

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 577 SS=C	The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 10/06/21. Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents. Based on observations, record review, and interviews, the facility failed to ensure the results	F 577			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 577	Continued From page 1 of the most recent health resurvey were available for residents, family, and legal representatives for review. Findings included: - On 09/23/21 at 03:20 PM a survey results binder was on a bookcase in the front sitting area behind the front entrance. The binder lacked the most recent health resurvey results and plan of correction from 2019. On 09/27/21 at 05:40 PM, Administrative Staff A stated she placed the most recent survey results and the plan of correction in the binder the moment she received them. The facility's "Examination of Survey Results" policy, last revised 04/07/21, directed survey reports and plans of correction are readily accessible to the resident and to the public. The policy directed a copy of the most recent survey report as well as the facility's plan for correcting identified problems was kept in a binder in the residents' day room. The facility failed to ensure the results of the most recent health resurvey were available for residents, families, and legal representatives to review.	F 577			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 2 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 3 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 4 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents. The sample included 26 residents; one resident sampled for discharge review. Based on observations, record reviews, and interviews, the facility failed to provide a written notification of transfer to Resident (R) 49 or to her family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to). This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services. Findings included: - R49 was admitted on 08/25/20, discharged to hospital on 06/13/21, and readmitted to facility 06/15/21. The "Diagnoses" tab of R49's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance and dislocation of left hip. The "Significant Change Minimum Data Set"	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 5 (MDS) dated 09/06/21, documented R49 had a Brief Interview for Mental Status of zero which indicated severe cognitive impairment. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/06/21, documented R49 had severe impairment and staff and family anticipated her needs. The "Care Plan" dated 06/15/21 documented R49 had a diagnosis of dementia and needed assistance with cares and daily activities. The "Assessments" tab of R49's EMR documented a "Transfer to Hospital" assessment that documented R49 was transferred to the hospital for left hip pain and her representative was notified of transfer. R49's medical record lacked documentation of a written notification of transfer to resident or family for the transfer on 06/13/21. Facility unable to provide written notification of transfer for transfer to hospital on 06/13/21. On 09/22/21 at 02:52 PM, R49 laid in bed on her left side, eyes closed. She rested comfortably without signs of distress. On 09/27/21 at 03:13 PM, Social Services X stated social services did not do any written notifications of transfer. On 09/27/21 at 04:48 PM, Licensed Nurse (LN) G stated when a resident transferred to the hospital, the family was notified by phone call and the transfer form was sent with the resident to the hospital. LN G did not know about a written	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 623	Continued From page 6 notification of transfer. On 09/27/21 at 05:24 PM, Administrative Nurse D stated when a resident transferred to the hospital, the family was notified by phone call and the resident/family was notified about their right to appeal their transfer. He stated the resident or family were not provided a written notification of transfer. The facility's "Transfer or Discharge Notice" policy, last revised 04/01/21, directed the resident and/or representative was provided the following information: reason for transfer; effective date of the transfer; location to which resident was transferred; name, address, and telephone number of the state long-term care ombudsman; and the name, address, and telephone number of the state health department agency that was designated to handle appeals of transfers. The policy lacked direction that the notification was to be written. The facility failed to provide a written notification of transfer to R49 or her family/DPOA. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare services.	F 623			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 7 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents. The sample included 26 residents, with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure reducing measures were placed on Resident (R) 128's bilateral lower extremities to prevent pressure ulcers. This placed R128 at increased risk for pressure ulcer development. Findings included: - R128's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), pressure ulcer on buttocks, and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 08/19/21 documented moderately impaired cognition from a staff interview. The MDS documented R128 required extensive assistance of two staff members for dressing and bed	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 8 mobility. R128 was totally dependent upon two staff members for transfers. The MDS documented R128 was at risk for pressure, she had pressure reducing devices in her chair and on her bed. The MDS documented she was on a turning and repositioning program, along with a nutrition or hydration interventions for her skin problems. R128's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 09/02/21 documented she had multiple chronic pressure ulcers. She was at increased risk for pressure ulcers related to her diagnoses and was dependent upon staff assistance for her activities of daily living. Preventive measures would be care planned and continue to work toward current pressure ulcers toward healing. R128's "Care Plan" dated 04/29/15 directed staff to encourage her to off load/reposition every two hours. The "Care Plan" dated 07/06/16 documented a pressure relieving chair, air mattress on the bed and a wedge for positioning. The "Care Plan" dated 12/28/16 documented position with pillow and float heels. An intervention dated 04/29/18 documented heels to be elevated off the bed with bunny boots or Prafo (pressure reducing ankle foot orthotic) boots in bed. Another intervention dated 04/29/20 documented an air mattress for pressure relief. On 09/22/21 at 08:12 AM R128 laid in bed on her back, head of elevated, eyes closed, and no distress noted. Her bilateral lower extremities rested directly on the mattress and lacked Prafo boots.	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 9 On 09/23/21 at 01:11 PM R128 laid in bed with her head of bed elevated, her eyes closed, and bilateral lower extremities lacked Prafo boots and laid directly on the mattress. On 09/27/21 at 09:30 AM R128 sat upright in bed, and nursing staff assisted her with breakfast. R128's bilateral lower extremities rested directly on the bed and lacked Prafo boots. On 09/27/21 at 10:00 AM two nursing staff turned R128 on to her left side for licensed nurse to preform a treatment to her buttocks, bilateral lower extremities rested directly on the mattress. On 09/27/21 at 02:46 PM R128 was asleep in bed, no distress noted, head of bed elevated, and bilateral lower extremities rested directly on pillow, no boots were present, and heels were not floated. On 09/27/21 at 01:45 PM in an interview, Certified Nurses Aide (CNA) M stated that R128 had a pressure reducing mattress on her bed for pressure ulcer prevention. CNA M stated that she was unaware of any other pressure reducing measures in place for R128. CNA M stated that the nurse printed off an information sheet from the Kardex (electronic care sheet used by staff) every day for the staff, which listed the care plan information. On 09/27/21 at 02:20 PM in an interview, Licensed Nurse (LN) I stated R128 had an air loss mattress on her bed for pressure reducing. LN, I stated she was not aware of any other pressure reducing devices that R128 had in place.	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	Continued From page 10 On 09/27/21 at 05:15 PM in an interview, Administrative Nurse D stated the skin preventive measures that are listed on the care plan are printed on an information sheet that the charge nurse printed off and is given to the CNA's at the start of the shift. The facility "Wound Management" policy last revision date August 2021 documented the facility provide care and services to: Promote the preventions of pressure ulcer development. Promote the healing of pressure ulcers that are present. Prevent the development of additional, avoidable pressure ulcers. the policy documented to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening staff would implement the following approaches: A. Stabilize, reduce or remove any existing and underlying risks. B. Monitor impact or interventions and modify interventions as appropriate based on any identified changes in condition. C. Reposition the resident. D. Use pressure relieving /reducing and redistributing devices (including but not limited to low air loss mattress, wedges, pillows, etc.) E. Use transfer techniques which minimize friction and skin tears/shears as applicable (mechanical lift). F. If the resident is incontinent, make sure that his/her skin remains clean and dry with regular peri care and toileting when appropriate. G. Implement measures to maintain or improve nutritional and hydration status related to wound prevention and healing. The facility failed to implement pressure reducing measures for R128, who was at risk for pressure	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021	
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page 11			F 686			
F 698	injuries. This placed R128 at increased risk for pressure/skin injuries.						
SS=D	Dialysis CFR(s): 483.25(l)			F 698			
	§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents. The sample included 26 residents; one resident sampled for hemodialysis (procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) review. Based on observations, record reviews, and interviews, the facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for Resident (R) 112. This deficient practice had the risk for adverse outcomes and unwarranted physical complications associated with dialysis. Findings included: - The "Diagnoses" tab of R112's Electronic Medical Record (EMR) documented R112 had diagnoses of end stage renal disease (occurs when chronic kidney disease or the gradual loss of kidney function reaches an advanced state) and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) without behavioral disturbance.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 698	Continued From page 12 The "Annual Minimum Data Set" (MDS) dated 08/06/21, documented R112 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. R112 received dialysis. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 08/06/21, documented R112 was at risk for cognitive decline due to diagnoses of vascular dementia and had a BIMS score of 12 which indicated mild cognitive impairment. The "Renal Function Care Plan" dated 10/26/1 documented R112 was on dialysis for end stage renal disease and documented an intervention dated 05/13/21 that staff nurse ensured dialysis paperwork was received, completed, and sent to medical records upon return from dialysis on Tuesday, Thursday, and Saturday. The "Orders" tab of R112's EMR documented an order with a start date of 05/15/21 that resident went to dialysis on Tuesday, Thursday, and Saturday at 06:15 AM. Review of R112's medical record revealed missing "Dialysis Communication Reports" for the following dates: 03/06/21, 03/20/21, 03/25/21, 03/27/21, 04/08/21, 04/20/21, 05/11/21, 05/25/21, 06/29/21, 08/24/21, and 08/26/21. Review of R112's medical record revealed missing pre-dialysis or post-dialysis assessments on the "Dialysis Communication Reports" for the following dates: 03/13/21, 05/01/21, 05/22/21, and 07/17/21.	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 698	Continued From page 13 Upon request, facility was unable to provide the missing "Dialysis Communication Reports". On 09/23/21 at 01:24 PM, R112 sat in his recliner in his room and watched television. He stated dialysis went well and he ate lunch when he returned. On 09/27/21 at 04:48 PM, Licensed Nurse (LN) G stated dialysis communication forms were completed with vital signs and assessment before and after dialysis. He stated if a communication form was not returned from dialysis, he contacted the dialysis company and requested it. He stated dialysis communication forms were placed in medical records once completed. On 09/27/21 at 05:24 PM, Administrative Nurse D stated dialysis communication forms were started by the nurse in the morning, completed with vital signs and assessment, then sent with resident or driver to dialysis. He stated dialysis was not consistent about sending the forms back, but staff were expected to call the dialysis center and request the form. The facility's "Hemo-Dialysis" policy, last revised 07/18/21, directed a facility dialysis documentation form accompanied the resident to all appointments. Documentation occurred according to protocols. The facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments before/after dialysis for R112. This deficient practice had the potential for adverse outcomes and unwarranted physical complications related to dialysis.	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756 F 756 SS=D	Continued From page 14 Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756 F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 15 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents. The sample included 26 residents, with five residents sampled for medication review. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP- a pharmacist who works as a consultant to provide advice on the use of medications by elders) identified irregularities for two of five residents sampled for medication review: Resident (R) 20's blood pressure and/or pulse being monitored prior to administration of the beta blocker (a medication used to treat control heart rhythm, treat angina, and reduce blood pressure) carvedilol and R120's missed medication administrations with no documented physician notification of missed medications. Findings included: - The electronic medical record (EMR) for R20 documented diagnoses of atrial fibrillation (a rapid, irregular heartbeat), hypertension (HTN- an elevated blood pressure), congestive heart failure (CHF) - a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic kidney disease (a gradual loss of kidney function over time). The "Annual Minimum Data Set" (MDS) dated 06/25/21 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 16 cognition. She required supervision to extensive assistance of one staff member for "Activities for Daily Living" (ADLs) and used a walker and wheelchair for mobility. The "Quarterly MDS" dated 09/09/21 documented a BIMS score of 15, which indicated intact cognition. R20 required supervision to extensive assistance of one staff member for ADLs. R20 used a walker and wheelchair for mobility. The "ADL Care Area Assessment (CAA)" dated 06/25/21 documented R20 had alterations in her ADL function related to her history of CHF. The "Circulatory Care Plan" revised 12/29/19 directed staff to give anti-hypertensive (a medication used to treat elevated blood pressure) medications as ordered, and to monitor for side effects such as orthostatic hypotension (a low blood pressure) and an increased heart rate. Under the "Orders" tab report in the EMR for R20 documented an order with a start date of 02/04/21 for carvedilol (a medication used to treat HTN and CHF) 12.5 milligrams(mg) to take by mouth twice daily for CHF, and hold if systolic blood pressure (SBP) reading was less than 110 or pulse reading was less than 55 beats per minute . This order was discontinued on 06/04/21. Under the "Orders" tab report in the EMR for R20 documented an order with the start date of 06/05/21 for carvedilol tablet 12.5 mg by mouth twice a day for atrial fibrillation, hold SBP was less than 110 or pulse was less than 55 beats per minute. The June 2021 to September 2021 "Medication	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 17 Administration Record (MAR)" for R20 lacked documentation that blood pressure and/or pulse readings were obtained as ordered twice daily when administering R20's carvedilol. Review of the CP's "Medication Regimen Review (MRR)" for the months of June, July and August 2021 lacked any recommendation to make ensure that a blood pressure and pulse reading was taken before administration of carvedilol for R20. On 09/23/21 at 08:28 AM R20 was observed in her room sitting in her wheelchair at her bedside table eating breakfast, she had her oxygen on via nasal canula (a hollow device used to supply supplemental oxygen) and she showed no signs of distress. In an interview with Certified Medication Aide (CMA) R stated on 09/27/21 at 4:38 PM that a medication would be held (not given) due to ordered blood pressure and/or pulse parameters, and he would then notify the nurse of reading and the medication that was held. He further stated that the physician and/or nurse practitioner put in their own new orders, otherwise the nurse that received the order enters the order into the MAR after it is verified with the provider. In an interview with Licensed Nurse (LN) G on 09/27/21 at 04:48 PM stated that a medication should be held when blood pressure and/or pulse reading were below ordered parameters, unless a physician specifically did ask for the parameters. There is a pop-up screen that will come up on the MAR to flag the blood pressure or pulse reading if it was outside of ordered parameter and would ask if they still wanted to administer the	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 18 medication. The medication should be held, and a note entered in the MAR as well as a progress note as to why the medication was held. The new medication orders are entered into the MAR when they are received, but sometimes the provider enters their own orders into the MAR. The night supervisor audits all the orders that were entered each day. In an interview with Administrative Nurse D on 09/27/21 at 05:25 PM stated that he received the monthly pharmacy reviews by email, then he printed them out and are given to the correct provider, the recommendation for the nurses are given to the charge nurses and completed by them. The pharmacist comes monthly to review the resident's medical records. A blood pressure medication should have ordered parameters for blood pressure and/or pulse if the provider wanted them. All new orders get entered the MAR when they are received, sometimes the provider will enter their own orders into the MAR. The MDS Coordinator and nurse managers check the orders frequently for errors. In an interview with CP GG on 09/28/21 at 1:10PM stated that she reviewed all residents charts including the progress notes, medications orders and MAR to make sure that medications were given as ordered, or why they might not have been given, to make sure parameters are being followed prior to a medication being given. She then made recommendations based on irregularities that she found in her review. The facility policy "Medication Regimen Review(MRR)" dated 09/01/21 documented: The drug regimen of each resident, which includes a review of the resident's medical chart; will be	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 19 reviewed at least once a month by a licensed pharmacist; Irregularities will be documented on a separate written report; that is sent to the attending physician, the facility's Medical Director and the Director or Nursing Services and lists of the resident's name, the relevant drug, and the irregularity the pharmacist identified. These reports will be acted upon. The MMR includes identification of irregularities, medication-related errors, adverse consequences, and use of unnecessary drugs. Unnecessary drug is defined as medications ordered: without adequate monitoring. The facility failed to ensure that the CP identified and reported irregularities in blood pressure and pulse monitoring not being obtained before staff administered R20's ordered carvedilol, which had the potential for unnecessary medications and unwarranted side effects. - The "Diagnoses" tab of R120's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure) and type two diabetes mellitus (a condition when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) without complications. The "Annual Minimum Data Set" (MDS) dated 12/17/20, documented R120 was unable to complete a Brief Interview for Mental Status (BIMS) due to rarely being understood. R120 received insulin seven days in the seven-day lookback period of the assessment.	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 20 The "Quarterly MDS" dated 08/16/21, documented R120 was unable to complete a BIMS score due to rarely being understood. R120 received insulin seven days in the seven-day lookback period. The "Cognitive/Dementia Care Area Assessment" (CAA) dated 12/17/20, documented R120 was severely cognitively impaired and at risk for continued cognitive decline due to diagnosis of dementia. The "Care Plan" last revised 04/11/19, documented R120 had alterations in cardiac function related to diagnosis of hypertension and directed staff gave anti-hypertensive medications (medications used to treat high blood pressure) as ordered. The "Care Plan" dated 02/19/16, documented R120 was at risk for hypoglycemia (low blood sugar) related to diabetes and directed staff checked blood sugar and gave insulin as ordered. The "Orders" tab of R120's EMR documented an order with a start date of 02/16/21 for amlodipine besylate (anti-hypertensive medication) 5 milligrams (mg) one time a day for primary hypertension; an order with a start date of 02/16/21 for metoprolol succinate extended release (ER) (antihypertensive medication) 25 mg one time a day for primary hypertension; an order with a start date of 05/07/21 for Tresiba (insulin-medication used to treat diabetes) 30 units every morning related to type two diabetes mellitus without complications; and an order with a start date of 05/06/21 for Novolog insulin sliding scale (scale with dosage dependent upon blood sugar reading) before meals related to type two	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 21 diabetes mellitus without complications. Review of the "Medication Administration Record" (MAR) for March through September 2021 revealed R120 missed daily medication administrations for amlodipine, metoprolol, and Tresiba with documented reason of "Resident Sleeping" for the following dates: 06/18/21, 06/30/21, 07/07/21, 07/08/21, 07/14/21, 07/19/21, 07/21/21, 08/01/21, 08/05/21, 08/11/21, 08/12/21, 08/18/21, 08/24/21, 08/25/21, 09/01/21, 09/06/21, 09/13/21, 09/15/21, 09/16/21, and 09/20/21. Review of the "MAR" for March through September 2021 revealed R120 missed scheduled lunch dose administration of Novolog with documented reason of "Resident Sleeping" for the following dates: 06/18/21, 06/30/21, 07/07/21, 07/08/21, 07/14/21, 07/19/21, 07/21/21, 08/05/21, 08/11/21, 08/12/21, 08/18/21, 08/20/21, 08/25/21, 08/25/21, 09/13/21, 09/15/21, and 09/16/21; and supper dose administration of Novolog with documented reason of "Resident Sleeping" for 07/17/21, 07/25/21, and 08/07/21. Review of R120's medical record lacked documentation the physician was notified of missed doses of antihypertensive and insulin medications. Review of the "Medication Regimen Reviews" for R120 from June 2021 to September 2021 lacked evidence the CP identified and reported to the facility the inconsistent administration of antihypertensive and insulin medications due to resident sleeping and lack of documentation the physician was notified of missed doses. On 09/22/21 at 09:25 AM, R120 sat in her	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 22 wheelchair in her room, she appeared comfortable and without signs of distress or discomfort. On 09/27/21 at 04:39 PM, Certified Medication Aide (CMA) R stated if a resident was sleeping, he waited until the resident was awake to give and if they slept through medication administration time then he notified the nurse who documented on the medication. On 09/27/21 at 04:48 PM, Licensed Nurse (LN) G stated if a resident was sleeping, depending on the medication, he held the medication and waited until the resident woke up. If the resident missed a couple doses due to sleeping, the provider was notified of missed doses. On 09/27/21 at 05:24 PM, Administrative Nurse D stated if a resident was sleeping then staff held the medication and attempted to administer when resident woke up. He stated if a resident missed several doses of medication due to sleeping, the provider was notified to potentially change medication administration times when resident was awake. On 09/28/21 at 01:10 PM, CP GG stated when she reviewed a resident's medications, she reviewed the charting to ensure medications were given as ordered and what reason they were not given and if a progress note was made when doses were missed. CP GG stated she made any recommendations as needed. The facility's "Medication Administration" policy, not dated, directed all medications were administered to every elder as ordered by a	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page 23 physician and medications were administered at general, liberalized times with exceptions to those that a physician placed at specified times. The policy directed that morning medications may be given 05:00 AM to 02:00 PM. The facility's "Medication Regimen Review" policy, dated 09/01/21, directed the pharmacist reviewed each resident's medication regimen at least once a month in order to identify irregularities and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications. The facility failed to ensure the CP identified and reported to facility missing doses of antihypertensive and insulin medications for R120 being asleep and lack of documentation the physician was notified of missed doses. This deficient practice has the risk for unwarranted physical complications, less than therapeutic drug levels, and unnecessary medication use.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 24 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: - The "Diagnoses" tab of R120's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure) and type two diabetes mellitus (a condition when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) without complications. The "Annual Minimum Data Set" (MDS) dated 12/17/20, documented R120 was unable to complete a Brief Interview for Mental Status (BIMS) due to rarely being understood. R120 received insulin seven days in the seven-day lookback period of the assessment. The "Quarterly MDS" dated 08/16/21, documented R120 was unable to complete a BIMS score due to rarely being understood. R120 received insulin seven days in the seven-day lookback period. The "Cognitive/Dementia Care Area Assessment" (CAA) dated 12/17/20, documented R120 was severely cognitively impaired and at risk for continued cognitive decline due to diagnosis of dementia. The "Care Plan" last revised 04/11/19,	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 25 documented R120 had alterations in cardiac function related to diagnosis of hypertension and directed staff gave anti-hypertensive medications (medications used to treat high blood pressure) as ordered. The "Care Plan" dated 02/19/16, documented R120 was at risk for hypoglycemia (low blood sugar) related to diabetes and directed staff checked blood sugar and gave insulin as ordered. The "Orders" tab of R120's EMR documented an order with a start date of 02/16/21 for amlodipine besylate (anti-hypertensive medication) 5 milligrams (mg) one time a day for primary hypertension; an order with a start date of 02/16/21 for metoprolol succinate extended release (ER) (antihypertensive medication) 25 mg one time a day for primary hypertension; an order with a start date of 05/07/21 for Tresiba (insulin-medication used to treat diabetes) 30 units every morning related to type two diabetes mellitus without complications; and an order with a start date of 05/06/21 for Novolog insulin sliding scale (scale with dosage dependent upon blood sugar reading) before meals related to type two diabetes mellitus without complications. Review of the "Medication Administration Record" (MAR) for March through September 2021 revealed R120 missed daily medication administrations for amlodipine, metoprolol, and Tresiba with documented reason of "Resident Sleeping" for the following dates: 06/18/21, 06/30/21, 07/07/21, 07/08/21, 07/14/21, 07/19/21, 07/21/21, 08/01/21, 08/05/21, 08/11/21, 08/12/21, 08/18/21, 08/24/21, 08/25/21, 09/01/21, 09/06/21, 09/13/21, 09/15/21, 09/16/21, and 09/20/21.	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 26 Review of the "MAR" for March through September 2021 revealed R120 missed scheduled lunch dose administration of Novolog with documented reason of "Resident Sleeping" for the following dates: 06/18/21, 06/30/21, 07/07/21, 07/08/21, 07/14/21, 07/19/21, 07/21/21, 08/05/21, 08/11/21, 08/12/21, 08/18/21, 08/20/21, 08/25/21, 08/25/21, 09/13/21, 09/15/21, and 09/16/21; and supper dose administration of Novolog with documented reason of "Resident Sleeping" for 07/17/21, 07/25/21, and 08/07/21. Review of R120's medical record lacked documentation the physician was notified of missed doses of antihypertensive and insulin medications. On 09/22/21 at 09:25 AM, R120 sat in her wheelchair in her room, she appeared comfortable and without signs of distress or discomfort. On 09/27/21 at 04:39 PM, Certified Medication Aide (CMA) R stated if a resident was sleeping, he waited until the resident was awake to give and if they slept through medication administration time then he notified the nurse who documented on the medication. On 09/27/21 at 04:48 PM, Licensed Nurse (LN) G stated if a resident was sleeping, depending on the medication, he held the medication and waited until the resident woke up. If the resident missed a couple doses due to sleeping, the provider was notified of missed doses. On 09/27/21 at 05:24 PM, Administrative Nurse D stated if a resident was sleeping then staff held the medication and attempted to administer when	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 27 resident woke up. He stated if a resident missed several doses of medication due to sleeping, the provider was notified to potentially change medication administration times when resident was awake. The facility's "Medication Administration" policy, not dated, directed all medications were administered to every elder as ordered by a physician and medications were administered at general, liberalized times with exceptions to those that a physician placed at specified times. The policy directed that morning medications may be given 05:00 AM to 02:00 PM. The facility failed to ensure consistent administration of antihypertensive and insulin medications for R120 when resident was sleeping and failed to document the physician was notified of missed doses. This deficient practice has the risk for unwarranted physical complications, less than therapeutic drug levels, and unnecessary medication use. - R115's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). The "Admission Minimum Data Set" (MDS) dated 08/23/21 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R115 required limited assistance of one staff member for activities of daily living	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 28 (ADL's). The MDS documented R115 had received diuretic (medication to promote the formation and excretion of urine) medication and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication for seven days, anticoagulant (class of medications used to prevent the formation of blood clots) medication for six days and antibiotic (class of medication used to treat bacterial infections) medication for two days during the look back period. R115's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 08/25/21 documented he was at risk for adverse reaction to medications related to the Black Box (BBWs-the most serious medication warning put in the labeling of prescription medications by the U.S. Food and Drug Administration when there is reasonable evidence of an association of a serious hazard with the drug) warning. The facility would address in the care plan to prevent serious or life-threatening adverse reactions going forward. R115's "Care Plan" dated 08/17/21 directed staff to monitor/record/report to physician any side effects and adverse reaction of medications. Review of the EMR under "Orders" documented physician order that lacked a diagnosis and blood pressure/pulse parameters for monitoring antihypertensive (class of medication used to treat hypertension (high blood pressure) medications: Bisoprolol-hydrochlorothiazide 5-6.25 milligrams (mg) tablet daily dated 09/16/21. Lisinopril 5mg daily dated 09/16/21.	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 29 On 09/23/21 at 08:04 AM R115 ambulated in hallway with front wheeled walker and stand by assistance of one staff member to the dining room. In an interview with Certified Medication Aide (CMA) R stated on 09/27/21 at 4:38 PM that a medication such a antihypertensive would have diagnosis and blood pressure and pulse parameters. CMA R stated that if there were no diagnosis and/or blood pressure parameters, he would notify the nurse. In an interview with Licensed Nurse (LN) G on 09/27/21 at 04:48 PM stated that each medication should have a diagnosis for why the medication is ordered. LN G stated antihypertensive medication should have blood pressure or pulse monitoring to monitor for effectiveness. In an interview with Administrative Nurse D on 09/27/21 at 05:25 PM stated each medication should have a diagnosis ordered by the physician for why the resident was receiving the medication for and antihypertensive medication should be monitored by the parameters set by the physician. The undated facility policy "Medication Administration" documented: All medication will be administered to every elder as ordered by a physician in a safe and sanitary manner. If a drug requires pre-administration assessment such as pulse or blood pressure, perform before administering drugs. Administer medication as specified by the manufacturer- take pulse rate prior to cardiac rhythm medications. The facility failed to ensure that antihypertensive	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 30 medication had a diagnosis and vital sign monitor for effectiveness or adverse side effects for R115. This deficient practice had the potential for the administration of unnecessary medications and unwarranted adverse side effects hypertension or hypotension (low blood pressure). The facility identified a census of 150 residents. The sample included 26 residents; five residents were sampled for medication review. Based on record observation, record review, and interview, the facility failed to ensure that staff monitored resident (R) 20's blood pressure and/or pulse prior to administration of carvedilol (a beta blocker medication used to control heart rhythm, treat angina, and reduce blood pressure); failed to ensure staff administered ordered medications in a timely manner and/or notify physician when ordered medications were not given when R120 was documented as sleeping; and failed to ensure R115 had a diagnosis listed on ordered antihypertensive (a medication used to treat elevated blood pressure) medications. Findings included: - The electronic medical record (EMR) for R20 documented diagnoses of atrial fibrillation (a rapid, irregular heartbeat), hypertension (HTN- an elevated blood pressure), congestive heart failure (CHF) - a condition with low heart output and the	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 31 body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic kidney disease (a gradual loss of kidney function over time). The "Annual Minimum Data Set" (MDS) dated 06/25/21 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. She required supervision to extensive assistance of one staff member for "Activities for Daily Living" (ADLs) and used a walker and wheelchair for mobility. The "Quarterly MDS" dated 09/09/21 documented a BIMS score of 15, which indicated intact cognition. R20 required supervision to extensive assistance of one staff member for ADLs. R20 used a walker and wheelchair for mobility. The "ADL Care Area Assessment (CAA)" dated 06/25/21 documented R20 had alterations in her ADL function related to her history of CHF. The "Circulatory Care Plan" revised 12/29/19 directed staff to give anti-hypertensive (a medication used to treat elevated blood pressure) medications as ordered, and to monitor for side effects such as orthostatic hypotension (a low blood pressure) and an increased heart rate. Under the "Orders" tab report in the EMR for R20 documented an order with a start date of 02/04/21 for carvedilol (a medication used to treat HTN and CHF) 12.5 milligrams(mg) to take by mouth twice daily for CHF, and hold if systolic blood pressure (SBP) reading was less than 110	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 32 or pulse reading was less than 55 beats per minute . This order was discontinued on 06/04/21. Under the "Orders" tab report in the EMR for R20 documented an order with the start date of 06/05/21 for carvedilol tablet 12.5 mg by mouth twice a day for atrial fibrillation, hold SBP was less than 110 or pulse was less than 55 beats per minute. The June 2021 to September 2021 "Medication Administration Record (MAR)" for R20 lacked documentation that blood pressure and/or pulse readings were obtained as ordered twice daily when administering R20's carvedilol. On 09/23/21 at 08:28 AM R20 was observed in her room sitting in her wheelchair at her bedside table eating breakfast, she had her oxygen on via nasal canula (a hollow device used to supply supplemental oxygen) and she showed no signs of distress. In an interview with Certified Medication Aide (CMA) R stated on 09/27/21 at 4:38 PM that a medication would be held (not given) due to ordered blood pressure and/or pulse parameters, and he would then notify the nurse of reading and the medication that was held. He further stated that the physician and/or nurse practitioner put in their own new orders, otherwise the nurse that received the order enters the order into the MAR after it is verified with the provider. In an interview with Licensed Nurse (LN) G on 09/27/21 at 04:48 PM stated that a medication should be held when blood pressure and/or pulse reading were below ordered parameters, unless a	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 33 physician specifically did ask for the parameters. There is a pop-up screen that will come up on the MAR to flag the blood pressure or pulse reading if it was outside of ordered parameter and would ask if they still wanted to administer the medication. The medication should be held, and a note entered in the MAR as well as a progress note as to why the medication was held. The new medication orders are entered into the MAR when they are received, but sometimes the provider enters their own orders into the MAR. The night supervisor audits all the orders that were entered each day. In an interview with Administrative Nurse D on 09/27/21 at 05:25 PM stated that he received the monthly pharmacy reviews by email, then he printed them out and are given to the correct provider, the recommendation for the nurses are given to the charge nurses and completed by them. The pharmacist comes monthly to review the resident's medical records. A blood pressure medication should have ordered parameters for blood pressure and/or pulse if the provider wanted them. All new orders get entered the MAR when they are received, sometimes the provider will enter their own orders into the MAR. The MDS Coordinator and nurse managers check the orders frequently for errors. The undated facility policy "Medication Administration" documented: All medication will be administered to every elder as ordered by a physician in a safe and sanitary manner. If a drug requires pre-administration assessment such as pulse or blood pressure, perform before administering drugs. Administer medication as specified by the manufacturer- take pulse rate prior to cardiac rhythm medications.	F 757			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page 34	F 757			
F 880 SS=E	The facility failed to ensure that staff monitored R20's blood pressure and/or pulse prior to administering ordered carvedilol (which included a written blood pressure and pulse parameter), which had the potential for the administration of unnecessary medications and unwarranted adverse side effects. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 35 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 150 residents.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 36 The sample included 26 residents. Based on observations, record review and interviews the facility failed to ensure that facility staff properly utilized accepted standard universal precautions (infection prevention practices which include, but are not limited to hand hygiene and use of gloves) while performing percutaneous endoscopic gastrostomy (PEG- a tube placed in the stomach that allows a person to receive nutrition through the tube) care for resident (R)68; failed to ensure staff did proper hand hygiene during wound care for R128; failed to ensure that staff used a protective barrier and disinfect a glucometer (a machine used to obtain blood glucose levels) while obtaining R56 blood glucose level; and failed to ensure that a container used to distribute ice to residents glasses was covered and the scoop properly stored. Findings included: - On 09/23/21 at 08:37 AM Licensed Nurse (LN) J entered resident R68's room to do PEG tube care. She donned (put on) clean gloves without washing/sanitizing hands prior to putting on gloves. Certified Nurses Aide (CNA) N also donned clean gloves without washing/sanitizing hand prior to putting them on. When procedure was completed both staff LN J and CNA N doffed their dirty gloves without hand hygiene after, placed a gait belt around R68 and assisted her back to the dining room, hand hygiene was performed after they left the resident. On 09/27/23 at 10:00 AM LN I entered R128's room and performed hand hygiene. She gathered supplies for wound care and placed the clean items on a clean barrier on the bedside table, performed hand hygiene again and donned clean	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 37 gloves. LN I removed the soiled dressing from one wound and cleansed the area. Without performing hand hygiene or changing gloves, she removed a soiled dressing from a different wound and cleansed it with cleaner (she failed to doff dirty gloves and do hand hygiene in between each wound). She doffed gloves and did hand hygiene and donned clean gloves. She obtained a clean dressing and applied the dressing as ordered to wound areas. LN I then doffed gloves and performed hand hygiene. On 09/23/21 at 08:01 AM LN H entered R56's room, she placed the glucometer, insulin pen, and medication cup on the tray table. No barrier was placed under the glucometer. LN H donned gloves and placed testing strip into the machine, and held the machine in his hand, cleansed the resident's finger, lanced resident's finger with the lancet (an device that has a small needle/scalpel to obtain small blood specimens) LN H disposed of lancet in sharps container, doffed gloves, did hand hygiene, then donned clean gloves. He then cleansed residents right lower belly area, and injected ordered insulin (a hormone made in your body that allows your body to use glucose for energy). LN H then carried the glucometer, insulin pen, and lancet container back to the medication cart and placed it in the top drawer. He did not disinfect glucometer before placing it in the drawer. On 09/21/21 at 08:10 AM observation revealed a cart that had a tray of uncovered ice on it that was outside of the serving area in the main dining area. A green handled slotted spoon laid in the ice with the handle touching the ice. On 09/22/21 at 01:10 PM a cart sitting outside of	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 38 the serving area was observed to have a tray/container of uncovered ice with a slotted scoop spoon laying in the ice. In an interview on 09/27/21 at 4:38 PM Certified Medication Aide (CMA) R stated that hand hygiene should be done when they first enter the facility, in between care of each resident, after taking a resident to the bathroom, in between glove changes, and in between each resident when passing medications. In an interview on 09/27/21 at 02:20 PM LN I stated that hand hygiene and gloves changed should be done in between each wound, but R128 wound not have allowed her to complete the treatment had she done that. In an interview on 09/27/21 at 04:48 PM with LN G stated that hand hygiene should be performed before and after providing care; before and after donning and doffing of gloves; and, should be done before, during, and after each wound during wound care. In an interview on 09/27/21 at 05:09 PM Administrative Nurse and Infection Preventionist E stated that hand hygiene should be done before and after each resident's care, hands can be sanitized up to five times before being washed again. Hands should be sanitized after taking gloves off, and gloves should be changed in between each dirty to clean wound dressing change and in between each wound site. A barrier should be placed underneath of the glucometer before it is placed on a resident's bedside table, and the glucometer should be sanitized after each use.	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 39 In an interview on 09/27/21 at 03:50PM with Certified Dietary Manager (CDM) BB stated that he was not aware that his staff was using a clear container and a scoop for ice. He stated that was not normal practice and there was an ice machine at the drink center that should be used to fill resident's cups with ice. If they did use and ice chest and/or other type of container for ice, there should be a lid on it when not in use and the scoop should never be left in the ice container. The facility policy "Infection Control Policy" dated 7/30/21 documented: The facility will facilitate safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The facility will follow Standard Precautions for Infection Control and Prevention including but not limited to: Hand hygiene-refers to both washing with plain or anti-microbial (a substance used to reduce the number of bacteria) soap and water and use of alcohol gel; when hands are not visibly soiled, alcohol gel is preferred method of hand hygiene. Perform hand hygiene: before and after contact with a resident; immediately after touching blood, bloody fluids, non-intact skin, mucous membranes or contaminated items; immediately after removing gloves; when moving from contaminated body sites to clean body sites during resident care area; after touching objects and medical equipment in immediate resident care area; before eating; after using restroom; and after coughing or sneezing in to a tissue. The facility policy "Finger Stick Blood	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 40 Sugars/Hypoglycemia (a low blood sugar reading)/Hyperglycemia (an elevated blood sugar reading)" dated 09/01/21 documented: It is the policy of this facility that the management of finger stick blood sugars involves the use of Point Click Care and the "Electronic Medication Administration Record (EMAR)". Procedure: Gather equipment; wipe down blood glucose monitor with approved germicidal disposable wipes; explain the procedure to the resident; provide privacy; wash hands; apply gloves; wipe resident's finger with and alcohol wipe, allow to air dry, do not blow on the area; obtain finger stick blood sugar level; discard lancet into a sharps container; wipe down blood glucose monitor with approved germicidal disposable wipes; wash hands; document fingers Blood Glucose/Sliding Scale insulin in EMAR. The facility policy for "Ice Machine/Chest Safety" dated 04/01/21 documented: All employees will use sanitary methods to obtain ice for themselves and for elders and visitors from any ice machine or portable ice chest and elders will use sanitary methods to obtain ice for themselves from self-dispensing ice makers. Only employees may obtain ice if the use of an ice scoop is needed; scoop must be clean; when and ice scoop is reused, it must be stored in an upright position in a clean container, ensuring that all moisture has been drained off the scoop before placing in a clean container; Keep ice container closed except when removing ice. The facility failed to ensure staff used standard precautions and proper use of hand hygiene when providing PEG tube care for R68, failed to ensure staff used standard precautions and proper use of gloves and hand hygiene during	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2021
NAME OF PROVIDER OR SUPPLIER VILLA ST FRANCIS CATHOLIC CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 W. 126TH ST OLATHE, KS 66062		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 41 wound dressing change and care for R128, failed to ensure staff used standard precautions during routine testing of blood glucose for R56, and failed to ensure staff stored ice in a covered container and stored the scoop in a container that ensured moisture drained off the scoop after being used. These practices had the potential for the development and spread of infectious disease to residents and staff.	F 880			