

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/18/2025	
NAME OF PROVIDER OR SUPPLIER SWAN HEALTH AT OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103RD STREET , OVERLAND PARK, Kansas, 66212			
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F0000	INITIAL COMMENTS		F0000				
	The following citations represent the findings of complaint investigation 2592925.						
	The 2567 was sent electronically on 10/15/25.						
F0692	Nutrition/Hydration Status Maintenance		F0692				
SS = G	CFR(s): 483.25(g)(1)-(3)						
	§483.25(g) Assisted nutrition and hydration.						
	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-						
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;						
	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;						
	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.						
	This REQUIREMENT is NOT MET as evidenced by:						
	The facility identified a census of 37 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to implement interventions to prevent further weight loss for Resident (R) 1. R1 was admitted to the facility on 06/05/25 and had a weight loss of 3.85% by 07/02/25 with no documented intervention or response to the loss. R1's weight further declined to a significant loss of 8.85% by 08/01/25 (more than 7.5% in three						

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 reverse for further 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
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F0692 SS = G	Continued from page 1 months) with no documented intervention or response from the facility until 08/14/25. This deficient practice resulted in a total significant weight loss of -11.15% for R1 from 06/06/25 to 08/20/25. Findings included: - R1's Electronic Medical Record (EMR) documented a diagnoses of nontraumatic subarachnoid hemorrhage (SAH- bleeding in the space just outside the brain), conversion disorder (a mental condition in which a person experiences blindness, paralysis or other nervous system symptoms that cannot be explained by illness or injury), dysphagia (swallowing difficulty), cerebral edema (abnormal accumulation of fluid in the brain, which causes it to swell), and dependence on a respirator, or ventilator (the inability to breathe on one's own, requiring mechanical ventilation to support or replace normal breathing function). The "Admission Minimum Data Set (MDS)," dated 06/12/25, for R1 noted the Brief Interview for Mental Status (BIMS) assessment was not completed as R1 was rarely or never understood. The MDS documented R1's short-term and long-term memory was not assessed. The MDS further documented R1 had severely impaired cognitive skills for daily decision making. The MDS documented R1 was dependent on staff for activities of daily living (ADL). The MDS documented R1 had functional limitation in range of motion to his upper and lower extremities, with impairment on both sides. The "Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA)," dated 06/12/25, documented R1 had decreased ability to make himself understood. The CAA documented R1 had confusion, disorientation and/or forgetfulness. The CAA further documented R1 was alert and able to answer simple yes or no questions by nodding or shaking his head. The "Nutritional Status CAA" dated 06/12/25, documented R1 had contractures (abnormal permanent fixation of a joint or muscle), partial or total loss of arm movement, functional limitation in range of motion, and hemiplegia (paralysis of one side of the body) and, or hemiparesis (muscular weakness of one half of the body). The CAA documented R1 had poor memory. The CAA documented R1 was to have nothing by mouth due to dysphagia, and all nutrition and or hydration were given via percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach).	F0692					

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F0692 SS = G	Continued from page 2 R1's "Care Plan," with an initiated date of 06/17/25, documented the following: R1 had an ADL self-care performance deficit related to being bedbound. R1 was bedfast all or most of the time. R1 was totally dependent on staff for transferring. R1 was totally dependent on staff for personal hygiene and oral care. R1 had a tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) related to respiratory failure. R1 required tube feeding related to dysphagia. R1 would maintain adequate nutritional and hydration status as evidenced by stable weight, no signs or symptoms of malnutrition, or dehydration through the review date. R1 was dependent on tube feeding and water flushes. The intervention directed staff to see the doctor's orders for the current feeding orders. R1's EMR revealed the following orders: An order, with an ordered date of 06/05/25, directed staff to weigh R1 monthly. An order, with a start date of 06/05/25 and a discontinue date of 06/16/25, documented the resident required enteral feed (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) six times a day. Staff were to give 200 milliliters (ml) of Jevity (a liquid nutrition with fiber providing complete nutrition) 1.5 by bolus feed and 180 ml water flush with each bolus feed six times a day via PEG. An order, with a start date of 06/16/2025 and a discontinue date of 08/11/25, documented the resident required enteral feed six times a day. Staff were to give 230 mL of Jevity 1.5 by bolus feed and 220 ml water flush with each bolus feed six times a day via PEG. An order, with a start date of 08/11/25 and a discontinue date of 08/15/25, documented an enteral feed order for the resident, every shift. Give Jevity 1.5 at 60 ml per hour plus water flush 220 ml every			F0692			

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F0692 SS = G	Continued from page 3 four hours continuously via PEG for nutritional management. An order, with a start date of 08/15/25 and a discontinue date of 08/22/25 documented the resident required enteral feeding every shift. Staff were to give Jevity 1.5 at 65 ml per hour plus water flush 220 ml every four hours continuously via PEG for nutritional management. An order, with a start date of 08/20/25, directed staff to obtain a Hoyer (total body mechanical lift) weight every two weeks. An order, with a start date of 08/22/25, documented the resident required an enteral feed every shift. Staff were to give Jevity 1.5 at 70 ml per hour plus a water flush of 250 ml every four hours continuously via PEG for nutritional management. R1's EMR lacked evidence of changes to R1's enteral feed orders from 06/16/25 to 08/11/25. R1's EMR lacked evidence of any changes in weight monitoring from 06/05/25 to 08/20/25. R1's EMR documented the following weights: 130.0 pounds (lbs.) on 06/06/25 125.0 lbs. on 07/02/25 118.5 lbs. on 08/01/25 117.5 lbs. on 08/15/25 115.5 lbs. on 08/20/25 117.6 lbs. on 09/02/25 120.5 lbs. on 09/17/25 R1 had a weight loss of 3.85% from 06/06/25 to 07/02/25 and R1's EMR lacked evidence of any interventions from the facility. R1 had a significant loss of 8.85% from 06/06/25 to 08/01/25. R1's EMR lacked evidence of interventions from the facility until 08/11/25. R1 had a loss of 9.62% from 06/06/25 to 08/15/25. R1 had a total significant loss of 11.15% from 06/06/25 to 08/20/25. A "Mini Nutrition" note dated 06/05/25 documented R1 had a moderate decrease in food intake in the last three months. The note documented the resident had a		F0692				

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F0692 SS = G	Continued from page 4 weight loss greater than three kilograms (kg) (6.6 lbs.) in the last three months. R1 was bed or chair-bound and had suffered psychological stress or acute disease in the past three months. The resident has mild dementia. A "Nutrition Therapy Progress Note" with a date of 08/14/25, documented R1 had a history of recent nausea, with one emesis (vomit) on 08/06/25, and weight loss over the past month. R1 had continual overall weight loss since SAH on 04/02/25. The order changed from bolus feeds six times a day to continuous enteral feeding via PEG with continued strict nothing-by-mouth orders due to dysphagia. R1 admitted on a bolus order of Jevity 1.5 200 ml six times per day with 180 ml water six times per day plus Prosource (nutrition product designed for patients with malnutrition or protein deficiencies) 15 grams (g) a day. The resident's weight on 05/26/25 prior to admission to the facility was 143 lbs. and 1.3 ounces. The note further documented the resident's weight on 08/02/25 of 118.5 lbs., was discussed with R1's primary care provider. The provider changed the resident to continuous infusion with a smaller volume of the meal supplement infused continuously. The resident required increased kilocalories (kcal- a unit of energy measurement used in nutrition) to about 100 kcal per day. Staff were to monitor the resident for gastrointestinal (GI) symptoms. Per the note, R1 lost 23 lbs. from 04/03/25 to 06/06/25 (the resident admitted to facility on 06/05/25). A "Nutrition/Dietary Note" dated 08/22/25, documented the resident with 3 lb. weight loss this week. A Certified Nurse Aide reported the resident had infrequent urine output. R1 indicated he was thirsty. R1's weight on 08/01/25 was 118.5 lbs., and on 08/15/25 weight was 117.5 lbs. The note documented an increase in the resident's enteral feed rate, but not water flush. On 08/20/25 the resident's weight was 115.5 lbs. No new labs were ordered. R1 had no edema or no skin breakdown. A new order was placed to increase the resident's water flush from 220 ml to 250ml every four hours, along with an increase in enteral feed rate of Jevity 1.5 from 65 to 70 ml per hour. The note documented speculation R1 had higher metabolic needs than typical, possibly due to increased activity, or fidgeting, and a history of asthma with episodes of coughing. The note documented for staff to monitor R1's tolerance to the feedings, hydration, weights every two weeks, labs, and skin integrity. R1's goal weight over the next six months was 125 lbs. to 135 lbs. A "Nutrition/Dietary Note" dated 09/02/25, documented		F0692				

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F0692 SS = G	Continued from page 5 R1's Hoyer weight was 117.6 lbs., which was up 2 lbs. since 08/20/25 with a weight of 115.5 lbs. The note documented a planned weight increase to a goal weight from 125 lbs. to 135 lbs. over the next six months, with noted muscle atrophy. The note documented weights every 14 days through October 2025 and longer as needed to achieve weight trending toward weight goals and stability. The note further documented R1 reported tolerance to continuous enteral feed without GI symptoms or issues with Jevity 1.5 at 70 ml per hour with a water flush of 250 ml every four hours via PEG tube. Feeds would provide 2520 kcals, 107 grams of protein, and 2776 ml of water. The note documented for staff to continue to monitor weights, tolerance, labs, hydration, GI issues, and medical progress. R1's EMR lacked evidence of dietary notes or dietary assessments from 06/05/25 to 08/14/25. A "Dietary Profile" dated 06/06/25, documented R1 required a strict nothing by mouth directive, and on was on bolus gravity PEG feeds six times a day. The "Dietary Profile" documented R1 had a tracheostomy, ventilator, and had a subarachnoid hemorrhage. The "Dietary Profile" documented R1 had a PEG tube for nutritional support due to dysphagia. The resident required increased volume and water flushes due to resident's hunger and continued weight loss. R1's usual weight was 153 lbs. on 04/02/25 at the onset of SAH, and he had a current admit weight of 130 lbs. on 06/06/25. The resident's goal weight was from 140 lbs. to 150 lbs., and the goal weight in the next three to six months would be 135 lbs. to 145 lbs. The "Dietary Profile" documented R1 was tolerating PEG feeds well and had no GI symptoms. A "Dietary Profile" dated 09/08/25 documented R1 was on a strict nothing-by-mouth directive and was on continuous enteral feed via PEG tube. The "Dietary Profile" documented R1's family was concerned about R1's weight decline post SAH on 04/02/25. The "Dietary Profile" documented R1's weight was 153 lbs., and noted he had a severe weight loss prior to admitting to the facility. The "Dietary Profile" documented R1's weight was 130 lbs. on 06/06/25 (admission weight) with a current weight of 117.6 lbs. R1 was on a planned weight increase plan. R1's EMR lacked evidence of any other "Dietary Profile" assessments. On 09/18/25 at 02:11 PM, R1 received a continuous enteral feeding via an enteral feeding pump (a medical device used to deliver liquid nutrition directly into a		F0692				

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F0692 SS = G	Continued from page 6 patient's digestive tract via a feeding tube), as he rested in his bed. On 09/18/25 at 03:35 PM, Licensed Nurse (LN) G stated if a resident had a significant loss, he would reweigh them to make sure the weight was correct. LN G stated he would report the noted loss to the Director of Nursing (DON), the PCP, and the dietician. LN G stated he would also put in a progress note documenting the loss. He stated the dietician would usually adjust the rate of a feeding if a resident was not getting enough calories. LN G stated he believed the facility weighed residents once per month, or every two weeks. LN G stated one of the nursing aides told him they thought R1 lost weight and R1's family reported R1 lost weight as well. LN G stated R1 was on bolus feeding and he stated he asked Dietary BB about changing R1's feedings to continuous instead of bolus, as he stated he was concerned R1 may not have been getting fed consistently. LN G stated he was not sure what other staff did on other shifts. He stated he knew what he did on his shifts, but was not sure what others did related to R1's scheduled bolus feedings. LN G stated the only thing he suspected was R1 may not have been receiving them consistently. LN G stated staff would know if R1 was being fed if the order was changed to consistent instead of bolus. On 09/18/25 at 03:54 PM, Dietary BB stated R1 was 153 lbs. prior to admitting to the facility and had lost weight prior to arriving at the facility. Dietary BB stated R1 admitted with a weight of 130 lbs. Dietary BB stated she could see R1's weight was already declining prior to admission, so she changed R1's enteral feeding orders to increase his calories. Dietary BB stated she gave R1 a big increase in calories when he came in and his loss slowed down compared to what he had lost prior to admitting to the facility. She stated in July, when R1 lost 3.85% in the first month at the facility, R1 was having a lot of stools and some reported nausea. She stated she was not sure if a further increase would cause more nausea or vomiting, and she wanted to give him time to adjust to the increase in calories. She stated sometimes, if they moved too fast and the resident started vomiting, they could move backwards and decline. Dietary BB stated she had the order changed to small volume continuous feeding on 08/11/25 instead of bolus and R1 tolerated the change well with no reported nausea. Dietary BB stated she would normally intervene and make adjustments when a noted loss occurred and before it became significant. Dietary BB stated the facility normally did monthly weights for residents, but they changed R1 to every two weeks. Dietary BB stated she should have changed R1 to weekly		F0692				

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F0692 SS = G	Continued from page 7 weights sooner than she did once R1 started having some loss in the facility, as he was still on monthly at that time. Dietary BB further stated there should have been interventions put into place in July when the initial loss of 3.85% was documented in the first month, even though the loss slowed when compared to pre-admission loss. Dietary BB stated they probably should have started continuous feeding in July and increased how often he was weighed then. Dietary BB R1 did not have any reported nausea with the continuous feeding, only when he had the bolus feedings. Dietary BB stated there were no dietary assessments done for R1 in July when the loss was first documented. Dietary BB stated she probably should have followed up and done an assessment during that time. Dietary BB stated the biggest error was not increasing how often R1 was weighed to stay on top of changes. On 09/18/25 at 05:05 PM, Administrative Nurse D stated the facility obtained weights monthly, and results were given to the dietitian to review. Administrative Nurse D stated the dietitian reviewed weights and PEG tub feedings and then made adjustments based on the findings and contacted the doctor. Administrative Nurse D stated it could be difficult to track loss based on weights obtained from a hospital, prior to admission to the facility, but if there was notable loss in the facility, interventions should be in place to prevent the loss from worsening. Administrative Nurse D stated if a loss was noted for a resident, it would be appropriate to change how often the resident was weighed to more closely monitor changes. On 09/18/25 at 05:25 PM, Administrative Staff A stated she believed residents were weighed weekly when admitted and then changed to monthly. Administrative Staff A stated Dietary BB was responsible for monitoring weight loss in the facility. Administrative Staff A stated Dietary BB would monitor loss and make dietary adjustments as needed to help prevent weight loss. Administrative Staff A stated she believed a resident's weight could go from some noted loss to significant within a month's time if not monitored. Administrative Staff A stated she was not a clinician, but it would make sense to check and monitor a resident's weight more frequently than once a month if there was some documented loss. The facility's "Enteral Nutrition" policy, with a revision date of November 2018, documented the dietitian, with input from the provider and nurse, estimates calories, protein, nutrients, and fluid needs, determines whether the resident's current intake is adequate to meet his or her needs, recommends			F0692			

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F0692 SS = G	Continued from page 8 special food formulations, and calculates fluids to be provided. The dietician monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. The facility's "Nutrition (Impaired)/Unplanned Weight Loss – Clinical Protocol" Policy, with a revision date of September 2012, documented the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.			F0692			