

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

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 08/24/2026	
NAME OF PROVIDER OR SUPPLIER SWAN HEALTH AT OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103RD STREET , OVERLAND PARK, Kansas, 66212			
(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
F0000	INITIAL COMMENTS			F0000			
F0610 SS = D	The following citations represent the findings of complaint investigations 3119655 and 3131970. The census was 39. The sample included five residents. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to conduct a complete investigation to rule out abuse or neglect for a right leg fracture of unknown origin for Resident (R) 1. Findings included: - R1 admitted to the facility on 04/17/2025. R1's Electronic Medical Record (EMR) documented a diagnosis of anoxic brain damage (brain injury that occurs when the brain is deprived of oxygen for too			F0610			

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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F0610 SS = D	Continued from page 1 long). The "Annual Minimal Data Set (MDS)," dated 04/25/2026, documented R1 was in a persistent vegetative state. R1 had impairment of her bilateral upper and lower extremities. R1 was dependent on staff for bed mobility. The "Quarterly MDS," dated 07/26/2026, documented R1 was in a persistent vegetative state. R1 had impairment of her bilateral upper and lower extremities. R1 was dependent on staff for bed mobility. The "Pressure Ulcer/Injury Care Area Assessment (CAA)," dated 05/04/2026, documented R1 was at risk for pressure ulcers due to immobility and she had no pressure ulcers at that time. R1's "Care Plan," dated 05/04/2025 and revised 07/30/2026, documented R1 had an activity of daily living (ADL) self-care performance deficit related to severe contractures (abnormal permanent fixation of a joint or muscle) to her bilateral upper extremities, decreased range-of-motion to her bilateral lower extremities, and a comatose state. R1 experienced muscle spasms and tremors. The "Care Plan" documented an intervention, dated 07/30/2026, that R1 was dependent on staff for rolling left and right. The facility's "Investigation," not dated, documented on 07/31/2026 at approximately 12:08 PM, staff notified Administrative Nurse D that R1 had bruising and swelling on her knee. The facility's conclusion documented that R1 had an acute impacted supracondylar distal femoral fracture (a break in the thigh bone just above the knee joint), and the provider gave orders to send R1 to the emergency room where they confirmed the fracture. Chart review and investigation showed that R1 was bed bound with contractures to bilateral upper and lower extremities. R1 was totally dependent on enteral feedings (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) for her entire admission. Her laboratory results showed a decline in her serum calcium levels during her stay leading to the demineralization (the progressive loss of minerals, primarily calcium and phosphate, from bone tissue, leading to reduced bone density and increased fragility) of the bone causing the bones to	F0610					

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F0610 SS = D	Continued from page 2 become brittle. The facility held an in-service immediately for all staff on abuse, neglect, and exploitation and an in-service with care staff on safe turning and repositioning. The facility's investigation concluded there were no findings of abuse and neglect. The facility's investigation did not include any witness statements from staff who worked around the time of the incident to rule out abuse or neglect as the cause of the injury of unknown origin. The investigation did not include any resident statements or interviews to rule out any possible patterns of abuse or neglect in the facility. Upon request, the facility did not have any staff witness statements regarding R1's right femur fracture of unknown origin to rule out abuse or neglect as the potential cause. R1's EMR revealed the following: A "Health Status Note" on 07/29/2026 at 10:54 PM, documented Licensed Nurse (LN) H noticed R1 had swelling from her right knee to her mid-thigh area that was warm to the touch with a small amount of redness over her kneecap, without bruising. R1 had an elevated heart rate and temperature. LN H notified the provider and received an order for blood work and an x-ray of her right femur (thigh bone) and right knee. A "Radiology Report," dated 07/30/2026, documented R1 had an acute impacted supracondylar distal right femoral fracture with soft tissue swelling and bony demineralization of her right femur. A "Transfer to Hospital Summary" on 07/31/2026 at 03:52 PM, documented R1 had an x-ray of her right femur on 07/30/2026. The x-ray showed an acute impacted supracondylar distal femoral fracture and soft tissue swelling without dislocation. A "Nurses Notes" on 07/31/2026 at 10:30 PM, documented ambulance personnel picked up R1 and transferred her to the hospital. On 08/24/2026 at 02:01 PM, R1 laid in bed with her eyes closed. There was a sheet over her upper and lower body with an outline of her legs visible. Her			F0610			

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F0610 SS = D	Continued from page 3 left leg was contracted inward at the knee, with her foot appearing at the level of her right thigh. Her right leg was straight, with her right foot contracted. On 08/24/2026 at 11:12 AM, Administrative Nurse D stated she had interviewed the nurse who reported the bruising to R1's right knee and the CNA who worked with R1. She stated the nurse reported they were unsure how the bruising happened, but the bruising was on the outer aspect of R1's right knee and her left leg/foot contracted up to her right knee. Administrative Nurse D stated staff reported that if R1's protective boots were off, they had found her left foot on her right knee in the past. She stated she talked to the night shift staff to see if they noticed anything with R1 and they had not. She stated she had the staff demonstrate how they repositioned R1 to make sure they were not using her right knee to move her. Administrative Nurse D stated the CNA reported during the demonstration that if staff did not hold her left leg just right, the left leg would kind of pop back and hit her right knee. Administrative Nurse D stated R1's x-ray showed demineralization of the bone, so she pulled R1's labs and noted her calcium had been decreasing. On 08/24/2026 at 03:18 PM, Certified Nurse Aide (CNA) M stated that sometimes, R1's left foot did touch her right knee depending on how staff repositioned her. On 08/24/2026 at 03:30 PM, LN G stated she worked on 07/31/2026 and did rounds with LN H when Administrative Nurse D went into R1's room. She stated they assessed R1's right leg which had bruising and swelling on her inner right leg and R1 appeared to be in pain. She stated she did not recall any incidents happening with R1 to have caused the injury. On 08/24/2026 at 03:44 PM, Administrative Nurse D stated on 07/31/2026, staff told her they found some bruising and swelling on R1's right knee. She entered R1's room to assess her. She stated while they waited for the x-ray results, she asked staff if anybody noticed any injury to R1's right knee and nobody did. Administrative Nurse D stated she reviewed R1's previous skin assessments and there was no bruising documented. She stated once they had the x-ray results, they sent R1 to the hospital. Administrative Nurse D stated based on the five staff	F0610					

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F0610 SS = D	Continued from page 4 she talked to, the x-ray report, and R1's labs, she ruled out any abuse. She stated she should have interviewed every staff member that took care of R1 in the last five days of the incident and got statements from them. She stated she did not interview any residents. On 08/24/2026 at 04:07 PM, LN H stated on 07/29/2026, he noticed R1's right leg had swelling, and she had a fever that night. He stated he talked to R1's provider and she ordered labs and an x-ray. LN H stated he did not see any bruising on R1's right leg/knee that night. He stated 07/31/2026, R1's right knee had small dots of discoloration and red skin. He stated R1's x-ray came back as a fracture, but no staff had reported any incidents to him about R1. The facility's "Abuse, Neglect, and Exploitation" policy, dated 07/01/2026, directed an immediate investigation was warranted when suspicions or reports of abuse, neglect, or exploitation occurred. The policy directed the written procedure for investigations included: identifying staff responsible for the investigation; exercising caution when handling evidence that could be used in a criminal investigation; identifying different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred with the extent and cause; and providing complete and thorough documentation of the investigation.			F0610			