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	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catholic Care Center, Inc	6700 E 45th Street North Bel Aire, KS 67226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 155 residents and 61 residents with full code status (decision to receive resuscitative measures). The sample included three residents. Based on observation, interview and record review, the facility failed to provide cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) to Resident (R) 1, who had a documented desire for full resuscitative measures. On [DATE] at 04:30 AM, Certified Nurse Aide (CNA) O observed R1 in his bed not breathing and CNA O immediately reported this to Licensed Nurse (LN) G. LN G assessed R1, then went to the nurse station to verify R1's code status in the Electronic Medical Record (EMR) and advised CNA O that R1's hospice providers would take care of the rest. At 04:42 AM LN G called R1's hospice provider to report the event. At 05:15 AM, R1's hospice providers arrived at the facility, assessed R1, and initiated CPR (approximately 45 minutes after staff found R1 unresponsive), per R1's physician's orders and recorded directives. Staff provided resuscitative measures until 05:30 AM when Emergency Medical Services (EMS) arrived and took over the resuscitation attempt. R1 was pronounced dead at 06:03 AM. The facility's failure to ensure staff initiated resuscitative measures per the resident's recorded wishes and physician's orders placed R1 and all full code residents in Immediate Jeopardy. Findings included:- R1's EMR documented R1 had diagnoses of malignant neoplasm (cancer) of the bronchus (airway) or lungs, acute respiratory failure, and heart failure.R1's admission Minimum Data Set (MDS) dated , [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R1 used a wheelchair for mobility and was independent for toileting, dressing, bed mobility, and transfer. The MDS documented R1 required continuous oxygen.The Cognitive Loss/Dementia Care Area Assessment (CAA), dated [DATE], documented R1's CAA triggered due to the low BIMS score.R1's Care Plan, dated [DATE], documented R1 requested CPR measures be performed (in the case of a cardiac event) and noted R1 was a full code. The care plan documented the facility staff would respect R1's wishes and rights to have CPR performed. R1's EMR recorded a Physician's Order, dated [DATE], that documented R1 was a full code.R1's Physician's Progress Note dated [DATE] at 07:00 PM documented R1 was a full code. The provider talked with the hospice nurse the day prior, and the hospice nurse reported R1 was a full code, and hospice staff would discuss with him the Do Not Resuscitate (DNR) recommendation. The note documented that when the provider talked to R1, the resident was in his room in his wheelchair with two liters of oxygen. R1 was irritable and stated he felt like he was not told the truth about hospice and that he was sent there, to the facility, to die.R1's Physician's Progress Note dated [DATE] at 05:43 PM noted that R1 was still listed as a full code, and the physician asked the nurse manager to check with hospice if there were any updates on the code status.R1's Progress Note-Late Entry dated [DATE] at 08:22 AM, documented staff found R1 unresponsive at approximately 04:30 AM. CNA O notified LN G of R1's status. LN G assessed R1, then went to the nurses' station to contact hospice. LN G verified R1's code status. LN G saw R1 was a full code and checked the chart for a DNR. LN G notified the hospice provider at 04:42 AM, and the hospice staff arrived at the facility at 05:15 AM. Upon arrival, the (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hospice nurse advised LN G that R1 was full code and a Code Blue (common term used to signify CPR initiation) was activated. LN G, with the assistance of another nurse, began CPR; the crash cart was taken to R1's room, the backboard was placed under R1, and CPR continued. EMS arrived at approximately 05:30 AM and took over compressions and the code. The time of death was called at 06:03 AM.LN G's Witness Statement dated [DATE] documented around 04:30 AM on [DATE], LN G assessed R1 and noted he had no pulse. LN G documented that since R1 was on hospice, she notified hospice at approximately 04:45 AM and then the staff straightened the resident on his bed and cleaned his body. When the hospice staff arrived at between 04:50 AM and 05:10 AM, they stated there was no DNR on file, so staff started CPR.The facility's investigation dated [DATE] documented the investigation conclusion was LN G failed to initiate CPR for R1 even after verifying the medical record which indicated R1 was a full code. The investigation documented during the facility's interview with LN G, she stated to Administrative Nurse D that she [LN G] used her nursing assessment and moral judgement not to initiate a code/administer CPR. LN G's CPR certification documented LN G had an active basic life support (BLS) CPR certification.Observation on [DATE] at 02:00 PM, a Code Blue was announced over the speakers with the location. Staff went to the location to find a mannequin on the floor. Staff inquired about the code status and were notified that the mannequin was a full code. Staff started CPR.On [DATE] at 09:45 AM, Administrative Nurse D stated that CNA O was the CNA who found R1 unresponsive and that she no longer worked at the facility.On [DATE] at 09:40 AM, CNA M stated if a resident had any kind of change (including not breathing or no pulse), the nurse would be notified immediately. CNA M stated new admissions would sometimes have a bracelet on from the hospital that had DNR on it, and some would keep it on. Also, the code status was also in the EMR. On [DATE] at 09:43 AM, CNA N stated the nurse would be immediately notified to assess the resident if there was any change. CNA N stated staff could look at the chart to know if residents were a full code, and the EMR listed the code status for each resident. On [DATE] at 09:45 AM, Administrative Nurse D stated that LN G was the charge nurse for R1's unit, and she had been terminated from employment after the incident. On [DATE] at 09:47 AM, LN H stated that the code status was in the residents' EMR, and said he carried a code report every morning when he started his shift. LN H said if he did not have the report, he could just go down the report sheet and mark everyone with an F or a D for full code or DNR based on the EMR information. LN H said he was not working when the incident with R1 occurred, and he came on shift after the incident. He stated if he was notified of a resident who had no pulse or breathing, he would look to see if they were a full code or DNR and start CPR immediately while calling for assistance to bring the crash cart and call 911.On [DATE] at 09:45 AM, Administrative Nurse D stated that the facility utilized a multi-system approach to code situations that had the nurse assess the resident while another staff member checked the resident's code status; a third staff member obtained the crash cart, and once the code status was verified, staff were to begin CPR. She said that she expected all staff to follow the multi-system approach. Administrative Nurse D verified code status was listed in the EMR, across the gray ribbon of the resident chart, and there were provider orders for full code or DNR, whatever the resident's code status was. Administrative Nurse D said all the nurses were BLS/CPR certified, and certification was verified upon hire, and education for certification is immediately provided if they are not.The facility policy Do Not Resuscitate order, dated 04/2017, documented the facility would not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident who had a DNR order in effect.On [DATE] at 02:41 PM, Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed that the facility's failure to ensure staff provided CPR to R1, who desired resuscitative measures, placed R1 and all 61 residents with full code status in IJ.The facility identified and completed the following corrective actions by [DATE]:1. The nursing staff were re-educated on residents' rights, including the right to self-determination and to formulate advanced directives, education on advanced directives, including DNR orders and DNR directives, Full Code status, and CPR protocols.2. All licensed nurses (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	demonstrated competency with the Code Status written quiz and Code Blue Protocols, including return demonstration.3. Mock Code Drills were completed two to four times a week.4. The Annual Education Calendar was updated to include code blue protocols and honoring code status.5. The facility added code blue response protocols to be demonstrated upon hire during clinical competencies.On [DATE], an onsite survey verified the facility completed the above corrective actions prior to the survey, therefore the deficient practice was deemed past noncompliance at a scope and severity of K (pattern, immediate jeopardy).