STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175503	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza Health Services at Santa Marta	13875 W 115th Terrace Olathe, KS 66062

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45668 The facility identified a census of 37 residents. The sample included 12 residents with one reviewed for accommodation of needs. Based on record review, interviews, and observations, the facility failed to ensure Resident (R) 23 had a call light within reach to communicate his need for staff assistance. This deficient practice placed the residents at risk for preventable falls and injuries. Findings Including: - The Medical Diagnosis section within R23's Electronic Medical Records (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), overactive bladder, cognitive communication deficit, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R23's Significant Change Minimum Data Set (MDS) completed 07/11/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated he had functional limitations in both his lower extremities. The MDS indicated he required substantial to maximal assistance from staff for bed mobility, transfers, toileting, bathing, grooming, and dressing. R23's Functional Abilities Care Area Assessment (CAA) completed 07/19/24 indicated he was recently admitted to hospice services. The CAA noted he required extensive assistance from staff for his activities of daily living (ADLs). The CAA noted R23's goal was to maintain his current levels of functioning. R23's Care Plan initiated on 01/25/24 indicated he had ADL deficits related to his medical diagnoses. The plan instructed staff to encourage him to fully participate. The plan noted he was a high risk for falls related to his impaired cognitive status and physical limitations. The plan indicated he had communication deficits related to not being able to understand others and mild hearing loss. The plan instructed staff to ensure his call light was always within reach. The plan indicated he had a pancake-style call light. On 07/30/24 at 11:10 AM R23 sat in his room next to the back wall facing his television. R23 called out help several times. R23's call light was attached to his bed and out of reach. He continued to call out for help and an unidentified staff member came in and asked if he needed to use the bathroom. R23 confirmed and she called for assistance to toilet him at 11:21 AM. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 08:15 AM Licensed Nurse (LN) H stated the call lights should be stored within reach. She stated staff were expected to ensure the lights were either pinned to the clothing of chairs to prevent them from falling. She stated R23 required close monitoring due to his cognitive impairment and used a pancake light. On 07/31/24 at 11:43 AM Administrative Nurse D stated staff were to ensure the call light remained within the resident's reach. She stated some of the residents were prone to drop the light so the lights should be attached to the chairs or clothing for easy access. The facility's Quality of Care policy revised 11/2017 indicated staff will ensure the necessary services and care were provided to the resident to attain the highest level of function attainable. The policy indicated staff was to ensure the residents' environment and rooms remained safe and functional. The policy indicated the facility would ensure each resident's communicated care needs were monitored and met. The facility failed to ensure R23 had a call light in order to communicate his need for staff assistance. This deficient practice placed the residents at risk for preventable falls and injuries.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50898 The facility identified a census of 37 residents with 12 residents included in the sample. Based on interview and record review the facility failed to issue the CMS (Center for Medicare/Medicaid Services) Notification of Medicare Non-Coverage (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) Form 10123 which contained the required information for Resident (R) 193. This failure placed the resident at risk for decreased autonomy and impaired right to appeal. Findings included: - A review of R193's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 01/13/24 and ended on 02/01/24. R193 was discharged home from the facility. The facility failed to provide evidence that the NOMNC was given to R193. A Plan of Care Progress Note dated 01/22/24 documented that a care plan meeting was held with the resident, interdisciplinary team, and the resident's two daughters with one son present via speaker phone. A date was discussed for return to home. The resident reported being anxious to go home with therapy, who was planned for the middle of the next week. On 07/30/24 at approximately 02:53 PM, Social Services X stated that the facility did not have a NOMNC for R193. Social Services X stated she thought if a resident initiated the discharge to home, a NOMNC did not need to be issued. Social Services X did confirm that a planned discharge date to home during care plan meetings was not a spontaneous resident-initiated discharge and even residents who discharge on their agreed-upon date have the right to appeal. The facility provided a Medicare Advance Beneficiary and Medicare on-Coverage notices policy. The policy stated for the Notice of Medicare Non-Coverage that if the resident's Medicare-covered Part A stay or when all of Part B therapies are ending, a NOMNC is issued to the resident at least two calendar days before benefits end. The NOMNC informs the resident of the pending termination of coverage and of his or her right to an expedited review by a Quality Improvement Organization. The notice of Medicare non-coverage is not given if the beneficiary exhausts the SNF benefits overage (100 days), thus exhausting their Medicare Part A SNF benefit and/or the beneficiary initiates the discharge from the SNF. The facility failed to provide a NOMNC to R193. This failure placed the resident at risk for decreased autonomy and impaired right to appeal.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42966 The facility identified a census of 37 residents. Based on observations, record reviews, and interviews, the facility failed to provide a method for residents to submit grievances anonymously. This deficient practice had the risk of loss of resident rights, unresolved grievances, and a loss of dignity for the residents in the facility. Findings included: - On 07/29/24 at 07:05 AM, entry into the skilled facility involved going through locked double doors from the main entrance area that Assisted Living shared. The double doors required a code to exit to the main entrance area from the skilled facility side. During the initial tour of the skilled facility on 07/29/24 at 07:30 AM, observation revealed there was no submission box or method for filing anonymous grievances. On 07/31/24 at 09:49 AM, Social Services X stated if a resident wanted to file a grievance anonymously, the facility encouraged them to talk to her. She stated if the resident wanted to remain anonymous, she left their name off of the grievance form and then distributed the grievance to the appropriate department to be addressed. Social Services X stated the facility did not have a box for residents to submit anonymous grievances. She agreed that it did not count as anonymous if residents submitted grievances through staff including herself. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated if a resident wanted to file a grievance anonymously then staff notified Administrative Nurse D who handled it from there. On 07/31/24 at 11:43 AM, Administrative Nurse D stated if a resident wanted to file a grievance anonymously, they told staff. She stated the facility did not have a method to submit anonymous grievances. On 07/31/24 at 12:30 PM, Administrative Staff A stated if a resident wanted to file an anonymous grievance, they could go through staff or ask staff for a grievance form. He stated the Assisted Living side had a box for grievance forms. The facility's Right to Voice Grievances and Have Grievances Resolved policy, revised in November 2017, directed if a resident or representative wished to remain anonymous then the resident or representative had the option to place it in a comment box. The facility failed to provide a method for residents to submit grievances anonymously. This deficient practice had the risk of loss of resident rights, unresolved grievances, and a loss of dignity for the residents in the facility.

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F 0620 Level of Harm - Potential for minimal harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. 42966 The facility identified a census of 37 residents. Based on record review and interviews, the facility failed to establish and implement an admissions agreement that protected the residents' right to personal property by not waiving the facility's liability. Findings included: - The facility's Nursing Admission and Care Agreement revealed under section D Standard Admission Waiver on page four, section four, that residents and their families realized the facility could not guarantee the safety of personal items and the facility was not responsible for loss, theft, or damage to resident's personal property. The facility maintained a safe in which personal articles of a small size or limited dollar value were stored. It was agreed by all parties that money, jewelry, documents, furs, and other personal articles of significant monetary value that were brought into the facility by the resident, responsible party, or other guests were a violation of D.4. of the agreement and were not the responsibility of the facility. On 07/31/24 at 12:30 PM, Administrative Staff A stated the facility reviewed the admission agreement annually and made changes. He stated if a resident lost an item, the facility did not immediately replace it but did make every effort to locate the item. He stated if the item was valued then the facility reported to the police department. Administrative Staff A stated if residents brought in items of excess value and they were lost or stolen, the facility did not necessarily accept responsibility for that item. He stated he did not interpret the admission agreement as a waiver of the residents' rights. The facility's Admission Orientation policy, revised in October 2012, directed nursing to provide newly admitted residents/family members with an orientation to the facility, facility programs, and facility services. The policy did not address the admission agreement. The facility failed to establish and implement an admissions agreement that protected the residents' right to personal property aby not waiving the facility's liability.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 37 residents. The sample included 12 residents. Two residents were reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide written notification of transfer to Resident (R) 12 and R29 or their representatives. The facility further failed to notify the State Long Term Care Ombudsman of transfers/discharges for R29. This deficient practice had the risk of miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services for R12 and R29 and placed R29 at risk for impaired rights. Findings included: - R12 admitted to the facility on [DATE], discharged to hospital on 07/01/24, and readmitted to the facility on [DATE]. R12's Electronic Medical Record (EMR) documented diagnoses of a fracture of the lower end of the right femur (thigh bone), weakness, pain in the right hip, and generalized muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], documented R12 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 06/26/24, documented R12 was dependent on staff for toileting, hygiene, lower body dressing, putting on shoes, bed mobility, standing, and transferring. R12's Care Plan, dated 06/26/24, documented R12 had an actual fall resulting in a right femur fracture and right fibula (one of two bones in the lower leg) fracture. She was at risk for further falls related to reduced mobility, pain, and weakness. The care plan directed staff to assess R12's pain and administer pain medications as ordered by the provider; educate and remind R12 to use her call light for assistance; staff ensured R12 wore appropriate footwear prior to ambulating, transferring, or working with therapy. R12's EMR revealed the following: A Physician Progress Note on 07/01/24 at 12:26 PM, documented that staff brought R12 back from therapy prior to lunch and R12 became unresponsive in her wheelchair. R12 did not respond to sternal rub and her respirations were shallow. Staff transferred R12 to bed and obtained vital signs. Staff placed R12 in Trendelenburg (a position in which the patient lies face upward on a tilted table or bed with the hips higher than the head) and her blood pressure improved. R12 became somewhat more responsive but was unable to answer questions. Emergency Medical Services (EMS) arrived to transport R12 to the emergency room (ER) for further evaluation. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Communication with Family/Next of Kin/Power of Attorney (POA- a legal document that named a person to make healthcare decisions when the resident was no longer able to) note on 07/01/24 at 10:52 PM, documented R12's representative called to update the facility on R12's health status. He informed the nurse that R12 was admitted to the hospital for observation, and the hospital planned to discharge her after 24 hours. R12's medical record lacked evidence the facility sent a written notification of transfer to R12 or her representative for her transfer on 07/01/24. Upon request, the facility did not provide a written notification of transfer for R12. On 07/30/24 at 12:17 PM, R12 sat in her wheelchair at a dining room table and ate lunch independently. On 07/30/24 at 12:46 PM, Administrative Nurse D stated the facility did not complete a written notification of transfer for R12's transfer to the hospital on 07/01/24. On 07/31/24 at 09:49 AM, Social Services X stated the facility did not place her in charge of sending written notification of transfers. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when the facility transferred a resident to the hospital, the facility called the family and asked if they had a preferred hospital. She stated she did not do written notification of transfers. On 07/31/24 at 11:43 AM, Administrative Nurse D stated when the facility transferred a resident to the hospital, the facility called the family, called in report, and notified the physician. The facility did not send a written notification of the transfer. The facility's Notice of Transfer or Discharge policy, revised in November 2017, directed the resident and their representative to receive a notice of transfer or discharge and the reason for the move. The policy directed the notice included the following: the reason for the transfer or discharge; the effective date of transfer or discharge; the location to which the resident transferred or discharged ; a statement with the resident's right to appeal the action to the State; the name, address, and telephone number of the State long term care ombudsman; for residents with disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; and for mentally ill residents, the mailing address, email address, and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals. The facility failed to send a written notification of transfer for R12. This deficient practice placed R12 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services. 45668 - R29 admitted to the facility on [DATE], discharged to hospital on 03/30/24, and readmitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of a right femur (large leg bone) fracture (broken bone), left femur fracture upon admission, muscle weakness, cognitive-communication deficit, repeated falls, and dementia (a progressive mental disorder characterized by failing memory, confusion). R29's Quarterly Minimum Data Set (MDS) completed 04/21/24 noted a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition. R29's Functional Abilities Care Area Assessment (CAA) completed 05/23/24 indicated she had a significant decline since her last MDS after a fall that resulted in a right pubis rami (pelvis) fracture. The CAA indicated she was unable to ambulate and required a wheelchair for mobility. The CAA indicated she could propel herself for short distances but required staff assistance to get around the facility. The CAA indicated she required substantial to maximal assistance with lower body dressing, bed mobility, standing, transfers, and bathing. R29's EMR under Progress Note indicated on 03/30/24, R29 was lethargic with no urine output. The note indicated she was sent out to an acute care facility for treatment. The EMR indicated she returned to the facility on [DATE]. The note indicated her representative was notified. R29's EMR lacked documentation showing that written notification of transfer was provided to R29 or her representative. The facility was unable to provide documentation showing the Long Term Care Ombudsman was notified of R29's transfer/discharge. On 07/30/24 at 12:46 PM, Administrative Nurse D stated the facility did not complete a written notification of transfer for R29's transfer to the hospital on 03/30/24. On 07/31/24 at 09:49 AM, Social Services X stated the facility did not place her in charge of sending written notification of transfers. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when the facility transferred a resident to the hospital, the facility called the family and asked if they had a preferred hospital. She stated she did not do written notification of transfers. On 07/31/24 at 11:43 AM, Administrative Nurse D stated when the facility transferred a resident to the hospital, the facility called the family, called in report, and notified the physician. The facility did not send a written notification of the transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Notice of Transfer or Discharge policy, revised in November 2017, directed the resident and their representative to receive a notice of transfer or discharge and the reason for the move. The policy directed the notice included the following: the reason for the transfer or discharge; the effective date of transfer or discharge; the location to which the resident transferred or discharged ; a statement with the resident's right to appeal the action to the State; the name, address, and telephone number of the State long term care ombudsman; for residents with disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; and for mentally ill residents, the mailing address, email address, and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals. The facility failed to send a written notification of transfer for R29. This deficient practice placed R29 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 37 residents. The sample included 12 residents. Two residents were reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide a bed hold policy notice to Resident (R) 12 and R29 or their representatives when they transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R12 and R29. Findings included: - R12 admitted to the facility on [DATE], discharged to hospital on 07/01/24, and readmitted to the facility on [DATE]. R12's Electronic Medical Record (EMR) documented diagnoses of a fracture of the lower end of the right femur (thigh bone), weakness, pain in the right hip, and generalized muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], documented R12 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 06/26/24, documented R12 was dependent on staff for toileting, hygiene, lower body dressing, putting on shoes, bed mobility, standing, and transferring. R12's Care Plan, dated 06/26/24, documented R12 had an actual fall resulting in a right femur fracture and right fibula (one of two bones in the lower leg) fracture. She was at risk for further falls related to reduced mobility, pain, and weakness. The care plan directed staff to assess R12's pain and administer pain medications as ordered by the provider; educate and remind R12 to use her call light for assistance; staff ensured R12 wore appropriate footwear prior to ambulating, transferring, or working with therapy. R12's EMR revealed the following: A Physician Progress Note on 07/01/24 at 12:26 PM, documented that staff brought R12 back from therapy prior to lunch and R12 became unresponsive in her wheelchair. R12 did not respond to sternal rub and her respirations were shallow. Staff transferred R12 to bed and obtained vital signs. Staff placed R12 in Trendelenburg (a position in which the patient lies face upward on a tilted table or bed with the hips higher than the head) and her blood pressure improved. R12 became somewhat more responsive but was unable to answer questions. Emergency Medical Services (EMS) arrived to transport R12 to the emergency room (ER) for further evaluation. A Communication with Family/Next of Kin/Power of Attorney (POA- a legal document that named a person to make healthcare decisions when the resident was no longer able to) note on 07/01/24 at 10:52 PM, documented R12's representative called to update the facility on R12's health status. He informed the nurse that R12 was admitted to the hospital for observation, and the hospital planned to discharge her after 24 hours. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's medical record lacked evidence the facility sent a bed hold notice to R12 or her representative for her transfer on 07/01/24. Upon request, the facility did not provide a bed hold notice for R12's transfer on 07/01/24. On 07/30/24 at 12:17 PM, R12 sat in her wheelchair at a dining room table and ate lunch independently. On 07/30/24 at 12:46 PM, Administrative Nurse D stated the facility did not send a bed hold notice for R12's transfer to the hospital on 07/01/24. On 07/31/24 at 09:49 AM, Social Services X stated the facility did not place her in charge of sending bed hold notices. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when the facility transferred a resident to the hospital, the facility called the family and asked if they had a preferred hospital. She stated she did not do bed hold notices, but the facility held the bed for the resident. On 07/31/24 at 11:43 AM, Administrative Nurse D stated when the facility transferred a resident to the hospital, the facility called the family, called in report, and notified the physician. The facility did not send a bed hold notice but they kept the resident's belongings in their room. She stated rarely, the facility needed the room and called the resident's representative to ask if they wanted the bed held. The facility's Bed Hold and Re-Admission policy, revised in November 2017, directed the facility to provide written information to the resident and their representative. The policy directed the facility to give two notices, the first notice on admission and the second notice at the time of transfer. The facility failed to provide a bed hold policy notice to R12 or her representative when she transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R12. 45668 - R29 admitted to the facility on [DATE], discharged to hospital on 03/30/24, and readmitted to the facility on [DATE]. The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of a right femur (large leg bone) fracture (broken bone), left femur fracture upon admission, muscle weakness, cognitive-communication deficit, repeated falls, and dementia (a progressive mental disorder characterized by failing memory, confusion). R29's Quarterly Minimum Data Set (MDS) completed 04/21/24 noted a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's Functional Abilities Care Area Assessment (CAA) completed 05/23/24 indicated she had a significant decline since her last MDS after a fall that resulted in a right pubis rami (pelvis) fracture. The CAA indicated she was unable to ambulate and required a wheelchair for mobility. The CAA indicated she could propel herself for short distances but required staff assistance to get around the facility. The CAA indicated she required substantial to maximal assistance with lower body dressing, bed mobility, standing, transfers, and bathing. R29's EMR under Progress Note indicated on 03/30/24, R29 was lethargic with no urine output. The note indicated she was sent out to an acute care facility for treatment. The EMR indicated she returned to the facility on [DATE]. The note indicated her representative was notified. R12's medical record lacked evidence the facility sent a bed hold notice to R29 or her representative for her transfer on 03/30/24. Upon request, the facility did not provide a bed hold notice for R29's transfer on 03/30/24. On 07/30/24 at 12:46 PM, Administrative Nurse D stated the facility did not send a bed hold notice for R29's transfer to the hospital on 07/01/24. On 07/31/24 at 09:49 AM, Social Services X stated the facility did not place her in charge of sending bed hold notices. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when the facility transferred a resident to the hospital, the facility called the family and asked if they had a preferred hospital. She stated she did not do bed hold notices, but the facility held the bed for the resident. On 07/31/24 at 11:43 AM, Administrative Nurse D stated when the facility transferred a resident to the hospital, the facility called the family, called in report, and notified the physician. The facility did not send a bed hold notice but they kept the resident's belongings in their room. She stated rarely, the facility needed the room and called the resident's representative to ask if they wanted the bed held. The facility's Bed Hold and Re-Admission policy, revised in November 2017, directed the facility to provide written information to the resident and their representative. The policy directed the facility to give two notices, the first notice on admission and the second notice at the time of transfer. The facility failed to provide a bed hold policy notice to R29 or her representative when she transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to the previous room for R29.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175503	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza Health Services at Santa Marta	13875 W 115th Terrace Olathe, KS 66062

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 37 residents. The sample included 12 residents. Two residents were reviewed for discharge. Based on record review and interviews, the facility failed to document a recapitulation of stay for Resident (R) 38 and R39. This deficient practice placed R38 and R39 at risk for miscommunication of services received during their stay in the facility and of their post-discharge care needs. Findings included: - R38 admitted to the facility on [DATE] and discharged on [DATE]. R38's Electronic Medical Record (EMR) documented diagnoses of essential hypertension (high blood pressure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and generalized muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], documented R38 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R38 planned to discharge to the community and active discharge planning occurred in the facility. The Functional Abilities (Self-Care/Mobility) Care Area Assessment (CAA), dated 06/17/24, documented R38 needed staff assistance and or supervision with ambulating using her walker and completing activities of daily living (ADLs). R38's Care Plan, dated 06/13/24, documented R38 planned to discharge back to her apartment after completing rehabilitation. The care plan directed staff encouraged R38 to discuss her feelings and concerns with the impending discharge, staff established a pre-discharge plan with R38 and evaluated her progress, and staff made arrangements with required community resources to support independence after her discharge. R38's EMR revealed a Discharge Summary on 07/05/24 at 11:23 AM that documented R38 discharged home at 11:10 AM with home health physical therapy (PT) and occupational therapy (OT) services. R38 left the facility with all of her belongings accompanied by her daughter and son. Staff reviewed R38's medication list and discharge summary and called her medications to the pharmacy. The Discharge Summary did not document a recapitulation of the stay that included what services R38 received during her admission at the facility. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when a resident was discharged , the night nurse and social services prepared the discharge instructions. She stated she educated the resident on their medications before discharge. LN G stated the discharge summary in the EMR included any concerns the resident had, who the resident was discharged with and where they went, education provided to the resident on their medications, and a recapitulation of stay. She stated she completed a recapitulation of her stay every time a resident was discharged that included the services they received as a resident. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 11:43 AM, Administrative Nurse D stated when a resident was discharged , staff reviewed medications with the resident, completed any needed resident education, and gave the discharge instructions to the resident or family. She stated the discharge summary note included when the resident left, a reconciliation of medications and services needed after discharge, and a recapitulation of stay for what services the resident received in the facility. The facility's Discharge Plan policy, dated November 2017, directed the interdisciplinary team (IDT) to develop and implement an effective discharge plan that focused on the resident's goals, allowed the resident to be an active partner, and effectively transitioned the resident to post-discharge care. The policy did not address a discharge summary including a recapitulation of stay. The facility failed to document a recapitulation of the stay for R38. This deficient practice placed R38 at risk for miscommunication of services received during her stay in the facility and of her post-discharge care needs. - R39 admitted to the facility on [DATE] and discharged [DATE]. R39's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (occurs when chronic kidney disease or the gradual loss of kidney function reaches an advanced state) and generalized muscle weakness. The Admission Minimum Data Set (MDS), dated [DATE], documented R39 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R39 planned to discharge to the community and active discharge planning occurred in the facility. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 04/08/24, documented R39 admitted with weakness and needed more assistance than she did prior to her illness with mobility and completion of her activities of daily living (ADLs). R39's Care Plan, dated 04/05/24, documented she wished to return to her apartment. The care plan directed staff encouraged R39 to discuss her feelings and concerns with the impending discharge, staff established a pre-discharge plan with R39 and evaluated her progress, and staff made arrangements with required community resources to support independence after her discharge. R39's EMR revealed a Discharge Summary on 04/30/24 at 11:56 AM that documented R39 discharged at that time with her family. Staff faxed R39's medications to the receiving facility and gave a copy to R39's family. Staff reviewed medications with R39 who had no questions or concerns. The Discharge Summary did not document a recapitulation of the stay that included what services R39 received during her admission at the facility. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when a resident was discharged , the night nurse and social services prepared the discharge instructions. She stated she educated the resident on their medications before discharge. LN G stated the discharge summary in the EMR included any concerns the resident had, who the resident was discharged with and where they went, education provided to the resident on their medications, and a recapitulation of stay. She stated she completed a recapitulation of the stay every time a resident was discharged that included the services they received as a resident. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 11:43 AM, Administrative Nurse D stated when a resident was discharged , staff reviewed medications with the resident, completed any needed resident education, and gave the discharge instructions to the resident or family. She stated the discharge summary note included when the resident left, a reconciliation of medications and services needed after discharge, and a recapitulation of stay for what services the resident received in the facility. The facility's Discharge Plan policy, dated November 2017, directed the interdisciplinary team (IDT) to develop and implement an effective discharge plan that focused on the resident's goals, allowed the resident to be an active partner, and effectively transitioned the resident to post-discharge care. The policy did not address a discharge summary including a recapitulation of stay. The facility failed to document a recapitulation of the stay for R39. This deficient practice placed R39 at risk for miscommunication of services received during her stay in the facility and of her post-discharge care needs.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility identified a census of 37 residents. The sample included 12 residents with three reviewed for accidents. Based on record review, interviews, and observations, the facility failed to ensure adequate supervision resulting in preventable falls for Resident (R) 29. This deficient practice resulted in a pelvic fracture for R29 and created the risk for pain and impaired mobility. The facility additionally failed to safely secure hazardous materials, cleaning chemicals, and supplemental oxygen cylinders from eight cognitively impaired ambulatory mobile residents. This placed the residents at risk for preventable accidents and injuries. Findings Including: - The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of a right femur (large leg bone) fracture (broken bone), left femur fracture upon admission, muscle weakness, cognitive-communication deficit, repeated falls, and dementia (a progressive mental disorder characterized by failing memory, confusion). R29's Quarterly Minimum Data Set (MDS) completed 04/21/24 noted a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. The MDS indicated she had lower extremity functional limitations and used a wheelchair for mobility. The MDS indicated she required supervision or touch assistance for bed mobility and transfers. The MDS noted she required substantial to maximal assistance with bathing, dressing, and toileting. The MDS indicated she was dependent on staff assistance during ambulation but used a wheelchair for mobility. The MDs indicated she had multiple falls since her prior assessment including one with a major injury. R29's Significant Change MDS completed 05/20/24 noted a BIMS score of 11 indicating mild cognitive impairment. The MDS indicated she had lower extremity functional limitations and used a wheelchair for mobility. The MDS indicated she required substantial to maximal assistance with bathing, toileting dressing, personal hygiene, and bed mobility and was dependent on staff for mobility in her wheelchair. The MDS indicated she had multiple falls since her prior assessment including one with a major injury. The MDS indicated she was dependent on staff assistance during ambulation but used a wheelchair for mobility. R29's Functional Abilities Care Area Assessment (CAA) completed 05/23/24 indicated she had a significant decline since her last MDS after a fall that resulted in a right pubis rami (pelvis) fracture. The CAA indicated she was unable to ambulate and required a wheelchair for mobility. The CAA indicated she could propel herself for short distances but required staff assistance to get around the facility. The CAA indicated she required substantial to maximal assistance with lower body dressing, bed mobility, standing, transfers, and bathing. R29's Fall CAA completed 05/23/24 indicated she had multiple falls since her admission. The CAA noted she had a major injury fall on 05/02/24 that resulted in a pelvic fracture. The CAA indicated she was a high fall risk due to her cognitive decline, medications, and medical diagnoses. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R29's Care Plan initiated 10/21/23 indicated she was at risk for falls and injuries related to her weakness and impulsive nature. The plan instructed staff to ensure she wore non-skid socks (10/21/23), ensure her call light was within reach (10/26/23), provide frequent room checks (10/29/23), encourage her to use common areas for supervision (10/29/23), and not to leave her unattended (01/20/24). The plan revealed that R29 had 21 unwitnessed falls since her admission. R29's EMR under Progress Notes revealed she was admitted to the facility following surgery for a left hip fracture and an open reduction internal fixation procedure (ORIF- a surgical procedure to fix broken bones). A Fall Investigation report indicated R29 had an unwitnessed fall on 12/29/23. The report indicated R29 attempted to get out of her recliner unassisted. The report indicated she was moved to a closer room for better supervision. The report also indicated staff were educated to bring R29 out to the common area for better supervision and interaction with other residents. R29's EMR under Progress Note revealed on 01/20/24 R29 was found on the floor in the television common area by staff. The note revealed R29 sat on her bottom with her legs out in front of her. The note revealed R29 reported that she slid out of her wheelchair attempting to pick up her pencil. A Fall Investigation report for R29's unwitnessed fall on 01/20/24 revealed staff were educated not to leave her unattended and to ensure she was seated at a table to prevent items from dropping. The report indicated she was assessed and had no injuries from the fall. A Fall Investigation report for R29 indicated a second unwitnessed fall occurred on 02/25/24. The report revealed R29 attempted to get out of her recliner without assistance and fell . The report indicated a medication review was completed and staff were educated not to leave R29 unattended. R29's EMR under Progress Note revealed on 02/25/24 staff were called to the television common area by R29. The note indicated R29 knelt to pick up an object off the floor and couldn't get back up. The note indicated the nurse briefly left the area before the fall. A Fall Investigation report for R29's unwitnessed fall on 02/25/24 revealed R29 was in the television common area and knelt on the floor to pick up an object but was unable to get up. The report indicated no injuries occurred from the incident. The report indicated staff were educated not to leave her unattended. R29's EMR under Progress Note on 05/02/24 revealed staff found her on the floor in the television common area. The note indicated she was found on her right side. The note indicated she complained of right hip pain upon moving or standing. The note indicated a stat x-ray for her right femur and pelvis was ordered. R29's EMR under Physician Progress Note on 05/03/24 indicated her x-ray showed no fractures were found but a computed tomography scan (CT scan - a test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) would be ordered if persistent pain continued. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R29's EMR under Progress Notes on 05/09/24 revealed a CT scan was completed due to persistent right hip pain. The CT scan revealed multiple pelvic fractures that occurred within her lower pelvic bone. On 07/30/24 at 12:50 PM, Staff pushed R29 in her wheelchair from the common television area to her room without foot pedals. R29's wore rubber-soled shoes. Her feet slid on the floor several times while being pushed. On 07/31/24 at 11:01 PM, R29 sat in her wheelchair in the television common area watching television. R29 was fidgeting with her shirt as she sat in front of the television room. Staff were not present in the day room or hallway to monitor R29. On 07/31/24 at 08:30 AM Certified Nurses Aid (CNA) (M) stated every resident's wheelchair should have foot pedals attached while being pushed. She stated the resident feet should never be allowed to drag during transport. She stated R29 was a high fall risk and required frequent reminders and redirections to wait for staff help. She stated higher fall-risk residents can be encouraged to use the television rooms and activities to prevent falls. She stated staff should monitor the residents while in the television room. On 07/31/24 at 08:15 AM Licensed Nurse (LN) H stated staff were expected to review the care plan and fall interventions for higher-risk residents. She stated staff were expected to provide frequent room checks and ask the residents to attend scheduled activities to provide supervision. She stated R29 had falls related to her impulsive behaviors and not knowing her limits when trying to transfer or stand. On 07/31/24 at 11:43 AM Administrative Nurse D stated the facility had attempted numerous interventions to reduce the number of falls for R29. She stated R29 was impulsive and would often attempt to stand or move herself without staff assistance. She stated staff were expected to offer activities and encourage her to use the common areas. She stated staff were expected to anticipate her needs and provide frequent checks while in her room. She stated R29 was supposed to be supervised while out in the common areas. She stated staff should never attempt to push the residents in their wheelchairs without foot pedals. The facility's Quality of Care policy (undated) indicates each resident will receive adequate supervision and assistance to prevent accidents. The policy indicated staff will ensure the environment remains free of potential hazards and each resident will be comprehensively assessed to identify potential risks related to falls and accidents. The policy indicated the facility will ensure the correct usage of assistance devices to allow safe treatment and care. The facility failed to ensure adequate supervision to prevent falls for R29. This deficient practice resulted in a pelvic fracture for R29. The staff further failed to use foot pedals when propelling the resident in the wheelchair placing the resident at risk for accidents. 42966 - On 07/29/24 at 07:26 AM, the unlocked soiled utility room on the 1900 hall revealed a bottle of Clean Power Profesco cleaning spray under the sink. The label said the spray caused skin irritation and serious eye damage and was directed to keep out of reach of children. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/29/24 at 07:34 AM, the isolation cart outside of R192's room had a container of Micro-Kill bleach wipes on the railing above it. The directions are directed to keep out of reach of children. On 07/29/24 at 07:56 AM, observation revealed five free-standing pressurized oxygen cylinders placed outside the oxygen storage rack in R191's room. On 07/29/24 at 07:56 AM, Licensed Nurse (LN) J stated the oxygen cylinders did not belong in R191's room and she did not know why they were there. LN J confirmed oxygen tanks should never be free-standing and should always be secured in a rack or other appropriate device. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated the facility locked up hazardous chemicals and stored oxygen cylinders in a locked room in the 1800 hall. On 07/31/24 at 11:43 AM, Administrative Nurse D stated the facility locked up hazardous chemicals and sanitation wipes. She stated the facility stored oxygen cylinders in the locked oxygen room in racks. Administrative Nurse D stated she heard hospice brought oxygen tanks in and placed them directly in the resident rooms, but the facility planned to address that. The facility's Storage Rooms policy, not dated, directed the facility to store cleaning supplies and chemicals in areas separate from food storage rooms and stored as instructed on the labels of such products. The facility's Oxygen Storage policy, dated November 2017, directed the facility to store oxygen cylinders in a dry, well-ventilated designated area. The facility stored empty oxygen cylinders separate from the full cylinders. The facility failed to store pressurized oxygen cylinders and hazardous chemicals securely and safely. This deficient practice had the risk of accidents and injuries to affected residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45668 The facility identified a census of 37 residents. The sample included 12 residents with one reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to implement timed toileting interventions as indicated in the assessment and failed to assess ongoing patterns of incontinence to establish bowel and bladder patterns to maintain or improve Resident (R)21's incontinence. This deficient practice placed R21 at risk for complications related to incontinence. Findings Including: - The Medical Diagnosis section within R21's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (high blood pressure), dementia (a progressive mental disorder characterized by failing memory, confusion), and benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections). R21's Significant Change Minimum Data Set (MDS) completed 05/24/24 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated he required substantial to maximal assistance with bed mobility, toileting, bathing, transfers, and lower body dressing. The MDS indicated he was always incontinent of bowel and bladder but not on a toileting program. R21's Functional Abilities Care Area Assessment (CAA) completed 05/29/24 indicated he required assistance from two staff and a Hoyer (full body lift) lift for transfers. The CAA indicated he required substantial to extensive assistance with transfers, dressing, toileting, bed mobility, bathing, and personal hygiene. R21's Urinary Incontinence CAA completed 05/29/24 indicated he had moderate cognitive impairment and required assistance with his activities of daily living (ADLs). The CAA indicated he was able to make his needs known. The CAA indicated he was incontinent of bladder and at risk for skin breakdown. R21's Care Plan initiated 05/15/24 indicated R21 had limited physical mobility related to weakness and his medical diagnoses. The plan indicated he required extensive assistance for bed mobility (two staff), dressing, toileting, transfers, and bathing. The plan indicated he was at risk for skin breakdown related to his incontinence. The plan lacked incontinence management interventions to maintain or improve his bowel or bladder needs. The lacked interventions related to the assessed time toileting recommendation. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's EMR revealed a Bowel and Bladder Program Screener completed 05/24/24 that indicated he always voided appropriately without incontinence but was incontinent of stool one to three times weekly. The assessment indicated he was immobile or required two-person assistance for bathroom transfers. The screen indicated he was forgetful but able to follow commands. The screen noted he had no predisposing factors or diagnoses influencing his incontinence. The evaluation indicated he was a candidate for scheduled toileting (timed toileting). On 07/29/24 at 07:10 AM R21 lay in his bed. R21 reported he was incontinent of bladder and waiting for staff to assist him. He reported that he's had issues with his incontinence since admission but was not sure if he was on a toileting program. On 07/31/23 at 08:10 AM Certified Nurse Aide (CNA) M stated all residents were checked and changed and offered restroom breaks frequently. She was not sure if R21 had a specific program but stated that staff would often provide incontinence care for him. On 07/31/24 at 11:40 AM Administrative Nurse D stated all residents were screened upon admission and quarterly for changes related to incontinence. She stated the results of the screening should be used to implement care related to the resident's needs. She stated the care plan should include interventions related to incontinence management and skin preventative measures. The facility's Quality of Care policy revised 11/2017 indicated the facility will implement and provide interventions related to maintaining or managing bowel and bladder incontinence care. The policy indicates the facility will provide the appropriate care to ensure the highest level of function. The facility failed to implement assessed timed toileting interventions and assess ongoing patterns of incontinence to establish bowel and bladder patterns to maintain or improve R21's incontinence. This deficient practice placed R21 at risk for complications related to incontinence.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45668 The facility identified a census of 37 residents. The sample included 12 residents with three residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R)14's bed rails were removed as indicated per her side rail assessment. This placed R14 at risk for impaired safety related to the risks associated with the use of side rails. Findings Including: - The Medical Diagnosis section within R14's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), encephalopathy (inflammatory condition of the brain), muscle weakness, overactive bladder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty walking. R14's Quarterly Minimum Data Set (MDS) completed 05/11/24 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated she required substantial to maximal assistance for bed mobility, transfers, bathing, grooming, dressing, personal hygiene, and mobility. The MDS indicated she used a walker for mobility. The MDS indicated she had no functional limitations for her upper or lower extremities. The MDS indicated she had no falls since her admission. R14's Functional Abilities Care Area Assessment (CAA) completed 12/07/23 indicated she required staff assistance for her activities of daily living (ADLs) and mobility. The CAA noted she required extensive to dependent on staff assistance in her EMR charting. The CAA indicated she required a sit-to-stand lift for transfers. The CAA indicated her care plan will be revised to reflect her current level of function. R14's Falls CAA completed 12/07/23 indicated she was at risk for falls related to her weakness and limited balance. The CAA instructed staff to encourage to use of her call light. R14's Care Plan initiated on 12/07/23 indicated she had deficits related to her mobility and activities of daily living. The plan indicated she required a stand-up lift for transfers. The plan indicated she required assistance from staff for bathing, transfers, dressing, bed mobility, and toileting. The plan instructed staff to remind her to use her bed assist rails to help with bed mobility. R14's EMR under the Assessments tab revealed a Bed Rail assessment completed on 07/24/24. The assessment indicated she was non-ambulatory. The assessment indicated R14 displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed. The assessment indicated R14 had no desire to have bed rails. The assessment revealed side rails or assist bars were not indicated at the time of assessment for R14's bed. On 07/30/24 at 07:04 AM R14 slept in her bed. Her bed had bilateral grab bars. R14 bed was in a low position to the floor. Her wheelchair was positioned next to her bed. (continued on next page)

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	175503	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza Health Services at Santa Marta	13875 W 115th Terrace Olathe, KS 66062

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 08:03 AM Certified Nurse Aide (CNA) M stated she was not sure how often the assistive rails on the beds were inspected or checked. On 07/31/24 at 08:15 AM Licensed Nurse (LN) H stated the nurse will complete the assessments for the bed rails and should report the results to the interdisciplinary team if they need to be removed or added. She stated she was not sure how often the rails were assessed. She stated staff should be physically looking at the rail to ensure the resident's safety. On 07/31/24 at 11:40 AM Administrator Nurse D stated the side rails should be assessed quarterly. She stated sometimes R14 didn't need them, and staff would put them in the down position. She stated staff should be assessing the railing for safety each shift and ensure no gaps or entrapment risks occurred. The facility's Quality of Care policy revised 11/2017 indicated the facility will ensure the safe utilization of treatment equipment within the resident's environment. The policy indicated the facility will ensure the resident's bed rails and equipment will be inspected and used according to the manufacturer's recommendations. The facility failed to ensure that R14's bed rails were removed per her assessed needs. This placed R14 at risk for impaired safety related to the risks associated with the use of side rails.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 37 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to notify the physician of elevated blood pressure as directed and failed to administer antihypertensive (medication used to treat high blood pressure) medications as needed for Resident (R) 26. This deficient practice placed R26 at risk for unnecessary medications and physical complications related to uncontrolled blood pressure. Findings included: - R26 was admitted to the facility on [DATE]. R26's Electronic Medical Record (EMR) documented diagnoses of essential hypertension (high blood pressure) and permanent atrial fibrillation (a-fib- rapid, irregular heartbeat). The Admission Minimum Data Set (MDS) dated [DATE], documented R26 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R26 received antidepressant (medication used to treat depression [abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness]) and anticoagulant (medication used to prevent blood from thickening or clotting) medications in the assessment period. The Quarterly MDS dated [DATE], documented R26 had a BIMS score of nine which indicated moderate cognitive impairment. R26 received antidepressants, antibiotics (medications used to treat bacterial infections), opioids (medications used to treat pain), and antiplatelet (medication that prevented or inhibited platelets [component of blood involved in clotting] from adhering to each other and reduced the risk of blood clot formation) medications in the assessment period. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 04/10/24, documented R26 needed partial to moderate assistance with one staff for bed mobility, dressing, transfers, toileting hygiene, and ambulating short distances with her walker. R26's Care Plan, dated 07/18/24, documented R26 had a diagnosis of hypertension and was at risk for cardiac complications. The care plan directed staff to administer a-fib medications as ordered, administer antihypertensive medications as ordered, monitor for side effects; obtain blood pressure readings as ordered, and report abnormal readings to the medical doctor (MD). R26's EMR documented an order with a start date of 04/01/24 for hydralazine hydrochloride (HCl) 10 milligrams (mg) every eight hours as needed (PRN) for hypertension for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) greater than 160 millimeters of mercury (mmHg) and an order with a start date of 04/09/24 for amlodipine besylate five mg one time a day for hypertension with instructions to notify the physician if the SBP was greater than 160 mmHg or the diastolic blood pressure (DBP- the minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R26's documented blood pressures from 04/01/24 to 07/30/24 revealed 35 SBP readings greater than 160 mmHg. A review of R26's Medication Administration Record (MAR) for 04/01/24 to 07/30/24 revealed R26 received PRN hydralazine four times. Review of R26's MAR for 04/09/24 to 07/30/24 revealed R26 had documented on her amlodipine 5 mg medication, she had SBP higher than 160 on the following dates: 05/08/24, 05/12/24, 05/17/24, 05/18/24, 05/19/24, 05/20/24, 05/23/24, 06/06/24, 06/14/24, 07/11/24, 07/12/24, 07/13/24, 07/17/24, 07/18/24, 07/20/24, 07/25/24, and 07/28/24. R26's clinical record lacked evidence the facility notified the physician as directed for her SBP greater than 160 mmHg for the above dates. On 07/30/24 at 12:15 PM, R26 sat in a chair in the dining room and ate lunch independently while conversing with the other residents at the table. On 07/31/24 at 10:19 AM, Licensed Nurse (LN) F stated most of the standing orders had blood parameters and were in the directions on the order. She stated she notified the physician for blood pressure outside of the ordered parameters and documented the notification in a progress note. LN F stated she took R26's blood pressure and if the SBP was above 160 mmHg then she gave the scheduled blood pressure medication and the PRN hydralazine. She stated if R26 received PRN hydralazine, the nurse noted it on the report sheet. On 07/31/24 at 11:43 AM, Administrative Nurse D stated she expected staff to notify the physician if the SBP was over 160 and she expected the nurse to document the notification and what the physician said. Administrative Nurse D stated she expected staff to give PRN hydralazine as ordered if R26's SBP was greater than 160 mmHg. The facility's Administering Medications policy, revised in April 2019, directed staff to administer medications in accordance with prescriber orders, including any required time frame. The facility did not provide a policy on notifying the physician. The facility failed to notify the physician of elevated blood pressure as directed and failed to administer antihypertensive medications as needed for R26. This deficient practice placed R26 at risk for unnecessary medications and physical complications related to uncontrolled blood pressure.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50898 The facility had a census of 37 residents. The sample included 12 residents with one reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)24. This placed R24 at risk for inappropriate end-of-life care. Findings included: - R24's Electronic Medical Record (EMR) revealed diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dementia (a progressive mental disorder characterized by failing memory and confusion), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R24's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R24 had a Brief Interview for Mental Status (BIMS) score of nine that indicated moderate cognitive impairment. The MDS documented the resident required substantial/maximal staff assistance with most activities of daily living (ADLs). The MDS documented the resident received hospice services. R24's Care Plan, dated 03/29/24, recorded R24 required substantial/maximal staff assistance with most ADLs. R24's Care Plan documented the resident received hospice services due to a terminal diagnosis of dementia. The interventions included adjusting the provision of ADLs to compensate for the resident's changing abilities and to encourage participation to the extent the resident wished to participate. The plan directed staff to assess the resident's coping strategies, respect the resident's wishes, and consult with the physician and Social Services to have hospice care for the resident in the facility. Staff were directed to encourage the resident to express her feelings, and listen with non-judgmental acceptance and compassion. Staff were to encourage support systems of family and friends and observe the resident closely for signs of pain administer pain medications as ordered and notify the physician immediately if there was breakthrough pain. Staff were to refer the resident for psychiatric/psychogeriatric consult if indicated. The plan directed staff to review the resident's living will and ensure it was followed and involve the family in discussion. Staff were to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Staff were to work with nursing staff to provide maximum comfort for the resident. R24's Care Plan lacked instruction on the services provided by hospice including hospice staff visits, supplies and medical equipment provided by hospice, and medications covered by hospice. (continued on next page)

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	175503	A. Building B. Wing	07/31/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's EMR revealed the resident was admitted to hospice on 03/29/24 but lacked evidence of coordination of care between hospice and the facility. The facility had received a hospice plan of care dated 03/29/24 located in the hospice provider's binder located in the nurse's station. The binder included a hospice plan of care, medications, and equipment to be provided. On 07/30/24 at 02:07 PM Certified Nurse Aide (CNA) N stated the CNA staff requested items from their charge nurse when they needed items that the hospice provided. On 07/31/24 at 08:15 AM Licensed Nurse (LN) H stated specific hospice information should be included in the care plan. She said she was unsure if the facility included hospice medications, equipment, and treatment services in the facility care plan. On 07/31/24 at 11:43 AM, Administrative Nurse D stated she expected the facility to have a hospice care plan for R24 to be able to coordinate care with hospice services. Administrative Nurse D verified the facility lacked a facility care plan that coordinated with the hospice care plan. The facility's Standards & Guidelines policy dated 11/2017 documented the coordinated plan of care will reflect the participation of Hospice, Licensed Nursing Home. The representative of the resident and the resident, to the extent possible. Care and services provided by nursing will be consistent with the Resident Assessment Instrument (RAI), the plan of care, and the Hospice plan of care. The facility failed to coordinate care between the facility and the hospice provider for R24, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42966 The facility identified a census of 37 residents. The sample included 12 residents. Based on observations, record review, and interviews, the facility failed to follow infection prevention standards related to disinfecting shared equipment and oxygen tubing storage and failed to place the appropriate isolation signage outside of Resident (R) 192's room after he tested positive for COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death). The facility further failed to assess, identify risks, and create a plan to address the risk for Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens. This deficient practice placed the residents at risk for infectious diseases. Findings included: - R192's EMR documented an order with a start date of 07/22/24 for isolation for 10 days starting 07/21/24 for a positive COVID-19 infection. On 07/29/24 at 07:14 AM, R14's oxygen concentrator had her oxygen tubing placed in the handle instead of a bag. On 07/29/24 at 07:18 AM, R192's room had an isolation cart outside of it. There was no signage on the door to alert staff and visitors of the transmission-based precautions or the personal protective equipment required. Licensed Nurse (LN) J confirmed R192's COVID-19 and stated there should be signage posted related to the transmission-based precautions and isolation status. On 07/29/24 at 09: AM, observation revealed three signs posted to R192's door which indicated the resident was on airborne, droplet, and contact precautions. On 07/30/24 at 07:30 AM, LN I obtained a glucometer (an instrument used to calculate blood glucose) from the other medication cart on 1700 Hall and placed it on top of her medication cart without a clean barrier. LN I went to R92's room to obtain her blood glucose level. She did not disinfect the glucometer before use and placed the glucometer on R92's dresser. LN I washed her hands and donned (put on) gloves then grabbed the glucometer and placed it on R92's bedside table without a clean barrier. She obtained R92's blood glucose level and doffed (removed) her gloves. LN I washed her hands then exited R92's bathroom with the glucometer. She returned to her medication cart where she placed the glucometer in the drawer without disinfecting the glucometer. On 07/30/24 at 07:26 AM, unidentified staff exited R8's room with the Hoyer lift (total body mechanical lift used to transfer residents) and placed it in an alcove in the hallway without disinfecting it. On 07/30/24 at 07:42 AM, unidentified staff grabbed the Hoyer lift from the alcove and entered R13's room. Staff exited the room with the Hoyer lift and placed it back in the alcove without disinfecting the Hoyer lift. Upon request, the facility was unable to provide a Legionella water management plan. (continued on next page)

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	175503	A. Building B. Wing	07/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/31/24 at 08:15 AM, LN H stated staff stored oxygen tubing in the mesh bag, not on the machine. She stated the facility posted isolation signs outside the resident rooms who were in isolation. LN H stated that R192 continued on isolation for COVID-19 but planned to come off isolation later that day with the room scheduled for terminal cleaning. LN H stated staff cleaned shared equipment. On 07/31/24 at 09:14 AM, Administrative Staff A stated the facility did not have a Legionella testing procedure in place and they were reaching out to a company to set that up. On 07/31/24 at 10:20 AM, LN G stated staff prevented cross-contamination during glucometer usage by cleaning the machine after using it and using a clean barrier. On 07/31/24 at 11:28 AM, Administrative Nurse E stated staff prevented cross-contamination during glucometer usage by cleaning it after using it. She stated if staff took the glucometer out of another cart then staff cleaned it again. Administrative Nurse E stated staff used a clean barrier with glucometer usage. She stated if a resident needed isolation, the facility placed a sign denoting the type of isolation and what personnel protective equipment (PPE) to wear along with an isolation cart with PPE supplies and isolation trash cans outside the room. Administrative Nurse E stated there should have been an isolation sign outside R192's room because, without a sign, she assumed staff would not know of his isolation. She stated staff disinfected Hoyer lifts from room to room and they obtained the disinfecting wipes from the nurses. On 07/31/24 at 11:43 AM, Administrative Nurse D stated staff prevented cross-contamination during glucometer usage by disinfecting it before and after use and using a clean barrier. She stated staff knew what residents were in isolation through report and a sign should be posted on the door with an isolation cart outside the room. Administrative Nurse D stated the isolation sign directed the type of isolation and what PPE to wear. She stated R192 tested positive for COVID-19 on 07/21/24 and the facility planned to remove his isolation later that day. Administrative Nurse D stated R192 should have had an isolation sign outside his door. She stated staff stored oxygen tubing in a bag when not in use. Administrative Nurse D stated staff did not store disinfecting wipes in the resident rooms, and she expected staff to go to central supply to obtain wipes when needed. She stated she expected staff to disinfect Hoyer lifts and shared equipment between each use to prevent cross-contamination. On 07/31/24 at 12:30 PM, Administrative Staff A stated he or the plant operations director would be responsible for the water management program. He stated he was under the impression the facility had a plan for Legionella but they did not. The facility's Oxygen Tubing Storage policy, not dated, directed the facility to cover oxygen masks, nasal cannulas, and/or nasal catheters when not in use and the equipment necessary included a covering such as a mesh bag. The facility's Coronavirus Disease (COVID-19)- Infection Prevention and Control Measures policy, revised in May 2023, directed the facility to implement source control measures and implementing universal use of PPE for staff. (continued on next page)

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	175503	A. Building B. Wing	07/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Isolation- Categories of Transmission-Based Precautions policy, revised September 2022, directed when the facility placed a resident on transmission-based precautions, the facility placed an appropriate notification on the entrance door so that personnel and visitors were aware of the need for and the type of precaution. The policy directed the signage informed staff of the type of precautions, instructions for the use of PPE, and/or instructions to see the nurse before entering the room. The facility's Blood Sampling- Capillary (Finger Sticks) policy, revised in September 2014, directed staff to always clean and disinfect blood glucose meters between resident uses. The policy directed staff to place the blood glucose monitoring device on a clean field. The facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised September 2023, directed staff to clean and disinfect reusable items between residents which included durable medical equipment. The facility's Legionella Water Management Program policy, revised September 2022, directed the water management program included the following elements: an interdisciplinary team (IDT) water management team, a detailed description and diagram of the water system in the facility, the identification of areas in the water system that encouraged the growth and spread of Legionella or other waterborne bacteria, the identification of situations that could lead to Legionella growth, specific measures used to control the introduction and/or spread of Legionella, the control limits or parameters that were acceptable and monitored, a diagram where control measures were applied, a system to monitor control limits and the effectiveness of control measures, and documentation of the program. The facility failed to follow infection prevention standards related to disinfecting shared equipment and oxygen tubing storage and failed to place the appropriate isolation signage outside of R192's room after he tested positive for COVID-19. The facility further failed to assess, identify risks, and create a plan to address the risk for Legionella disease or other opportunistic waterborne pathogens. This deficient practice placed the residents at risk for infectious diseases.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42966 The facility identified a census of 37 residents. The sample included 12 residents with five residents reviewed for pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer or obtain a signed declination for the Prevnar 20 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 20 serotypes of Streptococcus pneumoniae) pneumococcal vaccination for Resident (R) 23. This deficient practice placed R23 at risk of acquiring, spreading, and experiencing complications from pneumococcal disease. Findings included: - R23's clinical record documented he received Prevnar 13 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 13 serotypes of Streptococcus pneumoniae [bacteria that causes pneumonia]) on 02/25/14 and Pneumovax 23 (pneumococcal vaccination used for the prevention of pneumococcal disease caused by 23 serotypes of Streptococcus pneumoniae) on 03/22/17. R23's clinical record lacked evidence he was offered the Prevnar 20 vaccination. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) G stated when a resident was admitted to the facility, she obtained their immunization history and offered the pneumococcal vaccination. She stated if a resident consented to receive the pneumococcal vaccination, she put the order in the computer. On 07/31/24 at 11:28 AM, Administrative Nurse E stated the facility offered influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) and pneumococcal vaccinations yearly and obtained consents from the resident or family. She stated on admission, the nurse asked about the resident's immunization history and documented it in the resident's Electronic Medical Record (EMR). Administrative Nurse E stated that Administrative Nurse D tracked resident immunizations. Administrative Nurse E stated she did not know the current pneumococcal recommendations. On 07/31/24 at 11:43 AM, Administrative Nurse D stated Administrative Nurse F checked a resident's immunizations on admission to see if they were due for pneumococcal vaccination and asked if they wanted one. She stated they asked residents annually if they wanted a pneumococcal vaccination. She stated residents should be reviewed quarterly with their Minimum Data Set (MDS). The facility's Influenza and Pneumonia Immunization policy, dated 12/01/16, directed the facility to develop a program that assured all residents received education regarding immunization, staff offered immunization, and staff documented the resident's response or refusal of immunization. The facility failed to obtain a signed consent or declination for pneumococcal vaccination for R23. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.