STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175540	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nottingham Health and Rehabilitation	14200 W 134th Place 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to appropriately store medications and biologicals when staff failed to ensure the medication carts were always locked when the cart was not within the nurses' view.Findings included:- During the initial tour on 04/06/26 at 07:50 AM, a treatment cart on Holiday House was unlocked and unattended in the hallway. The treatment cart contained Resident (R) 2's enteral (within or via the small intestine) medications, residents supplies, and as needed (PRN) creams.On 04/06/26 at 08:10 AM, a treatment cart on [NAME] House was unlocked and unattended in the hallway. The treatment cart contained residents' treatment supplies, as-needed creams, and two insulin pens (hormone medication used to lower blood glucose). On 04/06/26 at 08:20 AM, a medication cart on [NAME] House was unlocked and unattended in the hallway. The medication cart contained three insulins and creams for treatments.On 04/07/26 at 07:36 AM, a medication cart on [NAME] House was unlocked and unattended in the hallway. The medication cart contained scheduled medications and over the counter medications.On 04/06/26 at 08:20 AM, Licensed nurse (LN) J stated the treatment cart and medication carts should be locked when out of the nurse's view.On 04/08/26 at 01:29 PM, Administration Nurse D stated medication carts and treatment carts should be locked when not being used.The facility's Medication Labeling and Storage policy dated 01/30/26 documented medications would be labeled and stored in accordance with facility requirements and Kansas and Federal laws. All drug containers would be labeled, and drug labels must be clear, consistent, legible, and in compliance with state and federal requirements. There would be a standard method for appropriately and safely labeling medications dispensed to all residents.

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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(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. Based on observation, record review, and interview, the facility failed to ensure Resident (R)80 had been assessed for the ability to safely self-administer medication before staff left medications at her bedside unsupervised. Findings included:- R80's Electronic Medical Record (EMR) included diagnosis of hemiplegia (paralysis that affects one side of the body), unspecified affecting left nondominant side.R80's Assessments tab of the EMR lacked an assessment for Self-Administration of Medications.R80's Annual Minimum Data Set (MDS) dated 03/27/26 documented she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition.On 04/08/26 at 10:58 AM R80's Baseline Care Plan dated 3/23/26 did not address self-medication.On 04/06/26 at 10:27 AM observation revealed R80 had a pill cup in front of her on her bedside table with two pills in it. R80 stated that she had a question and asked what the pills were. Licensed Nurse (LN)H walked into R80's room after knocking and R80 asked LN H what the two pills in her cup were and she stated that one looked like a Tylenol, but she would have to go check and see what the other pill was. Then LN H said she needed to ask the Certified Medication Aid (CMA) since she had placed them in her room and left them. LN H took the pills to go ask the CMA.On 04/06/26 at 10:27 AM R80 stated she had not ever been assessed to self-administer the medication that she could recall.On 04/08/26 at 01:30 PM, Administrative Nurse D and Administrative Staff A were asked how the staff would know which residents are safe to self-administer their own medications. Administrative Nurse D stated that it would be in their care plan after the provider was notified and an order was placed. Administrative Nurse D stated that medication should not be left by the bedside.The facility policy Medication Administration Policy dated 02-03-26, documented Self-administered medications are administered safely and accurately per the Self-Administration Policy and Procedure. Clinical staff will educate the resident and /or surrogate decision-maker regarding appropriate monitoring of medication effectiveness and adverse risks. The neighborhood nursing staff will monitor the resident's perception of side effects and the effectiveness of his/her medication(s).

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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 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, record reviews, and interviews, the facility failed to ensure Resident (R)15's call lights were within her reach.Findings Included:- R15's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), unsteadiness on feet, and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS document R15 needed set up or cleanup for eating and substantial/maximal assistance with bathing and oral care and was dependent on staff for toileting. The MDS documented R15 had an impairment of one side of her upper and lower extremities. The MDS documented R15 had not had any falls since admission.The Falls Care Area assessment dated [DATE] documented R15's falls CAA triggered due to a fall, and she took medication that could increase the risk for falls. The CAA documented R15 would receive medications as requested by the physician and would be assisted with activities of daily living (ADLs) as needed. The CAA documented R15 would wear nonskid footwear, and work with therapy.R15's Care Plan documented the following:01/06/24- Staff to place frequently used items within her reach at night. Staff would offer snacks she prefers at night.01/13/24- Staff were to re-educate R15 on the use of the call light.11/20/24- Facility to place nonskid strips in front and to the side of R15's bed.03/22/24- R15 was at risk for falls due to being unaware of her limitations.08/30/25- R15's fall intervention was bolsters were placed on her bed.On 04/06/26 at 08:25AM, R15 lay in her bed, the top of her body and her right arm leaned to the right and her legs were on the left side of the bed. R15 was yelling out for help to be repositioned. R15's portable box call light lay on her bedside table, and R15's cord call light was wrapped around her overhead table and caught under her bed. R15's call lights were not within her reach.On 04/06/26 at 08:30 AM, Certified Nurse's Aide (CNA) M stated R15's box call light should be on her overhead table where she can reach it. She stated, her cord call light should be placed where she can use the call light.On 04/08/26 at 12:04 PM, LN KK stated the residents' portable call light should be placed where the resident can touch the box easily. She stated residents have two call lights, a portable and a cord. She stated one of the two should always be within the resident's reach. On 04/08/26 at 01:29 PM, Administrative Nurse D stated residents call lights should be placed within the reach of the resident.The facility's Falls policy dated 01/26/26 documented each elder who resided at the facility would be provided services and care that ensures that the eider's environment remained as free from accident hazards as was possible and each elder received adequate supervision and assistive devices to prevent accidents.