

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

PRINTED: 01/14/2021
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 C 12/31/2020	
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			
	The following citations represent the findings of complaint investigation #KS00158976. The 2567 was sent electronically to the facility on 1/14/21.						
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility identified a census of 138 residents. The sample included seven residents reviewed for misappropriation. Based on record review, observation, and interview, the facility failed to ensure Resident (R)1 was free from misappropriation when a facility staff member deceived R1 into transferring funds from R1's bank account to Administrative Staff B's personal bank account. Administrative Staff B used to her position of trust within the facility to ensure R1 the funds were being transferred to the facility to cover R1's bill. This placed R1 at risk for negative psychosocial outcomes. Findings included: - R1's electronic medical record (EMR) documented diagnoses under the "Diagnosis" tab which include dysphagia (swallowing difficulty),			F 602			

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

TITLE

(X6) DATE

01/14/2021

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: 01/14/2021
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 C 12/31/2020
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 602	Continued From page 1 anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and hypertension (elevated blood pressure). The "Annual Minimum Data Set" (MDS) dated 04/23/20 documented a "Brief Interview for Mental States" (BIMS) score of 15 which indicated intact cognition. The "Quarterly" MDS dated 10/23/2020 documented a BIMS Score of 15 which indicated intact cognition. The "Care Area Assessment" (CAA) for "Cognition" dated 04/23/2020 did not trigger. The "Care Plan," initiated on 04/29/19 for R1 recorded she was at risk for altered mood/behavior due to anxiety related to her finances. This was resolved 10/03/2019 with no further care plan regarding finances noted. Review of the EMR and facility records lacked evidence of written or verbal authorization from the resident for Administrative Staff B or any facility staff member to withdraw money from R1's personal checking account. Review of the ongoing "Facility Investigation" revealed Administrative Staff B started work in the facility in the business office in April 2019. She resigned her position in December, 2020. Administrative Staff A began reviewing accounts, Administrative Staff A noted a large balance due on R1's account. When Administrative Staff A discussed the situation with R1, R1 indicated she had been paying her balance monthly. Together with R1, Administrative Staff A checked account	F 602			

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

PRINTED: 01/14/2021
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 C 12/31/2020
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 602	Continued From page 2 status and transfers for R1's account. It was noted the amount of R1's liability due to the facility each month was transferred from R1's account to an unknown account not associated with the facility. Further investigation revealed the last four digits of the account where R1's funds were being transferred matched the last four digits of Administrative Staff B's personal account used by the facility to direct deposit Administrative Staff B's earnings. Administrative Staff A interviewed R1 and learned Administrative Staff B had assisted R1 in establishing the payments with the explanation the funds were being used to pay R1's facility bill. Administrative Staff A notified local law enforcement, state agencies as applicable, and other relevant entities of the discrepancy. Per the ongoing "Facility Investigation", the misappropriation of R1's funds occurred monthly between April 2019 and December 2020. Review of R1's electronic bank statements from August 2019 to December 2020 revealed there were withdrawals which exceeded \$60,000 to a bank account that belonged to Administrative Staff B. On 12/30/2020 at 01:35 PM Administrative Nurse E stated that no one had been aware that this occurred. It was not discovered until after Administrative Staff B had quit. On 12/30/20 at 03:58 PM Administrative Staff A stated Administrative Staff B was only in charge of receiving private payments and the other accounts (Medicare and Medicaid) were done monthly and reviewed at that time. At the end of the month the facility did a "month end close" to	F 602			

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

PRINTED: 01/14/2021
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 C 12/31/2020
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 602	Continued From page 3 verify the total payment received off verses what was entered in the electronic system. Administrative Staff A stated there were several people involved in the total oversight of the process. She said the situation was identified due to missing liability payments. Administrative Staff A stated Administrative Staff B had circumvented the process by manually changing R1's facility account to a zero balance. Administrative Staff A stated she learned R1 had met with Administrative Staff B, who helped R1 establish an account to send her payments to. The account was Administrative Staff B's personal account and not a facility account. Administrative Staff B zero'd out the account for the residents liability each month so that it appeared there were no funds payed or owed. There were only two other residents that facility staff assisted with their payment from their personal account. Both were direct deposit and no account discrepences were noted when reviewed during the facility investigation. On 12/31/2020 at 02:42 PM R1 laid in her bed with her blankets up to her chin. She appeared comfortable while she watched television. She stated she was not aware that Administrative Staff B had taken any money from her until told by Administrative Staff A. R1 stated Administrative Staff B helped her set up a direct deposit from her personal checking account to be able to pay the amount owed monthly to the facility directly to the facility account. R1 stated Administrative Staff B helped her set that up when R1 arrived at the facility. R1 stated she did not have any worry or concern regarding the incident because Administrative Staff A had already discussed it with her, and the facility had taken care of any outstanding balance. She further stated she	F 602			

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

PRINTED: 01/14/2021
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 C 12/31/2020
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 602	Continued From page 4 enjoyed living in the facility, felt safe, received very good care, and was not worried about her finances at that time. In an interview on 12/30/20 at 04:14 PM Administrative Staff C stated he called Administrative Staff B and asked her about what had occurred with R1. Staff C stated when he told Staff B the facility matched the account with her personal account, Staff B started to cry and said that she had financial difficulties due to court costs. Staff C stated Staff B said that she would show the facility her account information to verify there were no other residents she had done this to. The facility had not received her account information. Administrative Staff C stated Staff B indicated she had planned to "pay the money back" in January. On 12/31/20 at 08:36 AM Administrative Staff B declined to comment on the situation with R1, stating her lawyer had directed her to not answer. The facility policy "Reporting Abuse to Facility Management" that lacked a date, documented it was the responsibility of employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The facility failed to protect R1 from	F 602			

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

PRINTED: 01/14/2021
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 C 12/31/2020
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 602	Continued From page 5 misappropriation when Administrative Staff B deceived R1 into creating a direct deposit to Administrative Staff B's personal account while leading R1 to believe R1 was paying her facility monthly bill. This failure had the potential to create a negative psychosocial outcome for R1.	F 602			