

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 The following citations represent the findings of a Health Resurvey and Complaint Investigation # KS00177109.	F 000			
F 657 SS=D	The 2567 was sent electronically on 03/14/23. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657			

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.

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 1 The facility identified a census of 30 residents. The sample included 12 residents with two residents reviewed for care plan revisions related to accidents. Based on observation, record review, and interviews, the facility failed to revise Residents (R)15 and R33's care plans to reflect interventions implemented for recent falls. This deficient practice placed both residents at risk for uncommunicated care needs. Findings Included: - The "Medical Diagnosis" section within R15's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), muscle spasms, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and muscle weakness. A review of R15's "Admission Minimum Data Set (MDS)" dated 01/12/23 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated she required extensive assistance from one staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated she had no falls since admission. The MDS indicated she used a walker and wheelchair for mobility. A review of R15's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 01/12/23 indicated she declined in her ADLs related to her medical diagnoses. The CAA instructed staff to ensure call light devices remained within reach, help and therapy to	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 2 improve transfers, and continue with supportive care plan. R15's was triggered for "Falls CAA" on 01/12/23 but no comments were documented. A review of R15's "Care Plan" revised 01/07/23 indicated she required limited assistance for meals. The plan indicated she required moderate to total assistance for transfers, bed mobility, personal hygiene, dressing, toileting, and bathing. The plan lacked documentation related to her landing strip (fall mat) located on the right side of her bed. A review of R15's "Comprehensive Care Plan" lasted revised 02/10/23 reflected previous admission care approaches created on 08/11/16. R15's "ADL Functional" entry indicated she only required limited assistance for ambulation, bed mobility, transfers, and toileting. A review of R15's EMR revealed a "Fall Incident" note on 01/28/23. The note revealed R15 was found on the floor next to her bed. The note revealed that R15 stated she had slid down her bed and onto the floor. The note revealed a landing strip was added to prevent her from sliding. On 02/23/23 at 08:02AM R15 sat in her wheelchair at the table in her room. R15's bed was in the low position and a landing strip was placed of the right side of her bed. R15 stated she slid out of bed and staff placed the landing strip next to her bed. She stated that she was not sure if staff was supposed to remove the mat when she was out of bed or just leave it on the floor all day. She stated that the landing strip was	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 3 hard to maneuver around to get to her bed and it often forced her wheelchair backwards when she attempted to go over it. She stated that some staff move it so she could access that side of her room and the sink area. On 02/28/23 at 01:49 PM Certified Nurses Aid (CNA) M stated R15 required staff assistance for all her ADLs and was a high fall risk. She stated all staff have access to the care plan in the Point of Care (EMR). She stated that a resident fall intervention should be listed in the care plan. She stated that R15 should have a fall mat and bed in the lowest position. On 02/28/23 at 01:49 PM Licensed Nurse (LN) G stated the R15 was a fall risk. She stated R15's fall interventions included a landing strip, frequent checks, call light within reach, and having her bed in the lowest position. She was not sure if the landing strip was to be moved during the day or remain in place while R15 was mobile. On 2/28/23 at 02:40 PM Administrative Nurse D stated R15's care plan should have included her active interventions. She stated the care plan should be based upon the admission assessment and revised each time an event or change occurs with the resident. She stated that all staff have access to the care plans and should be following the provided interventions. A review of the facility's "Care Plan" policy revised 09/2022 indicated the resident care plans will be continually evaluated to ensure interventions are being followed and effective to maintain the specified goals. The policy noted the plans should be updated to reflect changes, goals, and interventions are identified and effectively treated.	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 4 The facility failed to revise R15's care plan to reflect implemented fall interventions. This deficient practice both residents at risk for preventable falls and injuries due to uncommunicated care needs. -The "Medical Diagnosis" section within R33's Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, chronic obstructive pulmonary disorder (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). A review of R33's "Admission Minimum Data Set (MDS)" dated 01/26/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he required extensive assistance from one staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated he had two or more non-injury falls since admission. The MDS indicated he was taking insulin (hormone which regulates blood sugar) medication. The MDS indicated he used a walker and wheelchair for mobility. A review of R33's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 01/26/23 indicated he required limited to extensive assistance from one staff member for	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 5 his ADLs. The CAA instructed staff to offer and assist in ways that were familiar and safe for R33. The CAA instructed staff to promote independence and provide the least restrictive environment as permitted to enhance his quality of life. R33's "Fall CAA" completed 01/26/23 indicated that he was at risk for falls related to his medical diagnoses, impaired cognition, and weakness. The CAA noted for staff to ensure he was oriented with his new environment and provide reminders as needed. The CAA instructed that his bed be in the low position, call light within reach, and for staff to anticipate his needs. R33's "Cognitive Loss CAA" completed 01/26/23 noted that he was at risk for impaired cognition due to his diabetes mellitus diagnosis and hypoglycemia. The CAA instructed staff to monitor for changes in cognition, mood, behavior, and confusion. A review of R33's "Care Plan" initiated 01/25/23 indicated R33 was at risk for falls related to his fall history, medications, and functional deficits. The plan instructed staff to assist with ambulation and transfers, educate him on fall safety, encourage to call for assistance with his call light, added bolsters (cushioning or pillows used to prevent falls) to his mattress, and monitor him for medication side effects. R33's care plan lacked documentation related to his fall on 01/28/23 or include the increased glucose monitoring intervention put in place after his fall incident. A review of R33's EMR revealed a "Fall Incident" note on 01/28/23. The note indicated R33 was found on the floor bundled in his blankets. The	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 6 note indicated R33's blood glucose (blood sugar) was tested. R33's blood glucose was 39 milligram per deciliter (mg/dL). R33 was sent out to an acute care facility for treatment and evaluation and returned five hours later. A review of R33's "Physician's Orders" revealed an order dated 01/28/22 instructing staff to complete blood glucose checks daily at 12:00AM and 04:00AM related to hypoglycemia (low blood sugar). A review of R33's "Blood Glucose" history indicated that his levels was checks at 09:45PM on 01/27/23 before his fall incident occurred the morning of 01/28/23. His glucose level was 138mg/dL. On 02/23/23 at 01:23PM R33 sat in his recliner watching television. He wore non-slip shoes. His bed had mattress bolsters in place and was in the low position. His call light was within reach. R33 reported he had fallen several times before coming to the facility but could not remember his recent fall. He stated that he knows he fell but was not feeling well that day. On 02/28/23 at 01:49 PM Certified Nurses Aid (CNA) M stated that R33 was fall risk and has had a fall at the facility. She stated that R33 struggled with remembering and needed reminders to ask for help. On 02/28/23 at 01:49 PM Licensed Nurse (LN) G stated that staff should be following the given physician orders for checking vitals (heart rate, blood pressure, temperatures) as well as blood glucose. She stated that R33 had fallen before and gets his blood glucose checked at bedtime	F 657			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 657	Continued From page 7 and overnight. On 2/28/23 at 02:40 PM Administrative Nurse D stated R33's care plan should have included active interventions. She stated the care plan should be based upon the admission assessment and revised each time an event or change occurs with the resident. She stated that all staff have access to the care plans and should be following the provided interventions. A review of the facility's "Care Plan" policy revised 09/2022 indicated the resident care plans will be continually evaluated to ensure interventions are being followed and effective to maintain the specified goals. The policy noted the plans should be updated to reflect changes, goals, and interventions are identified and effectively treated . The facility failed to revise R33's care plan to reflect implemented fall interventions. This deficient practice both residents at risk for preventable falls and injuries due to uncommunicated care needs.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 30 residents. The sample included 12 residents with two reviewed for activities of daily living (ADL). Based on observations, record review, and interviews, the facility failed to provide consistent bathing	F 677			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 677	Continued From page 8 opportunities and the level of assistance required for Resident (R)15. This deficient practice placed R15 at risk for impaired skin integrity, discomfort, and decreased psychosocial well-being. Findings Included: -The "Medical Diagnosis" section within R15's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), muscle spasms, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and muscle weakness. A review of R15's "Admission Minimum Data Set (MDS)" dated 01/12/23 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated she required extensive assistance from one staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated she had no falls since admission. The MDS indicated she used a walker and wheelchair for mobility. A review of R15's "Activities of Daily Living Care Area Assessment (CAA)" completed 01/12/23 indicated she declined in her ADLs related to her medical diagnoses. The CAA instructed staff to ensure call light devices remained within reach, help and therapy to improve transfers, and continue with supportive care plan. A review of R15's "Care Plan" revised 01/07/23 indicated she required limited assistance for meals. The plan indicated she required moderate	F 677			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 677	Continued From page 9 to total assistance for transfers, bed mobility, personal hygiene, dressing, toileting, and bathing. A review of R15's "Bathing History" report from 01/01/23 through 02/27/23 (47 days reviewed) indicated she received six (1/12, 1/15, 2/2, 2/9, 2/16, 2/23) baths. No refusals were documented. A review of R15's EMR revealed no therapy baths, refusals, or documentation showing why bathing did not occur. On 02/23/23 at 08:02AM R15 sat in her wheelchair at the table in her room. R15 reported the facility had just given her a shower but did not properly dry her hair. R15 had a towel placed over her left shoulder and her hair was damp. R15 reported she was cold from not being fully dried off. She reported since arriving at the facility her bathing had been inconsistent. She stated that she was supposed to be bathed twice a week but had only been given one weekly. She stated that she missed a whole week of bathing a few weeks back. She indicated that she would like to receive bathing twice a week. On 02/28/23 at 01:49 PM Certified Nurses Aid (CNA) M stated each resident should be bathed at least twice a week but residents could request to be bathed daily if they wished to be. She stated the unit nurses put out the schedule of which residents were to be bathed and the CNA staff were responsible for completing the bathing. She stated that all baths were to be documented in the Point of Care (EMR) under "ADL Care". She stated that if a resident refused the CNA notified the nurse and documented the refusal. On 02/28/23 at 01:49 PM Licensed Nurse (LN) G	F 677			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 677	Continued From page 10 stated the CNA staff were responsible for completing baths and reporting to the nurses if cares were not completed. She stated that R15 received her baths, so she was not sure why they were not documented. On 2/28/23 at 02:40 PM Administrative Nurse D stated that R15 should have received her baths weekly and then during each incontinent episode as part of her plan. She stated that staff should be documenting all bathing and refusals in the EMR. She was not sure why the EMR was missing bathing occurrences. A review of the facility's "ADL Charting" policy 08/2020 indicated all resident will be provide ADL assistance based on the individualized plan provided. The policy indicated that staff will document all assistance provide and observed the resident throughout the shift for cares needed. The policy indicated staff will document if an activity did not occur. The facility failed to provide consistent bathing opportunities and the required assistance for R15. This deficient practice placed R15 at risk for impaired skin integrity, discomfort, and decreased psychosocial well-being	F 677			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent	F 689			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 689	Continued From page 11 accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to secure chemicals in a safe, locked area, and out of reach of the five cognitively impaired independently mobile residents. This placed the affected residents at risk for accidents. Findings Included: - On 02/23/23 at 07:05 AM an initial walkthrough of the facility revealed opened "Micro-Kill" germicidal cylindrical containers of disinfectant wipes were in the hallway, unsecured, outside of Residents (R)7, R23, R88, R90, and R142's rooms. The disinfectant wipes were also noted outside of unoccupied rooms 104, 105, 108, 114, and 134. The walkthrough revealed 12 total containers of chemical wipes left unsecured. The label of the wipes contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed". On 02/28/23 at 01:49 PM Certified Nurses Aid (CNA) M stated all chemical products should securely locked up away from resident access. On 02/28/23 at 01:49 PM Licensed Nurse (LN) G stated that hazardous chemicals should be secured out of reach from the residents. She stated staff use the wipes to wipes down areas to prevent the spread of infections but should not leave the wipes out for resident to have access. On 2/28/23 at 02:40 PM Administrative Nurse D	F 689			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(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 689	Continued From page 12 stated she was not aware that the wipes had been left out but stated that staff used them in the isolation rooms and areas that may be of high contamination risks. She stated that she would educate staff on safety and securing the wipes . The facility failed to secure chemicals in a safe, locked area, and out of reach of the five cognitively impaired independently mobile residents. This placed the affected residents at risk for accidents.	F 689			
F 812 SS=F	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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 30 residents. The facility had one main kitchen and one dining area. The facility failed to ensure that staff	F 812			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207			
(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 812	Continued From page 13 members properly tested the dishwashing sanitization chemicals and recording the dish machine temperatures. The facility also failed to ensure the ice machine lid was closed in the nourishment area was closed This deficient practice placed residents at risk for contamination and food borne illness. Findings included: - The initial tour of the facility on 02/23/23 at 07:04 AM the Dietary Staff DD reported the facility had changed chemical sanitization companies in the past two weeks and chemical strips provided by the new company had not been testing within the facility set guidelines. Dietary Staff DD stated the new distributor had been notified. On 02/23/23 at 07:05AM the door of the ice machine in the nourishment was left open with the ice exposed. Review of the "Dish Machine Temperature Log" from 02/01/23 to 02/27/23 revealed 17 undocumented dish machine water temperature opportunities out of 81 opportunities. Review of the parts per million column (PPM) revealed lack of documentation 16 days out of 27 opportunities. On 02/28/23 at 11:46 AM Dietary Staff BB stated the facility had changed companies that provided the sanitization chemicals and the facility had notified the provider of the problem. On 02/28/23 at 12:24 PM Dietary Staff CC stated the company had reviewed the concern of the chemical test strips the facility had used to check the PPM was for testing fruits and vegetables and			F 812			

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

PRINTED: 03/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2023	
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207			
(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 812	Continued From page 14 not for dish machines. On 02/28/23 at 01:50 PM Licensed Nurse (LN) H stated night was responsible for cleaning the ice machine in the nourishment area. LN H stated it was everyone's responsibility to close the lid to ice machine when finished getting ice. On 02/28/23 at 02:00 PM Certified Nurse's Aide (CNA) M stated the kitchen was responsible for any maintenance of the ice machine. CNA M stated she cleaned the ice chest at the start of each shift. CNA M stated it was everyone's responsibility to ensure the ice machine lid was closed when not in use. The facility's "Food handling" policy dated 08/06/20 documented sanitization solution must be changed when cloudy, when not with in the recommended concentration or temperature, or at least three times a day. The facility failed to ensure that staff members properly tested the dishwashing sanitization chemicals and recording the dish machine temperatures. The facility also failed to ensure the ice machine lid was closed in the nourishment area was closed. This deficient practice placed residents at risk for contamination and food borne illness.			F 812			