

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

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b> |                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>175491</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                            |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>09/23/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOEGER HOUSE</b>      |                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>20911 WEST 153RD STREET , OLATHE, Kansas, 66061</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| F0000                                                        | <p>INITIAL COMMENTS</p> <p>The Risk-Based Survey Process was used to conduct a federal recertification survey.</p> <p>The Health Recertification Survey on the above-named facility resulted in a finding of no deficiency citations respective to applicable regulations under 42 CFR Part 483, Subpart B, requirements for long term care facilities.</p> |                                                                            |  | F0000                                                                                               |                                                                                                                          |                                                     |                            |

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.

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