STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175115	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA ST FRANCIS CATHOLIC CARE CENTER INC	**16600 W. 126TH ST OLATHE, KS 66062**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 133. The sample included seven residents. Based on record reviews and interviews, the facility failed to ensure staff assessed and monitored Resident (R)1's changes in mental status in accordance with professional standards of practice., Findings included: - The [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition. She required extensive staff assistance with her Activities of Daily Living (ADLs). The Quarterly MDS dated [DATE] documented R1 had a BIMS score of 3, which indicated severely impaired cognition. She required extensive to total assistance with her ADLs. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/30/19 documented R1 had a self-care deficit and required extensive assistance with ADLs, transfers, and repositioning. She had [DIAGNOSES REDACTED]. The Care Plan revised on 03/04/20 documented R1 had cognitive and communication impairments. She was alert to self and responded to yes or no questions. A Progress Note dated 05/19/20 at 05:59 PM documented R1 had a runny nose. Her blood pressure was 158/94 mmHg (millimeters of Mercury), pulse was 98 beats per minute (BPM), respirations were 18 breaths per minute and regular, temperature was 98.4 degrees Fahrenheit (F), and oxygen saturation level (fraction of oxygen-saturated hemoglobin relative to total hemoglobin the blood) was 96 percent (%) on room air. Staff notified the nurse practitioner and received an order for [REDACTED]. She had a blood pressure of 163/83 mmHg, pulse of 88 BPM, 18 breaths per minute, temperature of 98.6 F, and an oxygen saturation level of 96%. Staff notified the nurse practitioner and R1's representative. The EMR documented a Physician order [REDACTED]. The facility did not receive new orders from the physician regarding the laboratory results. On 05/23/20 the Vital Signs tab of the EMR documented: At 08:16 AM a pulse of 135 BPM and a blood pressure of 159/80 mmHg At 12:22 PM a pulse 100 BPM and a blood pressure of 128/85 mmHg At 01:18 PM a temperature of 96.5F At 04:46 PM a pulse 101 BPM and a blood pressure of 144/79 mmHg At 04:59 PM respirations of 18 breaths a minute. A Progress Note dated 05/22/20 at 09:30 AM documented completion of ongoing monitoring for potential symptoms of respiratory infection with no new symptoms. A progress note dated 05/22/20 at 17:58 PM documented completion of ongoing monitoring for potential symptoms of respiratory infection with no new symptoms. A Progress Note dated 05/23/20 at 08:30 PM documented R1 transferred to the hospital for a change in mental status, lethargy, and abnormal lab results. A SBAR dated 05/23/20 at 08:33 PM documented R1 had mental status changes, was lethargic (lack of energy), and was diaphoretic (excessive sweating in relation to the environment). Her blood pressure was 144/79 mmHg, pulse was 101 BPM and regular, respirations were 18 per minute, temperature was 96.5F, and oxygen saturation level was 91%. The EMR lacked documentation of the R1's continued decline in mental status on 05/23/20 until the SBAR documented on 05/23/20 at 08:33 PM. On 07/13/20 at 10:57 AM Licensed Nurse (LN) G stated she remembered R1 did not feel well on the day she was sent to the hospital. She had a sudden decline in responsiveness and was sent to the hospital that evening. She would call the doctor if a resident had an elevated pulse rate. On 07/13/20 at 11:33 AM LN H stated the resident became weaker and had a decreased appetite recently. She would call the physician if a resident's pulse was greater than 110 BPM or with a generalized change in condition. On 07/13/20 at 12:35 PM Administrative Nurse D stated he expected staff to document changes in residents' condition in the progress notes and they should also complete a SBAR assessment. On 07/13/20 at 04:31 PM Certified Nurse Aide (CNA) M stated she did not think R1 looked well when she saw her the morning of 05/23/20. R1 did not smile as she usually did and she looked sick. She did not eat well. She notified LN G of her concerns. On 07/13/20 at 04:37 PM CNA N stated she noticed R1 did not look like she usually did. She did not eat well. That afternoon R1 had sweat on her arms and she notified LN G. The nurse did come in to check on R1. On 07/14/20 at 10:15 AM Physician Consultant GG stated the older population can show vague signs of physical/mental changes, and by the afternoon hours can become septic . The facility's Change in a Resident's Condition policy dated November 2016 documented the Nurse Supervisor or Charge Nurse recorded in the resident's medical record information relative to changes in the resident's condition. The facility failed to ensure staff assessed, monitored, and documented R1's change in condition in accordance with professional standards of practice.

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