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	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, 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 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 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 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 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 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 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.