

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

PRINTED: 05/28/2023
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 05/23/2023	
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 550 SS=D	The following citations represent the findings of a Health Resurvey and Complaint #KS00177319 and KS00172014. The 2567 was sent electronically on 05/30/23. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the			F 550			

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.

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect for one resident, Resident (R) 69, when another resident urinated on her while in the dining room. This placed R69 at risk for impaired dignity and psychosocial wellbeing. Findings included: - The Electronic Medical Record (EMR) for R69 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The "Quarterly Minimum Data Set" (MDS), documented R69 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and extensive assistance of one staff for eating and	F 550			

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F 550	Continued From page 2 personal hygiene. R69's "Care PLaN" dated 05/03/23 documented R69 was at risk for altered mood related to depression and directed staff to monitor for agitation, and behaviors. The care plan directed staff to honor her interpersonal space, maintain a distance, do not crowd or touch her. The plan directed staff to always prepare R69 if staff were going to touch her, and report to the physician any changes in mental health status. The "Nurse's Note," dated 02/26/23 at 07:10 AM, documented R69's colleague urinated on her at the common area in the dining room. The resident was cleaned up and taken away. The EMR lacked any follow-up related to the incident. On 05/22/23 at 03:35 PM, observation revealed R69 sat in her Broda chair (positioning chair), at the dining room table. On 05/18/23 at 01:00 PM, Certified Nurse Aide (CNA) O stated R69 had been urinated on when R69 was in bed but CNA O did not know about the incident in the dining room; CNA O stated it had happened more than once. On 05/18/23 at 01:30 PM, Administrative Nurse E stated she had not been made aware of the incident in the dining room but said she would investigate and talk with staff. At 03:00 PM, Administrative Nurse E stated the incident would be thoroughly investigated, reported, and the resident that urinated on R69 would be placed with staff 1:1. Administrative Nurse E further stated the physician and family were made aware	F 550			

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F 550	Continued From page 3 and R69's family had not seen any changes in R69's mood or psychosocial well being. Administrative Nurse E said staff would be educated on reporting after any incidents. On 05/22/23 at 10:09 AM, Licensed Nurse (LN) K stated there had not been a change in R69's behaviors since the incident and there had not been any further incidents between the two residents. LN K further stated, if residents were in the dining room, a staff member was always present. On 05/22/23 at 03:16 PM, Social Services X stated she had contacted the physician and family regarding the incident and R69's family visited quite often and had not seen any changes in the resident's behavior or demeanor. On 05/23/23 at 10:11 AM, Administrative Nurse D stated he had reported the incident and staff were educated on reporting. Administrative Nurse D further stated the facility was taking precautions so this would not happen again. The "Quality of Life-Accommodation of Needs" policy, dated 03/28/23, documented the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. The facility failed to promote care in a manner to maintain and enhance dignity and respect for R69 when another resident urinated on her while in the dining room. This placed R69 at risk for impaired dignity and psychosocial wellbeing.	F 550			
F 558 SS=D	Reasonable Accommodations Needs/Preferences	F 558			

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F 558	Continued From page 4 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to provide a comfortable table height while dining for Resident (R) 65. This placed the resident at risk for discomfort and weight loss. Findings included: - The Electronic Medical Record (EMR) for R65 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, pain, and need for assistance with personal cares. The "Quarterly Minimum Data Set" (MDS), dated 04/03/23, documented R65 had severely impaired cognition and required extensive assistance of two staff for transfers, extensive assistance of one staff for bed mobility, ambulation, dressing, and personal hygiene. The assessment documented R65 required supervision and set-up assistance for eating. The "Care Plan," dated 04/21/23, documented R65 was at risk for self-care deficit and emotional	F 558			

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F 558	Continued From page 5 well-being and directed staff to monitor for poor appetite, and used a pedal Broda chair (positioning chair) for mobility. On 05/17/23 at 12:14 PM, observation revealed R65 in her Broda chair at the dining room table. Further observation revealed the edge of the table was at chin level of the resident. Continued observation revealed R65 took the top of the croissant (roll) with her fork and tried to eat it. On 05/18/23 at 12:12 PM, observation revealed R65 at the dining table. The table was at her shoulder level and she had to take the bowl of fruit off the table and hold it so she could eat it. On 05/22/23 at 12:01 PM, observation revealed R65 in her Broda chair at the dining table waiting for the noon meal. Further observation revealed the edge of the table was at the residents shoulder. On 05/22/23 at 12:13 PM, Licensed Nurse (LN) J stated that if staff sat R65 at a bedside table instead of a dining table,, it would isolate her. LN J was not sure if the dining tables could be lowered. On 05/23/23 at 10:44 AM, Administrative Nurse D stated the facility would look at the tables to see if they could be adjusted for R65 so she would be able to eat better and be more comfortable. The facility's "Quality of Life-Accommodation of Needs" policy, dated 03/28/23, documented the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.	F 558			

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F 558	Continued From page 6	F 558			
F 609 SS=D	The facility failed to ensure the dining room tables were a comfortable height for R65. This placed the resident at risk for discomfort and weight loss. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609			

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F 609	Continued From page 7 The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility staff failed to report to administration a resident to resident incident for one sampled resident, Resident (R) 106, who urinated on another resident. This placed the residents at risk for unidentified abuse and/or ongoing mistreatment. Findings included: - The Electronic Medical Record (EMR) for R106 documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness). The "Admission Minimum Data Set" (MDS), dated 12/29/21, documented R106 had severely impaired cognition and required extensive assistance of one staff for bed mobility, toileting, dressing, personal hygiene, and required supervision and one staff for ambulation. The assessment further documented R106 had inattention, disorganized thinking and wandered daily. R106's "Quarterly MDS," dated 02/27/23, documented R106 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The assessment further documented	F 609			

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F 609	Continued From page 8 R106 had inattention, disorganized thinking, rejection of care one to three days, and other behavioral symptoms one to three days. R106 wandered daily, and his wandering significantly intruded on the privacy or activities of others. R106 received an antidepressant (medication used to treat depression) medication daily. The "Admission Assessment," dated 12/22/21, documented R106 had a history of wandering and was anxious and restless. The "Mood and Behavior Care Plan," dated 03/03/23, initiated on 12/22/21, documented R106 wandered around the special care unit and would go into other resident rooms at times. R106 would mimic the staff and follow them around. The update, dated 01/07/22, directed staff to give R106 time and space to ambulate and self sooth. R106 liked music and to sing. The update, dated 11/14/22, directed staff to give R106 items to fidget with, redirect as possible when wandered, and refer to the physician for review as needed. The update, dated 05/15/23, documented, when R106 declined cares, staff were to ensure he was safe and reapproach later or try other staff to approach. The "Bowel and Bladder Care Plan," dated 03/03/23, initiated on 12/22/21, documented R106 often pulled at his brief as a warning he needed to void or that he felt wet from already voiding. When he was wandering and staff were unable to redirect to the bathroom, staff were to give R106 time and space, redirect back as able, and when R106 paced, it was a warning for the need to be toileted. The care plan directed staff to offer assistance with toileting/check and change upon rising, before and after meals, bedtime, at	F 609			

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F 609	Continued From page 9 01:00 AM, 03:00 AM, at 05:00 AM rounds and as needed. The "Nurse's Note," dated 02/26/23 at 07:00 AM, documented R106 urinated on a fellow resident in the dining room area. The note further documented R106 was seen walking around the dining room prior to him urinating on the resident. The note documented staff took the resident to the bathroom and talked to him about boundaries. On 05/18/23 at 08:30 AM, observation revealed R106 independently wandered in the dining room, singing. R106 approached the surveyor, and tapped the outside of the computer. On 05/18/23 at 01:00 PM, Certified Nurse Aide (CNA) O stated R106 had urinated on another resident when the other was in bed but CNA O did not know about the incident in the dining room on 02/26/23. CNA O stated it had happened more than once. On 05/18/23 at 01:30 PM, Administrative Nurse E stated she had not been made aware of the incident in the dining room on 02/26/23 but said she would investigate and talk with staff. At 03:00 PM, Administrative Nurse E stated the incident would be thoroughly investigated, reported, and R106 would be placed 1:1 with staff. Administrative Nurse E further stated the physician and family were made aware and staff would be educated on reporting after any incidents. On 05/22/23 at 10:09 AM, Licensed Nurse (LN) K stated, since R106 urinated on the other resident there had not been any further incidents between	F 609			

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F 609	Continued From page 10 the two residents. LN K stated R106 had urinated on his roommates bed and on the floor of another resident's room. LN K further stated staff tried to redirect R106 but he could get agitated; staff kept trying. On 05/22/23 at 03:16 PM, Social Service X stated she had contacted the families involved and the physicians. Social Services X further stated she had also contacted the psychologist and he did visit with R106 and gave recommendations. On 05/23/23 at 09:51 AM, LN L stated staff were educated on reporting events and the staff in the Special Care Unit were provided with extra education on behaviors and dementia by outside sources and through computer training. On 05/23/23 at 10:11 AM, Administrative Nurse D stated he had reported the incident and staff were educated on reporting. Administrative Nurse D further stated, the facility was taking precautions so this would not happen again. On 05/23/23 at 11:11 AM, Administrative Staff A stated they have reeducated staff on reporting incidents and are utilizing a report from the computer that would be generated daily to see if there were any incidents or behaviors so they can make sure nothing like the incident with R106 would happen again. The facility "Abuse Prevention Policy and Procedure" dated 09/07/22, documented each resident had the right to be free from abuse and must not be subjected to abuse by anyone, including other residents. The policy further documented, mandated reporters are to	F 609			

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F 609	Continued From page 11 immediately report to their onsite supervisor when they have reasonable cause to believe abuse has occurred. The Director of Nursing and/or administrator shall be immediately notified of all allegations of abuse and neglect. Any incidents of abuse or injuries of unknown origin and resident to resident altercations would be reported to the state. The facility staff failed to report a resident to resident incident to administration awhen R106 urinated on another resident. This placed the residents at risk for unidentified and ongoing abuse and mistreatment.	F 609			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The	F 688			

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F 688	Continued From page 12 sample included 25 residents with two residents reviewed for range of motion difficulties. Based on observation, interview, and record review, the facility failed to provide care and services to maintain range of motion for Resident (R) 61 who had contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in both hands. This deficient practice placed R61 at risk for complications resulting from contracted hands. Findings included: - R61's Electronic Medical Record documented diagnoses of diabetes mellitus (group of diseases that result in too much sugar in the blood (high blood glucose), hypertension (high blood pressure), atrial fibrillation (irregular and often very rapid heart rhythm), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and contractures. The "Quarterly Minimum Data Set" (MDS), dated 02/11/23, documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. The MDS documented R61 required extensive staff assistance with all activities of daily living (ADLs), had range of motion (ROM) impairment in all extremities, and received passive ROM therapy. R61's "ADL Care Plan," dated 04/06/23, directed staff to provide palm protectors in both hands at all times except with hand hygiene. The plan	F 688			

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F 688	Continued From page 13 directed staff to provide range of motion (passive) to maintain current ADL level without avoidable declines. An intervention dated 08/2/21 directed a splint/brace was needed to maintain R61's current level of function of range of motion and further contracture prevention, 5-7 days a week, 15 minutes a day. Another intervention dated 02/22/2023 directed staff R61's splint was on hold at that time due to a skin tear to her hand. On 05/17/23 at 09:58 AM, observation revealed R61 in bed with severe contractures to both hands and no palm protectors in either hand. A sign from therapy services, on the wall by her bed, directed staff to place the right-hand palm protector with the black line facing out, and the left-hand protector with the line facing out. The sign also stated "Please wear these at all times except during hand hygiene." On 05/18/23 at 08:09 AM, observation revealed R61 in bed while Certified Nurse Aide (CNA) M fed her. R61 wore a hospital gown and had no palm protectors in either hand. On 05/18/23 at 12:20 PM, observation revealed CNA M fed R61, who laid in bed with a hospital gown on. R61 had no palm protectors in either hand. On 05/18/23 at 12:50 PM, upon surveyor request, Licensed Nurse (LN) H checked the resident's palms which had no redness but did have some odor. R61 complained of pain when the nurse gently tried to open her hand. LN H used a moist wipe and slowly drew it through R61's contractured palms to clean them and even that slight movement caused R61 pain.	F 688			

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F 688	Continued From page 14 On 05/18/23 at 12:20 PM, CNA M verified the resident did not have the hand splints or palm protectors on and stated he did not know where they were. On 05/18/23 at 12:33 PM, LN H verified the resident should have something in her hands due to the contractures. She stated R61's hand splints had been on hold since February 2022 due to a skin tear. On 05/22/23 at 09:55 AM, Consultant GG stated therapy ordered palm protectors to both R61's hands in February 2022. She stated the resident tilted her head to the side and sometimes food or drink dribbled down to her neck crease, and she had a history of yeast buildup there. Consultant GG stated therapy had provided staff education for ROM and staff were to ensure palm protectors were in at all times. She stated the resident was able to lift her left arm a little and had use of her left thumb. On 05/23/23 at 10:25 AM, Administrative Nurse D verified staff should have placed the palm protectors on the resident at all times. The facility's "Treatment of Contractures" policy, dated 02/01/23, stated restorative staff, nursing staff and therapy staff will work closely to prevent the progression of contractures with treatment of slow, gentle stretching and massage. Contracture treatment plans would be developed and supervised by skilled therapy and the restorative coordinator. Handrolls should be considered part of the routine care of all dependent residents and staff was responsible for keeping the skin clean and dry under the handroll. Staff were to remove the handroll each shift, wash the hand with soap	F 688			

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F 688	Continued From page 15 and water, dry the hand well and then reapply the handroll. The facility failed to ensure palm protectors were in place for R61's contractures in both hands, placing R61 at risk for complications resulting from contracted hands.	F 688			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690			

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F 690	Continued From page 16 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 104, who had incontinence, with toileting opportunities in an effort to avoid incontinence and related complications. This placed the resident at risk for skin breakdown and infections. Findings included: - The Electronic Medical Record (EMR) for R104 documented diagnoses of dementia without behavior disturbance (progressive mental disorder characterized by failing memory, confusion), difficulty walking, and muscle weakness. The "Quarterly Minimum Data Set" (MDS), dated 04/10/23 documented R104 had severely impaired cognition and required extensive assistance of two staff for transfers, toileting, and extensive assistance of one staff for bed mobility, ambulation, and personal hygiene. The MDS further documented R104 was frequently incontinent of bladder and had no toileting program. The "Bowel and Bladder Care Plan," dated 04/25/23, initiated on 11/04/21, documented R104 had a history of incontinence and, due to	F 690			

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F 690	Continued From page 17 dementia, was unable to voice her need to void. The care plan directed staff to use absorbent briefs for incontinence management to keep moisture away from the skin and for dignity, assist with peri-care after each incontinent episode, and to change brief when needed, R104's care plan directed staff to offer assistance with toileting/check and change upon rising, before and after meals, at bed time, 01:00 AM, 03:00 AM, at 05:00 AM rounds and as needed. On 05/18/23 at 11:15 AM, observation revealed Certified Nurse Aide (CNA) P and CNA Q assisted R104 to the bathroom. Further observation revealed CNA P placed a gait belt around R104's waist, took off the foot pedals on the wheelchair, and pushed the resident into the bathroom. Continued observation revealed, the room did not have a trash can and CNA Q had to leave to go find one. Upon her return CNA Q stood behind R104 and both CNA P and CNA Q assisted R104 to stand, and as CNA Q pulled down R104's pants, the incontinence brief was extremely soiled with urine and bowel was noted to be seeping out of the brief up to R104's back. Continued observation revealed when CNA Q removed the incontinence brief, R104's buttocks and the back of her legs were red. CMA P provided personal care, applied barrier cream and a new incontinence brief was placed on the resident. CNA P told CNA Q that R104's shirt was soiled and she would need a clean shirt. R104 was transferred into her wheelchair. On 05/18/23 at 11:20 AM, CNA Q stated R104 should be toileted every two hours and as needed and stated most of the time R104 was dry and she would fight the nurse aides when they tried to	F 690			

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F 690	Continued From page 18 toilet her. CNA Q verified R104 had not been toileted since 08:00 AM, when she was taken to the dining table for breakfast. When CNA Q was asked about the room not having a trash can and where they had thrown away the incontinence brief when they had gotten the resident up, she stated, R104 was dry when they got her up. On 05/22/23 at 12:04 PM, Licensed Nurse (LN) J stated staff offered toileting every two hours. LN J said staff should make sure R104 was toileted as care planned. On 05/22/23 at 01:30 PM LN GG stated a bladder assessment was completed at admission and was resolved so there was not one in the system for review.. On 05/23/23 at 10:34 AM, Administrative Nurse D stated R104 should be toileted on a timely basis and as care planned. The facility's "Bowel and Bladder" policy, dated 02/01/23, documented the facility would ensure a quality assessment and treatment for Bowel and Bladder incontinence and to establish appropriate toileting program for the resident's elimination. An assessment for incontinence was performed as part of the admission process and as clinical judgement determines, Staff will use clinical judgement to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trials. The resident's incontinence would be reviewed and the plan of care updated if there is a change in their baseline. The facility failed to provide R104, who had incontinence, with toileting opportunities in an effort to avoid incontinence and related	F 690			

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F 690	Continued From page 19	F 690			
F 744	Treatment/Service for Dementia	F 744			
SS=D	CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents, with five reviewed for behaviors. Based on observation, record review, and interview, the facility failed to provide the necessary dementia (progressive mental disorder characterized by failing memory, confusion) care and services for Resident (R) 106, who had behaviors of urinating in inappropriate places, grabbing items out of other resident's hands, and wandering. This placed the resident at risk for injury, unmet needs, and imapired quality of life. Findings included: - The Electronic Medical Record (EMR) for R106 documented diagnoses of dementia without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness). The "Admission Minimum Data Set" (MDS), dated 12/29/21, documented R106 had severely				

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F 744	Continued From page 20 impaired cognition and required extensive assistance of one staff for bed mobility, toileting, dressing, personal hygiene, and required supervision and one staff for ambulation. The assessment further documented R106 had inattention, disorganized thinking and wandered daily. R106's "Quarterly MDS," dated 02/27/23, documented R106 had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The assessment further documented R106 had inattention, disorganized thinking, rejection of care one to three days, and other behavioral symptoms one to three days. R106 wandered daily, and his wandering significantly intruded on the privacy or activities of others. R106 received an antidepressant (medication used to treat depression) medication daily. The "Admission Assessment," dated 12/22/21, documented R106 had a history of wandering and was anxious and restless. The "Mood and Behavior Care Plan," dated 03/03/23, initiated on 12/22/21, documented R106 wandered around the special care unit and would go into other resident rooms at times. R106 would mimic the staff and follow them around. The update, dated 01/07/22, directed staff to give R106 time and space to ambulate and self sooth. R106 liked music and to sing. The update, dated 11/14/22, directed staff to give R106 items to fidget with, redirect as possible when wandered, and refer to the physician for review as needed. The update, dated 05/15/23, documented, when R106 declined cares, staff were to ensure he was	F 744			

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F 744	Continued From page 21 safe and reapproach later or try other staff to approach. The "Bowel and Bladder Care Plan," dated 03/03/23, initiated on 12/22/21, documented R106 often pulled at his brief as a warning he needed to void or that he felt wet from already voiding. When he was wandering and staff were unable to redirect to the bathroom, staff were to give R106 time and space, redirect back as able, and when R106 paced, it was a warning for the need to be toileted. The care plan directed staff to offer assistance with toileting/check and change upon rising, before and after meals, bedtime, at 01:00 AM, 03:00 AM, at 05:00 AM rounds and as needed. The "Physician's Order," dated 02/03/22, directed staff to administer Depakote (medication used to treat manic-depressive illnesses), 125 milligrams (mg), by mouth, daily. This order was discontinued on 08/25/22. The "Physician's Order," dated 8/26/22, directed staff to administer Depakote Sprinkles, 125 mg, by mouth, daily. This order was discontinued on 08/29/22. The "Physician's Order," dated 08/30/22, directed staff to administer Depakote Sprinkles, 125 mg, by mouth, in the morning. This order was discontinued on 09/09/22. The "Physician's Order," dated 09/10/22, directed staff to administer Depakote Sprinkles, 125 mg, by mouth at bedtime. The "Physician's Order," dated 10/23/22, directed staff to monitor R106 for agitation with cares and	F 744			

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F 744	Continued From page 22 document the number of behavior episodes, interventions, and effectiveness of the interventions. The "Nurse's Note," dated 01/31/22 at 12:49 AM, documented R106 wandered into other residents' rooms and touched their belongings. The note documented staff found R106 urinating on his roommates bed. Staff were unable to redirect R106. He yelled and pushed staff's hand away when staff attempted to assist R106 to the bathroom. The note further documented toileting was frequently offered but the resident had started to refuse and became angry during cares. The "Nurse's Note," dated 07/28/22 at 01:04 PM, documented R106 wandered, and was disruptive. R106 grabbed food and items from other residents, upsetting residents, and redirection only escalated the behavior. The "Nurse's Note," dated 11/10/22 at 11:41 AM, documented R106 had increased behaviors with going into other resident rooms, including lying on their beds, and taking food from other resident's plates. When staff redirected R106 out of another residents room, he became agitated and did not want to leave. The note further documented R106 would also go over to the other hall on the Special Care Unit and do the same things. The note documented staff continued to redirect and tried to keep R106 occupied with other things but at times staff had to allow R106 to calm down for a few minutes before they tried to redirect him. The "Nurse's Note," dated 11/19/22 at 12:53 PM, documented R106 grabbed food items from other residents, tried to hold other resident's hands and tried to push wheelchairs.	F 744			

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F 744	Continued From page 23 The "Nurse's Note," dated 12/15/22 at 01:50 PM, documented staff tried to help R106 with cares but he would refuse, so staff would leave and try again at a later time to prevent R106 from becoming upset. The "Nurse's Note," dated 12/30/22 at 01:16 PM, documented R106 was restless, wandered, and was difficult to redirect. He grabbed other residents' food. The "Nurse's Note," dated 01/24/23 at 03:34 PM, documented R106 wandered into other resident rooms, grabbed items from other residents, and redirection was not effective most times. The "Nurse's Note," dated 02/02/23 at 02:18 PM, documented R106 required redirection throughout the shift with cares to prevent him from becoming agitated or from getting into other residents' faces. The "Nurse's Note," dated 02/25/23 at 01:45 PM, documented R106 did not want to use the bathroom and staff would continually take him until they were able to get him to go to the bathroom. The "Nurse's Note," dated 02/26/23 at 07:00 AM, documented R106 urinated on a fellow resident in the dining room area. The note further documented R106 was seen walking around the dining room prior to him urinating on the resident. The note documented staff took the resident to the bathroom and talked to him about boundaries. The "Nurse's Note," dated 05/08/23 at 08:04 PM,	F 744			

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F 744	Continued From page 24 documented R106 was intrusive, grabbed other residents' food and items, and staff redirected. On 05/18/23 at 08:30 AM, observation revealed R106 independently wandered in the dining room, singing. R106 approached the surveyor, and tapped the outside of the computer. On 05/18/23 at 01:00 PM, Certified Nurse Aide (CNA) O stated R106 had urinated on another resident when the other was in bed but CNA O did not know about the incident in the dining room. on 02/26/23. CNA O stated it had happened more than once. On 05/18/23 at 01:30 PM, Administrative Nurse E stated she had not been made aware of the incident in the dining room on 02/26/23 but she would investigate and talk with staff. At 03:00 PM, Administrative Nurse E stated the incident would be thoroughly investigated, reported, and R106 would be placed 1:1 with staff. Administrative Nurse E further stated the physician and family were made aware and staff would be educated on reporting after any incidents. On 05/22/23 at 10:09 AM, Licensed Nurse (LN) K stated, since R106 urinated on the other resident there had not been any further incidents between the two residents. LN K stated R106 had urinated on his roommates bed and on the floor of another resident's room. LN K further stated staff tried to redirect R106 and he can get agitated, but staff kept trying. On 05/22/23 at 03:16 PM, Social Service X stated she had contacted the families involved and the physicians. Social Services X further stated she had also contacted the psychologist	F 744			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 05/23/2023
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		
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F 744	Continued From page 25 and he did visit with R106 and gave recommendations. On 05/23/23 at 09:51 AM, LN L stated staff were educated on reporting events and the staff in the Special Care Unit are provided with extra education on behaviors and dementia by outside sources and through computer training. On 05/23/23 at 10:11 AM, Administrative Nurse D further stated, the facility was taking precautions so this would not happen again. On 05/23/23 at 11:11 AM, Administrative Staff A stated the facility reeducated staff on reporting incidents and are utilizing a report from the computer that would be generated daily to see if there were any incidents or behaviors so they can make sure nothing like the incident with R106 would happen again. The "Behavior Assessment, Intervention and Monitoring" policy, dated January 2023, documented the facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The behavior symptoms would be identified using facility approved behavioral screening tools and the comprehensive assessment. The team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies would be implemented immediately if necessary to protect the resident and others from harm.	F 744			

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F 744	Continued From page 26 The facility failed to provide the necessary dementia care and services for R106. This placed the resident at risk for injury, unmet needs and impaired quality of life.	F 744			
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: The facility had a census of 118 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed to provide food prepared in puree form (to chop or grind into a thick paste), from a standardized recipe for eight residents who received pureed meals which placed the residents at risk to not receive essential nutrients. Findings included: - On 05/18/23 at 11:10 AM, observation revealed Dietary Staff (DS) CC prepared the noon meal of which one of the menu items consisted of zucchini. DS CC placed the zucchini, with the liquid it had been prepared with, into the facility's blender. DS CC initiated the blender, added tap hot water and a commercial thickening agent. The facility's "Pureed Seasoned Zucchini" recipe instructed to place prepared, drained, vegetables in food processor and blend until a smooth consistency. The recipe instructed to add prepared hot broth if product needed thinning.	F 805			

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F 805	Continued From page 27 The recipe specifically directed not to use water. On 05/23/23 at 08:09 AM, DS BB verified DS CC had not followed the zucchini pureed recipe, by adding water, which changed the nutrient value. The facility's "Food Preparation and Service" policy, dated 03/13/23, documented food will be prepared and served in accordance with resident wishes and/or diets ordered. Diets may include but not limited to mechanically soft, puree, fortified foods, supplements, etc. The facility failed to follow pureed diet recipe which placed eight residents at risk to not receive essential nutrients from the facility's kitchen.	F 805			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812			

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F 812	Continued From page 28 This REQUIREMENT is not met as evidenced by: The facility had a census 118 residents. The sample included 25 residents. Based on observation, record review, and interview, the facility failed store, prepare, and serve food, in a sanitary condition for residents who received meals from the facility kitchen, which placed them at risk for food borne illness. Findings included: - On 05/18/23 at 11:00 AM, during observation of the kitchen, Dietary Staff (DS) BB reported the main kitchen dishwasher had not been working since 05/13/23. DS BB stated the repair required a part that had not been received. The kitchen was utilizing the three-compartment sink for washing cook and prep ware. The Hydrion Micro Essential sanitation test strip had an expiration date of September 15, 2021. DS BB reported she was not aware the testing strips had an expiration date. The facility's "Sanitation" policy, dated 11/01/22, documented manual washing and sanitizing will employ a three-step process for washing rinsing and sanitizing. Quaternary ammonium compound for time designated by the manufacturer. The facility failed to store, prepare, and serve food in a sanitary condition by using expired sanitation test strips which placed the residents at risk for food borne illness.	F 812			