note lacked family notification of the medication error. The “Nurse Practitioner’s Progress Note,” dated 04/23/26 at 01:57 PM, documented R1 was seen at staff’s request after a medication error. R1 received amiodarone, Eliquis, and “psych meds” overnight. R1 was placed on oxygen overnight for hypoxia. R1 was seen that morning off oxygen in the dining room before breakfast. R1 endorsed she felt well, with no complaints of pain, shortness of air, nausea/vomiting, fever, or chills. R1 had been taken off the oxygen before coming out for breakfast. R1 was unavailable for observation. On 05/05/26 at 01:30 PM, Administrative Nurse D stated LN G had been an agency nurse and should have followed the facility’s policy of medication administration and the five rights. Administrative Nurse D stated the nurse had not verified R1’s name with her picture on the MAR prior to administering the wrong medications. Administrative Nurse D stated all staff who administered medications had education on medication administration and following the five rights of medication administration and all education was completed by 04/28/26. On 05/05/26 at 02:30 PM, LN H stated she was the nurse who came onto the unit the morning following the medication error. LN H stated LN G, who was an agency nurse, felt really bad about the medication errors. LN H stated R1 was lucky the administration of insulin had not been detrimental and instead showed she had high blood sugars even though she was not diagnosed as being diabetic. The facility’s “Administering Medications Policy,” reviewed in 2022, documented medications are administered in a safe and timely manner, and as prescribed. Only people licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes	F0760		

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F0760 SS = D	Continued from page 7 and/or the need for additional staff training. The individual administering medications verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include but are not limited to checking the photograph attached to the medical record and verifying the resident's identification with other facility personnel.	F0760		