STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175115	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Francis Catholic Care Center Inc	16600 W. 126th St Olathe, KS 66062

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 136 residents. The sample included 27 residents with three residents reviewed for dignity. Based on observation, record review, and interviews the facility failed to provide services in a dignified manner for Resident (R) 1 when staff stood over R1 while feeding her a pudding cup. This deficient practice placed R1 at risk for impaired dignity and decreased psychosocial well-being. Findings Included: - R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), muscle weakness, dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hyperlipidemia (condition of elevated blood lipid levels), major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (condition with disordered or absent language function), respiratory failure (not enough oxygen passes from your lungs to your blood), and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R1 should not have an interview for mental status, as she was rarely understood. The MDS documented R1 was dependent on staff for oral hygiene, toileting, dressing, eating, and showers. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/28/24 documented R1 had alterations in her activities of daily living (ADL) function related to a diagnosis of cerebral palsy, and R1 was dependent on staff for ADLs. R1 used nonverbal cues, and staff anticipated R1's needs. R1's Care Plan dated 05/27/21 documented R1 needed assistance with eating. R1 required a pureed diet, with pudding thick fluids. R1's plan of care documented R1 was at nutritional risk due to cerebral palsy and dysphagia. R1's plan of care documented she was at risk for dehydration due to thickened liquids, she had a good appetite since admission and needed total assistance from staff for eating. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24 at 01:12 PM R1 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room while Licensed Nurse (LN) H stood over R1 and fed her a pudding cup. On 12/31/24 at 08:09 AM LN G stated staff should always sit and be at eye level with the resident. LN G stated staff should be engaged with the resident in conversation, even if the resident cannot communicate. On 12/31/24 at 08:22 AM Certified Nurse Aide (CNA) M stated staff should always sit next to the resident and never stand over the resident while helping the resident eat or drink. On 12/31/24 at 10:01 AM, Administrative Nurse D stated all staff members should sit next to the resident when they helped any resident with eating. The facility's Dignity policy dated 11/01/22 documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall always be treated with dignity and respect. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed hairstyles, nails, facial hair, etc.). Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns. The facility failed to ensure R1's dignity when staff stood while feeding R1 a pudding cup. This deficient practice placed R1 at risk for impaired dignity and decreased psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 136 residents. The sample included 27 residents. Three residents were sampled for reasonable accommodations of resident needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 16's call light was within her reach. This deficient practice left R16 vulnerable to unmet care needs due to the inability to call for staff assistance. Findings included: - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), cardiac arrhythmia (a condition where the heart beats abnormally), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented a mental status interview should not be conducted as R16 was rarely or never understood. The MDS documented R16 was dependent on staff for toileting, bathing, dressing, and eating. The Cognitive Loss/Dementia (CAA) dated 02/19/24 documented R16 was at risk for cognition decline due to her diagnosis of Alzheimer's disease. The Urinary Incontinence and Indwelling Catheter CAA dated 02/19/24 documented R16 was started on a toileting diary on admission, and a toileting pattern was not noted. R16 required staff assistance for toileting. R16's Care Plan dated 02/14/22 documented R16 was at risk for falls due to confusion and poor safety awareness. She was impulsive and tried to do for herself when she was unable. Staff were to ensure R16's call light was within her reach and anticipate her needs such as toileting and snacks. On 12/23/24 at 07:27 AM, R16 laid on her bed, her call light was dangling off the bed on the floor, and R16's call light was not within her reach. On 12/30/24 at 08:02 AM R16 laid in her bed, R16's call light was clipped to the room dividing curtain, and R16's call light was not within her reach. On 12/31/24 at 08:09 AM Licensed Nurse (LN) G stated call lights should be within the resident's reach. On 12/31/24 at 08:22 AM, Certified Nurse's Aide (CNA) M stated residents' call lights should be pinned to the resident or be within their reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 10:01 AM Administrative Nurse D stated the resident's call light was to be placed within the resident's reach. The facility's Accommodation of Needs policy dated 11/01/24 documented each elder has a right to reside and receive services at this facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the elder or other elders would be endangered. The facility maintains a safe, functional environment for all elders residing in the facility. Interior spaces meet the needs of each elder and the elder population in its entirety for safety and suitability for the care, treatment, and services provided. It is understood that interior spaces contain necessary equipment and therapeutic activities required to accomplish each eider's goals, but the environment will be arranged and maintained in a way that does not compromise the safety of the environment and will not detract from the environment of home provided by the facility. The facility failed to ensure R16's call light was within her reach. This deficient practice left R16 vulnerable to unmet care needs due to the inability to call for staff assistance.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41713 The facility identified a census of 136 residents. The sample included 27 residents with three residents reviewed for Beneficiary Notification. Based on record review and interview the facility failed to ensure a Centers for Medicare and Medicaid Services (CMS) form 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form was provided to Resident (R) 117. This placed R117 at risk of uninformed treatment decisions and unexpected costs. Findings included: - A review of R117's Electronic Medical Record (EMR) documented that her Medicare Part A episode began on 10/01/24 and ended on 10/09/24. R117 remained in the facility for custodial care. R117 was provided the CMS form-10123 Notice of Medicare Non-Coverage (NOMNC) on 10/07/24. R117 was not issued the SNF ABN, form CMS-10055 as required. On 12/31/24 at 10:29 AM Social Services X stated she had been issuing the ABNs except for residents on managed care as their insurance directed the care and would send the documents. Social Services X stated to her understanding, the ABN was not made mandatory until after 10/31/24. The Medicare Denial Notices (Advance Benefit Notification- ABN) policy dated 11/01/24 documented: The SNF ABN would be issued to the resident or representative by the facility staff in the following situations- In the situation the facility believed Medicare would not pay for extended care items or services that the physician had ordered, the facility would provide a SNF ABN to the resident or representative prior to furnishing the non-covered extended care items or services to the resident. In the situation in which the facility recommended a reduction to the resident's extended care items or services because other facility anticipated that Medicare would not pay for a subset of extended care items or services, or for any items or services at the current level and or frequency of care that a physician had ordered, the facility would provide a SNF ABN to the resident or representative prior to reducing the items or services to the resident. Or in the situation in which the facility proposed to stop furnishing all extended care items or services to the resident because the facility expected that Medicare would not continue to pay for items or services that the physician had ordered and the resident would like to continue receiving the care, the facility would provide a SNF ABN to the resident/representative prior to terminating extended care items or services. The facility failed to ensure a CMS-10055 SNF ABN form was provided to R117. This placed R117 at risk of uninformed treatment decisions and unexpected costs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 136 residents. The sample included 27 residents with three residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 1 with grooming and failed to ensure R1's fingernails were cut short and kept clean. This deficient practice placed R1 at risk for impaired dignity, comfort, and further decline in ADL. Findings Included: - R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), muscle weakness, dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hyperlipidemia (condition of elevated blood lipid levels), major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (condition with disordered or absent language function), respiratory failure (not enough oxygen passes from your lungs to your blood), and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R1 should not have an interview for mental status, as she was rarely understood. The MDS documented R1 was dependent on staff for oral hygiene, toileting, dressing, eating, and showers. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/28/24 documented R1 had alterations in her ADL function related to a diagnosis of cerebral palsy R1 was dependent on staff for ADLs. R1 used nonverbal cues and staff anticipated R1's needs. R1's Care Plan dated 05/27/21 documented R1 preferred to take a shower, on Tuesdays and Fridays during the day. R1's plan of care documented R1 required assistance with eating. R1 required a Hoyer (total body mechanical lift) lift assist of two staff with transfers. Staff were to keep R1's nails short, and to ensure her safety with hand movements. On 12/23/24 at 08:22 AM R1 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room, and staff assisted her with eating. R1's fingernails were not trimmed short and R1 had a dark substance under her nails. R1's hair appeared greasy and was uncombed. On 12/30/24 at 8:12 AM, R1 sat in the dining room while staff assisted her with eating breakfast. R1's fingernails were not trimmed and there was a dark substance under her fingernails. R1's hair was greasy and uncombed. On 12/31/24 at 08:09 AM Licensed Nurse (LN) G stated R1 got a bed bath twice a week. She stated staff should have looked at R1's fingernails to ensure they were clean and cut short. She stated R1's fingernails were kept short to ensure she was not scratching herself. LN G stated the resident's hair should have been washed when she needed it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 08:22 AM Certified Nurse Aide (CNA) M stated she would talk to the nurse before cutting anyone's fingernails. She stated the charge nurse let her know if anyone needed their nails trimmed and she would trim them. CNA M stated she would give baths or showers if they were to be done on her shift. On 12/31/24 at 10:10 AM, Administrative Nurse D stated all nursing staff have access to the care plan and would know which residents required their fingernails to be trimmed short. All nursing staff should have monitored residents to ensure each resident's fingernails were kept clean. Administrative Nurse D stated CNAs fill out a shower sheet for each resident on his or her shower day. He stated this was also documented in the resident's EMR. The facility's ADLs policy dated 11/01/24 documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff will ensure that each resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable, including: bathing, dressing, grooming, transferring, locomotion, ambulation, toileting, eating, and communication including using speech, language, or other functional communication systems specific to the needs of the individual resident. The facility failed to ensure staff assisted R1 with grooming and failed to ensure her fingernails were cut short and clean. This deficient practice placed R1 at risk for impaired dignity and further decline in ADLs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 136 residents. The sample included 27 residents with four reviewed for pressure ulcers (localized injury to the skin or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 66's low air-loss mattress was set to the appropriate weight settings for pressure reduction. This deficient practice placed R66 at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Medical Diagnosis section within R66's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, dysphagia (difficulty swallowing), and type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R66's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted bilateral lower extremity impairment. The MDS indicated R66 used a wheelchair for mobility. The MDS indicated R66 required substantial to maximal assistance with bed mobility, transfers, bathing, personal hygiene, dressing, and toileting. The MDS noted R66 was at risk for developing pressure injuries. The MDS indicated R66 weighed 202 pounds (lbs.). The MDS indicated R66 was placed on hospice services. R66's Pressure Injuries Care Area Assessment (CAA) completed 12/10/24 indicated he was at increased risk for pressure ulcers related to his history of incontinence weakness, and immobility. The CAA noted he started hospice services on 11/18/24 due to his cognitive decline and a care plan would be implemented to minimize the risks. R66's Care Plan initiated on 01/07/22 indicated he was at risk for alterations in skin integrity related to his medical diagnoses. The plan noted R66 required extensive assistance from staff for his Activities of Daily Living (ADLs). The plan instructed staff to complete skin inspections during his ADLs. The plan instructed staff to keep R66's linen clean, dry, and wrinkle-free. The plan instructed staff to educate him not to sit for prolonged periods in his wheelchair. The plan instructed staff to offload R66's heels while in bed. R66's EMR under Physician's Orders instructed staff to ensure R66's air mattress was set to his current weight each shift. The order instructed staff to ensure the power unit was on and working. The order instructed staff to ensure the mattress was not set to static. R66's EMR under Vitals noted he weighed 195.9 lbs. on 12/24/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the low air-loss mattress manufacturer's operation guide (Drive Model 14530) indicated the pump and mattress were intended to reduce the incidence of pressure ulcers while optimizing comfort. The guide indicated that firmness can be adjusted based on the recommendations of the health care professional and the patient's weight. On 12/23/24 at 07:05 AM R66 rested in his bed. R66's low air-loss mattress control panel was set to 350 lbs. (maximum weight setting). The Drive low air-loss mattress system range was between 50-350 lbs. adjustable weight increments. The panel indicated the mattress was set to the static setting. On 12/23/24 at 12:45 PM, R66 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room. R66's low air-loss mattress panel was still set to 350 lbs. R66 stated he was not sure about the weight settings or if staff asked him if he wanted it adjusted. On 12/24/24 at 09:54 AM an inspection of R66's low air-loss mattress revealed it was set between 125 lbs. and 150 lbs. On 12/31/24 at 10:02 AM Certified Nurse's Aide (CNA) O stated the low air-loss mattresses should be set to the closest weight setting and staff should check on them each shift. On 12/31/24 at 08:30 AM Licensed Nurse (LN) G stated the air mattresses should be set per the resident's current weight. She stated the mattresses should not be too firm or too soft to be effective at preventing skin injuries. On 12/31/24 at 10:05 AM Administrative Nurse D stated staff were expected to set the pumps per the resident's current weight. The facility's Pressure Ulcer Prevention policy revised 11/2024 indicated the facility will implement preventative interventions to minimize the risk associated with skin breakdown and pressure injuries. The policy noted the facility will utilize pressure redistribution surfaces deemed appropriate based on the resident's risk factors and care needs. The facility's Low Air Loss Mattress policy dated 11/2024 indicated the facility would ensure pressure settings were adjusted to match the resident's current weight as closely as possible. The policy indicated proper use of the air mattresses was essential to prevent pressure injuries and promote resident comfort. The facility failed to ensure R66's low air-loss mattress system was set to his appropriate weight. This deficient practice placed R66 at risk for complications related to skin breakdown and pressure ulcers.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 136 residents. The sample included 27 residents with five residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1's washcloth was applied to her hands. This deficient practice placed the resident at risk for discomfort and decreased range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Findings Included: - R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), muscle weakness, dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hyperlipidemia (condition of elevated blood lipid levels), major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (condition with disordered or absent language function), respiratory failure (not enough oxygen passes from your lungs to your blood), and insomnia (inability to sleep). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R1 should not have an interview for mental status, as she was rarely understood. The MDS documented R1 was dependent on staff for oral hygiene, toileting, dressing, eating, and showers. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/28/24 for R1 had alterations in her activities of daily living (ADL) function related to a diagnosis of cerebral palsy. R1 was dependent on staff for ADLs. R1 used nonverbal cues and staff anticipated R1's needs. R1's Care Plan revised 09/02/24 documented R1 would have passive ROM to maintain her current level of ADL level without avoidable decline. R1's plan of care documented passive range of motion to the right wrist. R1's right wrist presented with contracture (abnormal permanent fixation of a joint or muscle). Staff were to apply a clean washcloth to R1's right hand to prevent contracture daily, the washcloth was acceptable to use in place of a splint. On 12/23/24 at 08:22 AM R1 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room, and staff assisted her with eating. R1 did not have a washcloth in her right hand. R1's right hand was closed tight. On 12/30/24 at 8:12 AM, R1 sat in the dining room staff assisted her with eating breakfast. R1 did not have a washcloth in her right hand. R1's hands were closed tight. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 08:09 AM Licensed Nurse (LN) G stated if a resident's care plan states there should be a washcloth in their hand for contracture, all nursing staff would be responsible for ensuring the washcloth was placed daily. LN G stated all nursing staff have access to a summary of care for each resident. She said she was unsure if the Certified Nurse Aide (CNA) had full access to the care plan. On 12/31/24 at 08:22 AM, CNA M stated she goes by what the charge nurse tells her to do, and the summary of the resident's care paper that was handed to her each morning. CNA M stated she did not know if she could see the full resident's care plan. On 12/31/24 at 10:01 AM, Administrative Nurse D said all nursing staff and CNAs can pull the full care plan up on their phones at any time. He stated each CNA was given a care summary every morning, but they do have access to the care plan. He stated the charge nurse was responsible for ensuring each resident received care as ordered. The facility's Range of Motion policy documented Based on the comprehensive assessment of an elder, facility staff will ensure that each elder who enters the facility without a limited range of motion does not experience a reduction in range of motion unless the elder's clinical condition demonstrates that a reduction in range of motion is unavoidable and an elder with a limited range of motion receives appropriate treatment and services to increase range of motion and, or to prevent further decrease in range of motion. Authorized personnel will use specific protocols when performing a range of motion exercises on elders. Elders of this facility will be provided care to prevent the formation and progression of contractures and deformities. Active and passive ROM exercises are therapeutic activities that are implemented by nursing order. The facility failed to ensure R1's washcloth was applied to her hands to treat her contracture. This deficient practice placed R1 at risk for discomfort and decreased ROM.

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	175115	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Francis Catholic Care Center Inc	16600 W. 126th St Olathe, KS 66062

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 136 residents. The sample included 27 residents, with five residents reviewed for accidents and, or hazards. Based on observation, record review, and interview, the facility failed to secure areas containing hazardous materials to keep them out of reach of 28 cognitively impaired, independently mobile residents. This deficient practice placed the affected residents at risk for preventable injuries and accidents. Findings Included: - On 12/23/24 at 07:10 AM, a walkthrough of the facility was completed with the following observation: An inspection of the 100-unit (secured unit for severely cognitively impaired residents) revealed unlocked closets in the sitting area of the left-side dining room. Both closets contained purple disinfectant wipe containers and tile cleaner spray bottles. All products contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, and harmful if swallowed. An inspection of the facility's HM -hallway revealed a spray bottle of window cleaner in the kitchenette sink. The spray bottle contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, and harmful if swallowed. An inspection of the facility's 600 and 700 hall's lift storage rooms revealed purple disinfectant wipes stored in the rooms. The room's doors were propped open. The wipe's containers contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, and harmful if swallowed. An inspection of the 600-hallway revealed an unlocked electrical panel room. An inspection of the room revealed boxed supplies of personal protective equipment (PPE) and eight large unlocked electrical panels. The panels contained the warning, high voltage - danger of electric shock. At 07:45 AM, Certified Nurse's Aide (CNA) P secured the door and stated all the rooms with potential hazards should remain locked. On 12/31/24 at 08:24 AM, CNA M stated chemicals and electrical rooms should be locked. CNA M stated cleaning materials should never be left out for residents to access. On 12/31/24 at 08:30 AM, Licensed Nurse (LN) G stated the residents should not have access to areas with potential hazards. On 12/31/24 at 10:05 AM, Administrative Nurse D stated staff should never leave potentially hazardous materials within reach or access to the residents. Staff were expected to lock all products and areas with potential hazards. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Accidents policy revised 11/2024 documented the facility will ensure a safe environment for all residents. The policy indicated staff will assess each resident's potential risks, including functional abilities, potential falls, assistive devices, and environment, to ensure resident safety. The facility failed to secure rooms containing hazardous materials out of reach of 28 cognitively impaired, independently mobile residents. This deficient practice placed the affected residents at risk for preventable injuries and accidents.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 136 residents. The sample included 27 residents, with three residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R) 66. This deficient practice placed the resident at risk for delayed services and uncommunicated care needs. Findings included: - The Medical Diagnosis section within R66's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), muscle weakness, dysphagia (difficulty swallowing), and type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R66's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted bilateral lower extremity impairment. The MDS indicated R66 used a wheelchair for mobility. The MDS indicated R66 required substantial to maximal assistance with bed mobility, transfers, bathing, personal hygiene, dressing, and toileting. The MDS indicated R66 was placed on hospice services. R66's Pressure Injuries Care Area Assessment (CAA) completed 12/10/24 indicated R66 was at increased risk for pressure ulcers related to his history of incontinence, weakness, and immobility. The CAA noted R66 started hospice services on 11/18/24 due to his cognitive decline, and a care plan would be implemented to minimize the risks. R66's Care Plan initiated on 01/07/22 indicated he was at risk for skin breakdown, falls, incontinence, and a decline of his Activities of Daily Living (ADLs) related to his medical diagnoses and cognitive decline. The plan noted R66 required assistance from staff for all transfers and his ADLs. The plan noted R66 began hospice services on 11/19/24 and instructed staff to encourage him to express his feelings and allow family support. The plan instructed staff to provide non-judgmental acceptance and compassion. The policy indicated equipment and medication will be provided by hospice per the admission agreement. The plan lacked documentation related to the staff and services provided by his assigned hospice. R66's EMR under Miscellaneous revealed his Hospice Admission form was completed on 11/18/24. The form indicated he was admitted to hospice for senile degeneration (age-related cognitive decline). The form indicated he was assigned a hospice nurse, social worker, and health aide but failed to indicate the date, time, and frequency of the hospice visits. The documentation indicated hospice would provide his low air-loss mattress, Broda chair (specialized wheelchair with the ability to tilt and recline), and incontinence products. The agreement failed to identify which medications the hospice provided. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/24 at 10:44 AM R66 sat in a Broda chair in his room. R66 stated he was put on hospice services and had no concerns with the care provided to him. On 12/31/24 at 08:12 AM Certified Nurse's Aide (CNA) M stated the care plan should include the services provided by hospice, medications, visit frequency, and equipment. On 12/31/24 at 08:25 AM Licensed Nurse (LN) G stated the facility's care plans should indicate the hospice selected, but she was not sure if the care plan identified staffing, equipment, and medications. She stated the hospice admission paperwork should show that information. On 12/31/24 at 10:05 AM Administrative Nurse D stated the facility holds frequent care plan meetings with hospice services to ensure each resident's hospice choices are reflected in the care plan. He stated the plan should notify staff of the hospice service information, equipment, medications, and staff services. He stated staff may also refer to the hospice admission agreement. He stated the agreement should show what service hospice provided and how often they were provided. The facility's Hospice Program policy 01/2023 indicated the facility will create a management program with contracted hospice services to provide quality care for terminally ill residents. The policy indicated the facility will ensure coordinated care planning with each resident, family, and hospice service. The facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-provided services and medication for R66. This deficient practice placed both residents at risk for delayed services and uncommunicated care needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 136 residents. The facility identified 19 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure the blood pressure cuff, pulse monitor, and oxygen saturation equipment were sanitized after each resident's use and further failed to ensure all oxygen cannulas and nebulizer masks were stored in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - On 12/23/24 at 07:07 AM on the initial walk-through of the facility, Resident (R) 1's nebulizer mask laid directly on her dresser on a box next to her bed, and a rolled-up nasal cannula laid directly on the bedside table. On 12/24/24 at 07:18 AM, a tour through the laundry room revealed wet linens were left in the washer overnight. On 12/30/24 at 07:21 AM R1's nasal cannula laid over her oxygen canister next to her bed, unbagged. On 12/30/24 at 07:40 AM Certified Medication Aide (CMA) R obtained an unidentified residents' vital signs. CMA R did not sanitize the blood pressure cuff, pulse monitor, and oxygen saturation equipment before or after the resident's vital signs were obtained. On 12/30/24 at 02:32 PM, R39 was asleep in his electric wheelchair. R39's nasal tubing was thrown over the nightstand in his room and was not in a bag. On 12/31/24 at 08:09 AM, Licensed Nurse (LN) G stated nasal cannulas were stored in a bag when not in use and were changed weekly. LN G stated nebulizer masks were rinsed and laid on a paper towel, and then the mask was put into a bag. LN G stated blood pressure cuffs should be sanitized with wipes before the cuff after each resident's use. On 12/31/24 at 08:41 AM, Housekeeping Supervisor U stated the evening shift would wash a load of linens each evening before they would leave, and this practice helped the laundry department. She stated damp laundry could not be left in the dryer, but it could be left overnight in the washer. On 12/31/24 at 10:01 AM, Administrative Nurse D stated the blood pressure cuff and shared resident equipment should be sanitized after staff used it on a resident. He stated nasal cannulas, if not in use, are placed in a bag. Administrative Nurse D stated nebulizer bulbs and masks were to be rinsed and laid to dry before being bagged. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Infection Control policy dated 11/01/24 documented that the facility will facilitate safe care of all residents and staff with known or suspected communicable diseases by establishing and maintaining an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transition of communicable diseases and infections. The policy applies to all staff members from all departments of this facility, including direct and indirect care staff, contracted staff, consultants, volunteers, and others who provide care and services to residents on behalf of the facility. The facility failed to ensure shared equipment was sanitized after each resident's use and further failed to ensure respiratory equipment was stored in a sanitary manner. These deficient practices placed the residents at risk for infection.