

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

PRINTED: 03/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2024
NAME OF PROVIDER OR SUPPLIER ADVENTHEALTH CARE CENTER OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 75TH STREET OVERLAND PARK, KS 66204		
(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 complaint investigations #KS00186316 and KS00185952.	F 000			
F 941 SS=E	The 2567 was sent electronically on 03/25/24. Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: The facility identified a census of 77 residents. Based on record review and interviews, the facility failed to ensure an agency nurse, Licensed Nurse (LN) G, had the required effective communication education. This deficient practice placed residents at risk for impaired communication with LN G. Findings included: - In a "Grievance/Complain Report" dated 02/29/24, Resident (R) 1's family stated she felt R1 was not being cared for appropriately. When she arrived on 02/28/24, R1 was lying in bed with a brief on, no incontinence pad, and a brown stain on the sheet. R1's family asked staff to change R1 and staff stated they were giving a bed bath. R1's family requested again and staff stated R1 had to wait until help came. R1's family stated she told staff they were not going to talk to her like that and that they were neglecting R1. LN G came into R1's room and pulled the privacy curtain. R1's family stated LN G loudly and rudely stated staff were "done" with R1's family.	F 941			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/25/2024

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

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F 941	Continued From page 1 Upon request, the facility was unable to provide documentation that LN G completed education on effective communication before she started working at the facility. On 03/12/24 at 02:22 PM, Administrative Nurse D stated the facility made sure agency nurses had their license before they started working at the facility, but they did not look at the education documentation. The facility's "In-Service Training, All Staff" policy, revised in August 2022, directed all staff were required to participate in regular in-service education and staff included all new and existing personnel, individuals providing services under contractual agreement, and volunteers. The policy directed required training topics included effective communication with residents and family and training requirements were met before staff provided services to residents, annually, and as necessary based on the facility assessment. The facility failed to ensure LN G had the required effective communication education. This deficient practice placed residents at risk for impaired communication with LN G.	F 941			
F 942 SS=E	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced	F 942			

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F 942	Continued From page 2 by: The facility identified a census of 77 residents. Based on record review and interviews, the facility failed to ensure an agency nurse, Licensed Nurse (LN) G, had the required resident rights education. This deficient practice placed residents at risk for impaired resident rights. Findings included: - In a "Grievance/Complain Report" dated 02/29/24, Resident (R) 1's family stated she felt R1 was not being cared for appropriately. When she arrived on 02/28/24, R1 was lying in bed with a brief on, no incontinence pad, and a brown stain on the sheet. R1's family asked staff to change R1 and staff stated they were giving a bed bath. R1's family requested again and staff stated R1 had to wait until help came. R1's family stated she told staff they were not going to talk to her like that and that they were neglecting R1. LN G came into R1's room and pulled the privacy curtain. R1's family stated LN G loudly and rudely stated staff were done with R1's family. Upon request, the facility was unable to provide documentation that LN G completed education on resident rights before she started working at the facility. On 03/12/24 at 02:22 PM, Administrative Nurse D stated the facility made sure agency nurses had their license before they started working at the facility, but they did not look at the education documentation. The facility's "In-Service Training, All Staff" policy, revised in August 2022, directed all staff were required to participate in regular in-service	F 942			

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F 942	Continued From page 3 education and staff included all new and existing personnel, individuals providing services under contractual agreement, and volunteers. The policy directed required training topics included resident rights and responsibilities and training requirements were met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. The facility failed to ensure LN G had the required resident rights education. This deficient practice placed residents at risk for impaired resident rights.	F 942			