STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175183	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Joseph	11901 Rosewood Overland Park, KS 66209

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 39752 The facility identified a census of 98 residents which included ten residents reviewed for transfers to another room in the facility for the convenience of staff. Based on observations, interviews, and record review, the facility failed to inform Residents (R) 1, R2, R3, R4, R5, R6, R7, R8, and R9 in writing of the impending room change in order to create a hall to group skilled residents. This placed the residents at risk for impaired resident rights and decreased psychosocial well-being. Findings included: - R9's Electronic Medical Record (EMR) recorded a Family Communication Note dated 07/23/24 at 11:10 AM that documented R9 (Brief Interview for Mental Status [BIMS] score of 15 which indicated intact cognition), discussed moving rooms on 07/33/24. R9 was agreeable to a new room. On 08/01/24 at 12:30 PM R9's Notification of Room Change located under the Evaluations tab documented the reason for the room change was a transfer from post-acute to long-term care. Administrative Staff C spoke with R9 and R9's family member on 07/22/24 regarding the move. R3's EMR recorded a Family Communication Note dated 07/23/24 at 12:53 PM that documented R3 (BIMS score of three which indicated severely impaired cognition) was spoken to on 07/23/24 related to changing rooms. R3 stated she was 'OK' with changing rooms if R3's representative was ok with the change. On 08/01/24 at 12:08 PM R3's Notification of Room Change located under the Evaluations tab documented the reason for the room change was R3 being transferred to long-term care from the post-acute unit. Administrative Staff C placed calls to R3's family member on 07/19/24 and 07/22/24 and finally spoke with R3's family member on 07/23/24 regarding the move. R2's EMR recorded a Family Communication Note dated 07/23/24 at 02:15 PM that documented R2 (BIMS score of one which indicated severely impaired cognition) was visited on 07/19/24 regarding changing rooms. R2's representative was also spoken with related to R2's room move and was agreeable to the room picked for R2. On 08/01/24 at 12:16 PM, R2's Notification of Room Change located under the Evaluations tab documented the reason for the room change was to transfer from the post-acute care to long-term care. Administrative Staff C spoke with R2 and R2's representative on 07/19/24 regarding the move. (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's EMR recorded a Family Communication Note dated 07/24/24 at 05:53 PM that documented R5's (BIMS score of 15) family member was given a compassionate ear related to R5's change in rooms. On 08/01/24 at 12:25 PM R5's Notification of Room Change located under the Evaluations tab documented the reason for the room change was to transfer from post-acute to long-term care. Administrative Staff C spoke with R5 and R5's family member on 07/19/24 regarding the move. R6's EMR recorded an Other Note dated 07/25/24 at 10:46 AM that documented R6 (BIMS score of 15) would be taken to see the room R6 would move into by unidentified administrative staff. On 08/01/24 at 12:33 PM R6's Notification of Room Change located under the Evaluations tab documented the reason for the room change was to transfer to long-term care from post-acute care. Administrative Staff C spoke with R6 on 07/19/24 regarding the move. R1's EMR documented a Notification of Room Change dated 08/01/24 at 12:41 PM that documented the reason for the room change was to transfer to long-term care from post-acute care. Administrative Staff C spoke with R1 and R1's family representative on 07/05/24 regarding the move. R7's EMR recorded a Notification of Room Change dated 08/02/24 at 12:37 PM that documented the reason for the room change was to transfer from the post-acute. R4's EMR noted a Notification of Room Change dated 08/05/24 at 12:20 PM, that documented the reason for the room change was to transfer from the post-acute care unit to long-term care. Administrative Staff B spoke with R4's family on 08/05/24 regarding the move. R8's EMR recorded a Notification of Room Change dated 08/05/24 at 12:53 PM that documented the reason for the room change was to transfer from the post-acute care unit to long-term care. Administrative Staff B spoke with R8's family representative and R8 regarding the move. The list of residents provided by the facility via electronic mail on 08/21/24 documented that were recently moved from P hall documented staff spoke with R1 regarding changing rooms and R1's family representative, R2 and R2's family representative, R3 and R3's family representative, R4's family representatives, R5 and R5's family representative, R6, R7 and R7's family representative, R8's family representative, and R9 and R9's family representative to move to a different room. On 08/28/24 at 12:48 PM R1 (BIMS score of 15) lay in his bed with his blankets up to his chest. R1 stated that he knew he was moved for a reason but R1 he could not remember why. On 08/28/24 at 01:40 PM, R6 sat in her wheelchair in her room painting on an easel. R6 stated she was not asked but was told she was moving and the room she was in would be used for dialysis (a procedure where impurities or wastes were removed from the blood). R6 further stated she did not want to move because she would lose her shower. R6 revealed that she had not gotten anything in writing and only remembered hearing about it through word of mouth. R6 revealed she was disappointed with the room move. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/24 at 02:12 PM, R5 appeared well-groomed and clean. R5 sat in her wheelchair watching the television. R5 stated she was told she had to move that the new owners wanted the hallway she used to live on for acute care and that everyone on that hall had to move. R5 revealed she had not received a letter about the move and was not told she could stay if she did not want to move. R5 stated she cried and felt very unhappy about the move. R5 stated she had lived in the facility for over two and a half years, and it was quite upsetting. On 08/29/24 at 03:09 PM, R9 lay in bed with a clean blanket draped over him up to his chest with his arms and hands laid on top of the blanket. R9 stated that he had no option to stay in his old room. R9 revealed that the room move was heard through word of mouth and that neither he nor his family member had received written notice of the room change. R9 stated that if he would thought he could have stayed in his old room, he would have fought it and put up a stink. R9 stated he felt like a number or an object and wished he could have stayed in his old room. On 08/28/24 at 01:15 PM, R1's representative stated neither he nor R1 had received written notification about the room move. R1's representative stated they were not given an option to stay in the room R1 had been in. R1's representative stated that R1 and he chose that room due to it being smaller and that way he would not end up with a roommate. R1's representative stated that the residents and residents' family members were fearful that the bigger rooms with be doubled up with more than one resident in the room. On 08/28/24 at 01:35 PM, R2's representative stated that he had been told that R2 needed to move rooms. R2's representative stated the facility had taken good care of R2 and R2 was not up out of bed so R2's representative had no concerns with the room move. R2's representative verified he had not been informed of the move in writing. On 08/28/24 at 02:10 PM, R7's representative stated she was told that R7's old room was going to be used for therapy. R7's representative stated it took multiple family members making numerous statements to get R7 moved to a room where R7's wheelchair would fit through the bathroom door. On 08/28/24 at 02:21 PM, R3's representative stated that she was told that R3 had to move and that the incoming company wanted everyone moved off of the hall that R3 was on, and the new company wanted to use that hall for rehabilitation. R3's representative stated that she had not received anything in writing explaining the room move, nor was R3 staying in the old room even an option. R3's representative stated if R3 could have stayed in the old room, R3's representative would have wanted that. On 08/29/24 at 02:29 PM, R8's representative stated that the room move happened and there was no choice to be able to stay in R8's current room. R8's representative further revealed that she had received nothing in writing related to the room move. R8's representative stated that R8's room was chosen because it is small because the family was fearful that the bigger rooms in the building were going to be doubled up. On 08/29/24 at 03:15 PM, Certified Nurse Aide (CNA) M stated that the room moves happened so that the P hallway where the resident previously lived, could be made into a rehabilitation hall. On 08/29/24 at 03:24 PM License Nurse (LN) G stated that the room moves occurred so that residents that were being skilled were all in one location. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Room Moves policy revised in April 2024, documented that when it is decided by the facility administrator or per resident request of a room move, guest services/social services or designee would call the family and inform the resident of the room move if time allows. If time does not allow (urgent isolation need or new admission entered building early) or the facility is unable to inform the resident/family of the room move for any number of reasons (resident is on appointment, outside facility, in dialysis, etc.) facility would inform resident/family at earliest possible availability. If a resident is alert and oriented times three, the facility can notify the resident only. If a resident is not alert and oriented times three, then the facility should notify the Power of Attorney (POA) or representative. The facility failed to inform R1, R2, R3, R4, R5, R6, R7, R8, and R9 in writing of the impending room change in order to create a hall to group skilled residents. This placed the residents at risk for impaired resident rights and decreased psychosocial well-being.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752 The facility identified a census of 98 residents. The sample included three residents reviewed for weight loss. Based on record review, observation, and interview, the facility failed to monitor the effectiveness of weight loss interventions after a significant weight loss for Resident (R)1. This deficient practice placed R1 at risk for further loss and malnutrition. Findings included: - R1's Electronic Medical Record (EMR), under the Diagnosis tab documented diagnoses of need for assistance with personal care, difficulty in walking, dysphagia (swallowing difficulty), paralysis (the loss of muscle function, sensation, or both) of vocal cords and larynx, and iron deficiency. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required setup or clean-up assistance with meals but was independent with eating. R1 weighed 173 pounds upon admission. The Five day Scheduled MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R1 required supervision or touching assistance on one staff providing verbal cues and or touching/steadying assistance with eating. R1 weighed 160 pounds. The Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 06/20/24 documented R1 had weakness and required assistance with ADLs. Staff were directed to assist with R1's ADLs. R1 was able to feed himself. The Nutrition CAA dated 06/20/24 documented R1 had a therapeutic diet with no added salt. R1's Care Plan dated 07/22/24 documented R1 was able to feed himself after staff assistance setting his meal up. The plan documented R1 was offered the diet as prescribed to him and the registered dietitian (RD) would consult as needed. Staff were directed to monitor for changes in R1's intake pattern and report changes as needed. R1 was to be provided snacks and beverages during and in between meals. R1 was to be encouraged to weigh per facility protocols. Staff were directed to monitor for significant weight gain or loss and to notify the medical director. R1's Order Summary retrieved 08/28/24 recorded the following orders: Diet order for no added salt (NAS) diet, regular texture with thin consistency dated 07/30/24. Ensure Enlive (a liquid supplement designed to help rebuild strength and energy in patients recovering from illness, injury, and surgery) two times a day for a supplement dated 07/30/24 (discontinued on 08/01/24). Daily weights-notify provider for a gain of over three pounds in 24 hours or more than five pounds in seven days every dayshift dated 07/30/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Tasks for snacks for the last 30 days documented snacks were given on 08/12/24, 08/16/24, 08/18/24, 08/19/24, 08/20/24, 08/25/24, and 08/26/24 with no other snack intakes documented during the last 30 days. Review of R1's Tasks for amount eaten for the last 30 days documented meals eaten for lunch and dinner on 08/12/24, breakfast and dinner on 08/16/24, dinner on 08/18/24, lunch on 08/19/24, lunch on 08/20/24, dinner on 08/22/24, lunch and dinner on 08/25/24, and lunch and dinner on 08/26/24 with no other meal intakes documented during the 30 days look back. R1's Nutrition Risk assessment dated [DATE] documented R1 reported a weight loss of 25 pounds from recent surgery and a previous liquid diet. R1 spoke of wanting a chocolate Ensure for a snack with breakfast. R1 reported he disliked breakfast compared to other meals and felt hungry. R1 was educated on weight gain, eating meals, and drinking water throughout the day. R1's EMR was documented on 06/21/24 at 05:15 PM the Behavioral Note documented R1 stated he wanted to start drinking Ensure twice a day at 10:00 AM and 02:00 PM and R1 only wanted chocolate shakes. At 10:00 AM staff attempted to give R1 his requested Ensure to which R1 refused stating he did not order it. R1 failed to recall he had seen his physician and requested the Ensure drinks and did not want them anymore. R1's Nutrition Risk assessment dated [DATE] documented R1 was at risk for malnutrition. R1 had supplemental Ensure Enlive twice a day at 10:00 AM and 02:00 PM. It was recommended R1 trial a Thrive (Gluten-free, protein-rich ice cream, packed with 24 vitamins and natural prebiotics) cup for weight maintenance. R1's August 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) documented R1 received Ensure Enlive twice daily but lacked a record of the intake amount of the supplement the resident consumed. A review of R1's Task: Snacks intake record for the last 30 days documented snacks were given on 08/12/24, 08/16/24, 08/18/24, 08/19/24, 08/20/24, 08/25/24, and 08/26/24 with no other snack intakes documented during the last 30 days. Review of R1's Task:Amount Eaten intake record for amount eaten for the last 30 days documented meals eaten for lunch and dinner on 08/12/24, breakfast and dinner on 08/16/24, dinner on 08/18/24, lunch on 08/19/24, lunch on 08/20/24, dinner on 08/22/24, lunch and dinner on 08/25/24, and lunch and dinner on 08/26/24 with no other meal intakes documented during the 30 days look back. On 08/28/24 at 12:48 PM R1 laid in his bed with his blankets up to his chest. R1 stated that lunch was ok, but the staff always took a long time to get him a beverage with his meal. R1 revealed that a lot of the time he had finished his meal before staff would bring him a beverage. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 12:56 PM, R1 lay in his bed visiting with his family. R1 reported that he had not received his lunch tray until after 12:30 and then when it had arrived it was a chicken burrito with beans. R1 stated he could not eat the chicken in the burrito or the beans due to both being too hard for him to chew. R1 revealed he was able to eat the burrito around the outside. R1 stated he was given a strawberry Ensure but he did not like it and could not consume it. R1 stated he had not seen the RD in quite a while. R1 went on to say that staff often left his tray of food on the bedside table when he was sleeping, and the staff did not attempt to alert him the food was there. R1 stated that staff often left the room without checking to see if he needed help cutting up his food or if he needed anything else. On 08/29/24 at 03:15 PM, Certified Nurse's Aide (CNA) M stated that that the CNA staff weighed residents, but she was unsure which residents were at risk for weight loss. CNA M stated staff charted the percentage eaten for the meals into the point of care charting system. On 08/29/24 at 03:24 PM Licensed Nurse (LN) G stated the MDS and plan of care informed the staff which residents needed assistance with eating and if the residents required assistance with meals, there was an assisted dining room set up where the staff assisted those residents. LN G stated that if a resident was triggering for weight loss, he would check with the physician to see if a resident needed a supplement or more assistance eating. The facility's Weight Change Investigation policy revised in May 2023 documented that weight change investigations would be initiated with the following: a significant weight change of 5% or more in one month. Once the weight change investigations were completed, the dietician and physician would be contacted for interventions. Interventions would be updated on the resident's chart if appropriate, and the resident or resident's representative would be notified of the interventions. The facility failed to consistently monitor the effectiveness of interventions, including intake amounts for meals, snacks, and nutritional supplements, after a significant weight loss for R1. This deficient practice placed R1 at risk for continued weight loss and malnutrition.