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	05/14/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interdisciplinary staff assessed Resident (R) 8 for the ability to safely self-administer medication before the staff gave R8 her Flonase nasal spray, to keep in her room, per R8's request. Findings include:- R8's Electronic Medical Record (EMR) documented diagnoses of pulmonary fibrosis (a progressive disease where the lung tissue thickens, making it increasingly difficult for oxygen to pass into the bloodstream), chronic obstructive pulmonary disease (COPD- causes obstructed airflow from the lungs, making it difficult to breathe), interstitial pulmonary disease (a disorder that causes progressive scarring of lung tissue), chronic hypoxia (inadequate supply of oxygen), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), vertigo, and transient ischemic attack (TIA- brief blockage of blood flow to the brain, causing stroke-like symptoms). R8's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R8's Care Plan dated 04/27/26 documented she had a self-care deficit related to limited immobility and generalized weakness, and she requires partial to moderate assistance from staff with many activities of daily living (ADL). The EMR for R8 revealed Consultant GG placed an order on 05/12/26 at 07:30 PM for staff to administer Flonase Nasal Suspension, for use in both nostrils, once daily, for 15 days. R8's EMR lacked an order to confirm the ability for R8 to self-administer medications and lacked evidence the interdisciplinary team/staff assessed R8 for her ability to safely self-administer her medication or keep medication at her bedside. During an observation on 05/14/26 at 09:30 AM, R8 exited the restroom and sat in her recliner without assistance. A small white bottle of Flonase sat on her table next to her bed, with the label that stated her name and other pharmacy information. An interview with Licensed Nurse (LN) H on 05/14/26 at 09:40 revealed the resident was in possession of the bottle of Flonase. LN H stated R8 wanted to keep the Flonase in her room. LN H went into R8's room and brought out the bottle, which was confirmed to be Flonase, with date and instructions on the label. During an interview conducted at 09:55 AM on 05/14/26, Administrative Nurse D confirmed R8 was not allowed to self-administer medication(s), as she had not been assessed. Administrative Nurse D stated the floor nurse needed to assess the resident for this and then obtain a physician's order. Administrative Nurse D verified the staff did not complete those steps for R8. A facility policy for Self-Administration of Medications, dated February 2021 (revised), was provided upon request, and documented the residents have the right to self-administer medications, upon assessment by the interdisciplinary team, that indicates it is clinically appropriate and safe for the resident to do so.

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the Office of the Long-term Care Ombudsman (LTCO) for the discharge of Resident (R) 46. Findings included:- R46's Electronic Medical Record (EMR) revealed diagnoses of: Traumatic subarachnoid hemorrhage (bleeding into the area between the brain and the protective tissue covering it, resulting from a head injury), right upper humerus fracture, cardiomegaly (an enlarged heart), atrial fibrillation (A-fib - a rapid, irregular heartbeat), muscle weakness, and a cognitive communication deficit. R46's Discharge with Return Not Anticipated Minimum Data Set (MDS) dated [DATE] documented a BIMS score of 10, indicating moderate cognitive impairment, without a diagnosis of dementia. On 03/18/26 at 03:16 PM, a progress note documented a conversation with R46's daughter, discussing provisions for R46, as family wanted the resident to move back to her Independent Living (IL) apartment on 03/19/26. The interdisciplinary team (IDT) was notified, according to the progress note. A Discharge Summary Note on 03/19/26 at 02:21 PM documented R46 reviewed and signed a written notice of transfer, and the facility discharged R46 at approximately 02:20 PM on 03/19/26. Upon request, the facility could not provide evidence of notification of R46's discharge to the LTCO. During an interview on 05/13/26 at 02:18 PM, Administrative Nurse E confirmed the facility had not notified the LTCO of tR46's discharge. The facility did not provide a policy related to transfers and discharges as requested.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify and implement resident-centered interventions and monitor effectiveness of interventions to prevent falls for Resident (R) 27, who was at high risk for falls. Findings included: - R27's Electronic Health Record (EHR) documented diagnoses of anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), major depressive disorder (major mood disorder that causes persistent feelings of sadness), weakness, abnormalities of gait and mobility, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), repeated falls (two or more falls within a specific time frame, typically a year or six months), and dementia (a progressive mental disorder characterized by failing memory and confusion). R27's Annual Minimum Data Set (MDS), dated 05/20/25, documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R27 required a wheelchair or walker for mobility. The MDS documented that R27 was independent for eating and was substantial to maximum assistance for the rest of her activities of daily living (ADL) and for transfers. R27's Falls Care Area Assessment (CAA), dated 05/20/25, documented she had taken antianxiety and antidepressant medication, and she had fallen at least once since the previous assessment. R27's Psychotropic Drug Use CAA, dated 05/20/25, documented she had received antianxiety and antidepressant medication. R27's Quarterly MDS, dated 02/20/26, documented a BIMS of five, which indicated severe cognitive impairment. R27 required a wheelchair or walker for mobility. The MDS documented that R27 required supervision or touching assistance for eating and oral hygiene. R27 required partial to moderate assistance for personal hygiene; she was dependent on staff for lower body dressing. R27 required substantial to maximum staff assistance for toileting hygiene, bathing, upper body dressing, and all transfers. R27's Care Plan, with a revision date of 02/20/26, documented she was at high risk for falls related to injury related to falls, weakness and impulsive nature. The care plan documented that R27 had an unwitnessed fall on 05/10/25 while trying to transfer herself from the toilet back to her wheelchair. The intervention, dated 05/15/26, instructed staff to remain with R27 for the duration of toileting and to remain outside the bathroom door if R27 needed more privacy. R27's Care Plan documented that R27 had a witnessed fall on 03/07/26 when she tried to transfer from her bed to her wheelchair. The intervention, dated 03/19/26, instructed staff to check on R27 before and after each shift change and during shift change, staff could bring R27 into the common area, so they were aware of her location. R27's Care Plan documented she had an unwitnessed fall on 03/26/26 and instructed staff to continue checking on R27 frequently, and that R27 would use her recliner for shorter periods of time, and staff were to offer R27 activities in the common area for better supervision. Staff were also instructed to keep R27's door open if she wanted to nap. R27's Fall Risk Evaluation, dated 05/10/25, documented that she a balance problem while walking and decreased muscular coordination. The assessment also documented that she required the use of assistive devices and had jerking or was unstable when making turns. R27's Fall Risk Evaluation, dated 02/09/26, documented that she had a balance problem while standing and while walking. R27's EHR Incident Note, dated 05/10/25 and timed 10:13 PM, documented that the Certified Nurse Aide (CNA) found R27 on the bathroom floor at approximately 10:00 PM. R27 had increased confusion but denied hitting her head. The nurse notified the physician, and an antibiotic was started to treat her for urinary tract infection. R27's EHR Incident Note, dated 03/07/26 and timed 10:10 PM, documented that the CNA had discovered R27 trying to transfer herself into her wheelchair. R27 was not positioned correctly so the CNA had to lower her to the floor. The wheelchair was found unlocked, beside the bed near the resident. There was no Incident Note documented in R27's EHR for the unwitnessed fall that was documented in the Care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan. Observed on 05/13/26 at 02:36 PM, R27 sat in her wheelchair in the common area television room and played dominoes with staff and another resident. Observed on 05/14/26 at 09:39 AM, R27 was in the dining room eating breakfast with staff assistance. On 05/13/26 at 02:42 PM, CNA M said that if a resident was a fall risk, it was documented on the care plan and could be read on the [NAME] phone (wireless call system for long term care facilities) that the CNAs carried. She stated that there would be notes with certain interventions listed, but the longer employed staff learned the residents and inherently knew what to do. CNA M also said that as soon as the CNA logged onto the [NAME] phone, new indications, injuries or resident status changes were alerted to the CNA. CNA M further stated that fall and accident residents were frequently checked throughout the shift, at least every two hours and toileting was offered, especially with R27 because she would not use her call light. On 05/14/26 at 09:40 AM, Licensed Nurse (LN) G said that fall risk assessments were completed on residents monthly or with any change of condition and re-done every time a fall occurs. She said that new interventions were added to the care plan after each fall. LN G also said that interventions were to be changed based on the change of condition and based on the root cause analysis. On 05/14/26 at 09:47 AM, Administrative Nurse D said that all residents were to be checked by nursing staff before and after each shift change. She also said that staff educated to check resident before and after each shift was not an appropriate fall intervention. Administrative Nurse D stated that fall risks were performed upon admission, quarterly, annually and anytime a resident had a significant change and after each fall. The facility policy Falls, Prevention, Procedure, Investigation, dated 07/2017, documented that it was the policy of the facility to identify residents at risk for falls, implement appropriate preventative interventions, respond promptly and appropriately to falls, and monitor outcomes to reduce fall-related injuries and complications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary dialysis post assessment, care, and services for Resident (R) 23 when staff failed to provide post-dialysis assessments. Findings included:- R23's Electronic Health Record (EHR) documented diagnoses that included Infection and inflammatory reaction due to peritoneal dialysis (procedure performed to remove toxins, drugs, or other wastes in the blood normally excreted by the kidney) catheter (a flexible tube inserted through a narrow opening into a body cavity), spontaneous bacterial peritonitis (a life threatening, severe inflammation of the peritoneum) (the thin tissue that lines the inside of your abdomen and covers your organs), intestinal obstruction, intestinal adhesions, end stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus (DM-when the body cannot use glucose when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissue), femur (thigh bone) fracture (broken bone), and obstructive sleep apnea (a disorder of sleep characterized by periods without respirations).R23 was admitted to the facility on [DATE], the admission MDS assessment was not completed prior to 05/14/26.R23's EHR in assessments documented a brief interview of mental status (BIMs) score of 15, indicating R23 is cognitively intact.R23's Care Plan, dated 05/05/26, documented R23 had dialysis treatment. The plan instructed staff to encourage R23 to attend dialysis on her scheduled treatment days. The plan also directed staff to monitor, document, and report as needed for signs or symptoms of renal insufficiency, changes to R23's level of consciousness. The plan further instructed staff to monitor changes in skin turgor, oral mucosa and, changes in heart and lung sounds. The plan also instructed staff to Monitor, document, and report as needed any new or worsening peripheral (outside, surface, or surrounding area of an organ, other structure, or field of vision) edema (swelling resulting from an excessive accumulation of fluid in the body tissues).R23's EMR under the Physician Orders documented the following orders:Dialysis communication book filled out by the nurse and sent with R23 to dialysis. Ensure resident returns with communication book and new information reviewed two times a day every Monday, Wednesday, and Friday. Auscultate (listen) thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's (shunt) (tube or device implanted in the body to redirect a body fluid from one cavity to another) and bruit (blowing or swishing sound heard when blood flows through a shunt. Dialysis Precautions: No blood pressure taken to left upper extremity, every shift for left upper extremity dialysis fistula.R23's dialysis communication book revealed the following:R23's Assessment of Site after Returning to Facility was not completed on 05/11/26 and 05/12/26.R23's Dialysis Communication Form from 05/12/26 had a note from the dialysis center that ordered medication via intravenous (IV-administered directly into the bloodstream via a vein) was received at dialysis center.An observation on 05/13/26 at 09:43 AM R23's husband was placing medication from a tube onto R23's left lower arm. R23's husband then wrapped the left lower arm with plastic wrap, covering the area where the medication was placed. R23's husband stated he has been doing this treatment for his wife since she started dialysis.In an interview on 05/14/26 at 09:07 AM, Licensed Nurse (LN) J reported that prior to dialysis a charge nurse will fill out the Dialysis Communication Form, obtain vital signs, and assess the resident. LN J reported that facility staff had not assessed R23 after she returned to the facility from dialysis.In an interview on 05/14/26 at 09:20 AM, Administrative Nurse D reported It is the expectation that the charge nurses complete the post dialysis assessment as they know they should. The facility's Renal Dialysis Communication Form documents that an assessment of the dialysis site be done, the assessment should include the presence of bruit, the presence of thrill, and for signs or symptoms of infection or bleeding at site.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to display accurate and identifiable posted nurse staffing information. Findings included:- On 05/12/26 at 07:25 AM, observation revealed a daily staffing sheet hanging on the wall near the administrative offices of the facility. Review of the Daily Nursing Staffing Information sheet on 05/12/26 revealed the sheet lacked the correct posting date. The posted sheet on 05/12/26 was dated 05/08/26. On 05/12/26 at 08:54 AM the posted daily nursing staffing information sheet was posted with the date 05/12/26.On 05/14/26 at 09:42 AM, Administrative Nurse A reported they oversee the facility staffing coordinators. Administrative Nurse A further reported the position is split between 2 people. A charge nurse would be responsible for posting the daily nursing staffing sheet if a staffing coordinator is not available for that day. It is my expectation that the daily nursing staffing sheet is changed & updated daily. This is the reason we now have 2 staffing for complete coverage of this function.On 05/14/2026 at 10:21 AM, Administrative Nurse A reported the facility did not have 18 months of staffing sheets. Administrative Staff A stated she could provide the posted staff sheets from 12/25/25 forward only. She said staff attended a seminar recently and learned that they need to retain 18 months of staffing sheets and have that process in place now. Facility policy Posting Direct Care Daily Staffing Numbers, version 1.2 (H5MAPL0656), dated August 2022, documented our facility will post daily for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.