STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175240	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highcrest Hospital of Overland Park	6505 W 103rd Street Overland Park, KS 66212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 29 residents. Based on record review and interviews, the facility failed to notify Resident (R) 1's representative of the plan of care changes. This deficient practice had the risk of miscommunication between R1, their representative, and the facility. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of encounter for attention to gastrostomy (G-tube: tube surgically placed through an artificial opening into the stomach) and anoxic brain damage (brain injury that occurs when the brain is deprived of oxygen for too long). The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a feeding tube and received 51% or more total calories and 501 cubic centimeters (cc) or more of fluids through tube feeding daily. The Quarterly MDS dated [DATE], documented R1 had a feeding tube and received 51% or more total calories and 501 cc or more of fluids through tube feeding daily. The Feeding Tube Care Area Assessment (CAA) dated 10/14/24, lacked an analysis of findings. R1's Care Plan dated 12/17/24, documented R1 required tube feeding related to dysphagia (difficulty swallowing). The plan directed staff to check for tube placement and gastric contents/residual volume per facility protocol; staff monitored, documented, and reported as needed (PRN) any signs and symptoms of aspiration, fever, shortness of breath, tube dislodgement, infection at tube site, tube dysfunction or malfunction, abnormal breath sounds, abnormal lab values, abdominal pain, abdominal distention, abdominal tenderness, constipation or fecal impaction, diarrhea, nausea and vomiting, and dehydration; staff provided local care to G-tube site as ordered and monitored for signs and symptoms of infection; and staff provided tube feedings and water flushes. R1's EMR documented an order with a start date of 02/18/25 for amoxicillin-potassium clavulanate (Augmentin- an antibiotic used to treat infections) 875-125 milligrams (mg) every 12 hours for bacterial infection for 10 days. R1's clinical record revealed the following: (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER: Highcrest Hospital of Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 6505 W 103rd Street, Overland Park, KS 66212	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing (N) Advanced (Adv) Skilled Evaluation note on 02/18/25 at 12:11 AM documented R1's abdomen was distended and tender. A Orders- Administration Note on 02/18/25 at 12:36 AM documented the nurse held R1's tube feeding. A Health Status Note on 02/18/25 at 05:34 AM documented at the beginning of the shift, R1 had a swollen abdomen with a huge palpable mass predominantly around the percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) side extending towards the right side of her abdomen. The area was inflamed, warm, and tender to touch with pus noted from the PEG tube site. R1's vital signs included a pulse of 110 beats per minute (bpm) and a temperature of 101.2 degrees Fahrenheit (F). Staff administered PRN Tylenol (medication used to treat pain and fever) 650 mg and turned off R1's tube feeding that shift. Staff notified Consultant GG who stated he would see R1 soon. Staff notified R1's representative and oncoming nurse. A Medical Doctor (MD) note on 02/18/25 at 08:40 AM documented R1 had a persistent vegetative state with total care for PEG tube and had cellulitis surrounding the PEG tube. R1 had a low-grade fever with no evidence of an abscess (cavity containing pus and surrounded by inflamed tissue) on examination but the area surrounding the PEG tube was indurated and erythematous. Consultant GG initiated Augmentin to cover the usual skin cellulitis organisms. R1's EMR lacked evidence the facility notified R1's representative of the new Augmentin order for her PEG tube site cellulitis. On 03/03/25 at 11:25 AM, LN K stated she notified the doctor and Administrative Nurse D for any changes in condition and if she received any new orders, she wrote the orders up. She stated she notified the resident's representative or family on new orders, the doctor's plan, and changes in condition. LN K stated she documented the notification in a nurse's note and passed the information on to the next nurse. On 03/03/25 at 11:30 AM, LN L stated she notified the doctor for any change in condition or if she saw anything that looked different then she documented it. She stated she notified the resident's representative and Administrative Nurse D of any change in condition. On 03/03/25 at 12:06 PM, Administrative Nurse D stated she expected staff to notify the family of any medication changes, changes in conditions, mental status changes, or anything outside the resident's baseline. She stated she expected the notification to be documented under family notification in the EMR. The facility's Physician Notification of Change in Condition policy, dated June 2014, directed if any change in condition occurs that necessitated a transfer to a higher level of care, an order must be written or received by the physician. Patients can be transferred immediately to a higher level of care with the approval of CCO or designee if the physician cannot be immediately reached, and it was felt a higher level of care was immediately necessary to safeguard a patient's health and safety. The policy did not address representative or family notification or changes. The facility failed to notify R1's representative of plan of care changes. This deficient practice had the risk of miscommunication between R1, their representative, and the facility.

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NAME OF PROVIDER OR SUPPLIER Highcrest Hospital of Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103rd Street Overland Park, KS 66212	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 29 residents. The sample included three residents reviewed for feeding tubes. Based on record review and interviews, the facility failed to prevent the neglect of Resident (R) 1 when staff did not provide adequate monitoring and timely care and attention to R1's percutaneous endoscopic gastrostomy (PEG tube- feeding tube through the abdominal wall directly into the stomach) site, which became infected, her abdomen became swollen and inflamed, and her right lower abdomen developed darkening, which staff documented as bruising. On [DATE] at 05:34 AM, R1 had a swollen abdomen and a large palpable mass around the PEG tube, with pus noted coming from the site. Staff notified Consultant GG, who assessed R1, and a note at 08:40 AM documented R1 had cellulitis (skin infection caused by bacteria) surrounding her PEG tube site with the skin indurated (hardened, firm) and erythematous (redness). Six days later, on [DATE] at 12:13 PM, Licensed Nurse (LN) G documented R1's PEG tube balloon appeared displaced and noted bruising around R1's right lower abdomen. LN G documented a new PEG tube was placed with a KUB (Kidney, Ureter, Bladder) x-ray ordered. LN G documented leaving a message for Consultant GG with the KUB results. On [DATE] at 05:59 AM, LN H documented R1 continued on an antibiotic for bacterial infection, R1's right side of her abdomen remained very swollen, inflamed, had blisters, the PEG tube stoma (surgically created opening of an internal organ on the surface of the body) size increased and the inflated balloon was visible. At 06:52 AM, LN H notified Consultant GG that no new orders were received. On [DATE] at 10:15 AM, LN I documented R1's PEG site was very inflamed with bruising noted from the PEG tube site across R1's left breast and down her left side to her hip. LN I notified Consultant GG and received an order to send R1 out to the hospital. R1 died at the hospital the same day. The facility's failure to ensure R1 remained free from neglect placed R1 in Immediate Jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of encounter for attention to gastrostomy (G-tube: tube surgically placed through an artificial opening into the stomach) and anoxic brain damage (brain injury that occurs when the brain is deprived of oxygen for too long). The Admission Minimum Data Set (MDS) dated [DATE], documented R1 was in a persistent vegetative state. R1 had impairment on both sides of her upper and lower extremities and was dependent on staff for her activities of daily living (ADL). R1 had a feeding tube and received 51% or more total calories and 501 cubic centimeters (cc) or more of fluids through tube feeding daily. The Quarterly MDS dated [DATE], documented R1 was in a persistent vegetative state. R1 had impairment on both sides of her upper and lower extremities and was dependent on staff for her activities of daily living (ADLS). R1 had a feeding tube and received 51% or more total calories and 501 cc or more of fluids through tube feeding daily. The Feeding Tube Care Area Assessment (CAA) dated [DATE], lacked an analysis of findings. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan dated [DATE], documented R1 required tube feeding related to dysphagia (difficulty swallowing). The plan directed staff to check for tube placement and gastric contents/residual volume per facility protocol; staff were to monitor, document, and report as needed (PRN) any signs and symptoms of aspiration, fever, shortness of breath, tube dislodgement, infection at tube site, tube dysfunction or malfunction, abnormal breath sounds, abnormal lab values, abdominal pain, abdominal distention, abdominal tenderness, constipation or fecal impaction, diarrhea, nausea and vomiting, and dehydration. The plan directed staff to provide local care to the resident's G-tube site as ordered and monitored for signs and symptoms of infection, and staff provided tube feedings and water flushes. R1's EMR documented an order with a start date of [DATE] for enteral feedings (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) every shift with Osmolite (enteral formula) 1.2 at 50 milliliters (mL) per hour with 40 mL water flushes every four hours. R1's EMR documented an order with a start date of [DATE] for amoxicillin-potassium clavulanate (Augmentin- an antibiotic used to treat infections) ,d+[DATE] milligrams (mg) every 12 hours for bacterial infection for 10 days. R1's clinical record revealed the following: A N (Nursing) Adv (Advantage) Skilled Evaluation note on [DATE] at 12:11 AM documented R1's abdomen was distended and tender. An Orders - Administration Note on [DATE] at 12:36 AM documented the nurse held R1's tube feeding. A Health Status Note on [DATE] at 05:34 AM documented at the beginning of the shift, R1 had a swollen abdomen with a huge palpable mass predominantly around the PEG tube side extending towards the right side of her abdomen. The area was inflamed, warm, and tender to touch with pus noted from the PEG tube site. R1's vital signs included a pulse of 110 beats per minute (bpm) and a temperature of 101.2 degrees Fahrenheit (F). Staff administered as needed (PRN) Tylenol (medication used to treat pain and fever) 650 mg and turned off R1's tube feeding that shift. Staff notified Consultant GG who stated he would see R1 soon. Staff notified R1's representative and oncoming nurse. A Medical Doctor (MD) note on [DATE] at 08:40 AM documented R1 was in a persistent vegetative state with total care provided by facility staff for her PEG tube and noted the resident had cellulitis surrounding the PEG tube. R1 had a low-grade fever with no evidence of an abscess (cavity containing pus and surrounded by inflamed tissue) on examination but the area surrounding the PEG tube was indurated and erythematous. Consultant GG initiated Augmentin to cover the usual skin cellulitis organisms. A N Adv Skilled Evaluation note on [DATE] at 12:13 AM documented R1 had new, generalized pain in her abdomen with facial expressions as indicators of pain. R1's abdomen was tender and distended. A Health Status Note on [DATE] at 06:27 AM documented R1 continued Augmentin for bacterial infection. R1's abdomen was still swollen, inflamed, and blistering. R1's heart rate fluctuated with lows of 41 bpm. R1 had no adverse reactions from antibiotics noted or reported that shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A N Adv Skilled Evaluation note on [DATE] at 06:03 PM documented R1 had unchanged generalized abdominal pain with facial expressions as indicators of pain. A N Adv Skilled Evaluation note on [DATE] at 02:33 AM documented R1 had unchanged generalized abdominal pain. A N Adv Skilled Evaluation note on [DATE] at 05:25 PM documented R1 had unchanged generalized abdominal pain. The record lacked any progress notes after [DATE] at 05:25 PM until [DATE] at 12:13 PM. R1 ' s KUB x-ray results on [DATE] at 11:56 AM documented R1's bowel gas pattern was normal without any obstruction or free air. There was a moderate amount of stool in R1's colon and rectum. The x-ray did not address the PEG tube placement. A Communication - with Physician note on [DATE] at 12:13 PM documented R1's PEG tube balloon appeared to not be in place with noted bruising around her right lower abdomen. Staff placed a new PEG tube and ordered a KUB x-ray. LN G documented a new PEG tube was in place, and he left a message for Consultant GG with the x-ray results. LN G documented R1's right lower abdomen was firm with discoloration and bruising. A Communication - with Family/Next of Kin (NOK)/Power of Attorney (POA) note on [DATE] at 03:02 PM documented R1's family member visited and was aware of KUB results. A Communication - with Family/NOK/POA note on [DATE] at 03:14 PM documented R1's representative was notified of KUB results and provided an update on R1. A N Adv Skilled Evaluation note on [DATE] at 12:15 AM documented R1's abdomen was distended and tender. A Health Status Note on [DATE] at 05:59 AM documented R1 continued Augmentin for bacterial infection. R1's right side of her abdomen was still very swollen, inflamed, and blistered. R1's stoma had increased in size and the inflated balloon was visible. R1 had hypoactive (less than normal activity in the body or its organs) bowel sounds present in all quadrants and her PEG tube was in place. R1 had a temperature of 99.9 degrees F and received Tylenol 650 mg. The nurse notified the oncoming nurse. A Health Status Note on [DATE] at 06:52 AM documented staff notified Consultant GG with no new orders at that time. A eInteract SBAR Summary for Providers note on [DATE] at 07:04 AM documented R1's gastrostomy tube had a blockage or displacement. R1 had a distended abdomen and skin discoloration. Consultant GG ordered a KUB x-ray. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A No Type Specified note on [DATE] at 10:15 AM documented upon assessment that morning, R1's PEG tube site was very inflamed, and she had bruising from her PEG tube site across her left breast and down her left side to her hip. LN I notified Consultant GG who gave the order to send R1 to the hospital. LN I notified R1's representative at 07:10 AM. The ambulance arrived at 07:45 AM to transfer R1 to the hospital. Per request, the facility obtained hospital records for R1's visit on [DATE] which revealed the following: An Emergency Provider Report on [DATE] at 09:38 AM documented R1 was sent to the emergency department (ED) for an issue with her PEG tube. Emergency Medical Services (EMS) stated R1 had redness around her PEG tube and was sent to the hospital for a concern it was in the wrong place. The assessment revealed R1's PEG tube was present with the area medial (towards the middle) to the tube drained [NAME] (clinically evident) pus. There was erythema (redness or inflammation of the skin) that extended from the right abdomen all the way around to the flank (side of the body between the rib cage and the hip). A Computed Tomography [CT scan - test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessel] Abdomen and Pelvis with Contrast on [DATE] at 10:50 AM documented R1's gastrostomy tube with the balloon was outside of the stomach in the anterior (front) abdominal wall. The results documented an abnormal appearance of the gastrostomy tract with a suspected herniation of the stomach through the abdominal muscle with a recommendation for a surgical consultation. A History and Physical on [DATE] at 11:13 AM documented R1 presented with an anterior abdominal wall infection. CT scan revealed feeding tube was outside of the peritoneum (membrane that lines the abdominal cavity) with a large fluid collection in the subcutaneous (beneath the skin) tissues. The assessment revealed widespread cellulitis across R1's right abdomen extending to the feeding tube. An Attestations noted on [DATE] at 01:00 PM documented the provider responded to the ED for a concern of drainage around R1's PEG tube. A quick examination revealed an obviously dislodged PEG tube with a large amount of erythema, induration, and foul-smelling drainage coming from around the PEG tube. R1's representative initially wanted everything done but needed to talk to other family. The provider called R1's representative back 45 minutes later for follow-up and discussed the surgery would be extensive debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) of all infected abdominal wall tissues and removal of the current tube. R1 would need to return to the operating room every two to three days for ongoing debridement which the provider expected would go on for several weeks with months of ongoing wound care. R1's representative wanted to talk to further family members before agreeing. The provider talked to R1's representative a third time and she expressed she did not want to cause any further pain or suffering to R1. R1 was transferred to the Intensive Care Unit (ICU) where the PEG tube was removed with approximately 400 mL of purulence (pus) mixed with tube feedings and debris was evacuated with gentle pressure applied. At 07:00 PM, R1's representative and family arrived, and they wished to proceed with comfort care. At 07:30 PM, R1's experienced an acute rhythm change and the provider let R1's family know she was getting ready to pass away. R1's time of death was at 07:33 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 01:36 PM, Certified Nurse Aide (CNA) M stated she did not usually care for R1 but would do R1's hair for her. She stated she was not sure of the date but maybe, a couple of weeks prior, R1's abdomen was swollen and red on one side. She stated she reported it to LN G who stated he was aware of it. On [DATE] at 01:51 PM, LN J stated she worked the last week R1 was in the facility and did not see any issues with R1. She stated that R1's PEG tube site was not swollen when she changed the dressing. She stated she checked PEG tube placement by auscultating (listening with a stethoscope) for air, aspirating for gastric return, and palpating around the site for protrusions. LN J stated if a PEG tube needed to be replaced, the nurses could replace the PEG tube in the facility with a two-nurse verification process to check for placement. On [DATE] at 01:57 PM, Administrative Nurse D stated to her knowledge, R1 had not had any problems until the day before she went to the hospital when she was notified by LN G of R1's PEG tube issues and bruising on her abdomen. She stated LN G replaced the PEG tube and auscultated the tube for placement along with obtaining a KUB x-ray. She stated the nurses were able to replace the PEG tubes with a two-nurse placement verification with a KUB and documented it in the nurses' notes. Administrative Nurse D stated the x-ray would indicate if the PEG tube was not in the correct place. She stated LN G called Consultant GG with the results of the KUB and received no new orders. Administrative Nurse D stated the next morning on [DATE], Consultant GG gave orders to send R1 to the hospital for evaluation. She stated she knew Consultant GG started R1 on Augmentin for cellulitis on [DATE]. On [DATE] at 11:25 AM, LN K stated she notified the doctor and Administrative Nurse D for any changes in condition. LM K said if she received any new orders, she wrote the orders up. She stated if a PEG tube needed to be replaced, two nurses verified placement and an x-ray confirmed placement. On [DATE] at 11:30 AM, LN L stated she notified the doctor for any change in condition or if she saw anything that looked different then she documented it. The facility's Physician Notification of Change in Condition policy, dated [DATE], directed if any change in condition occurs that necessitated a transfer to a higher level of care, an order must be written or received by the physician. Patients can be transferred immediately to a higher level of care with the approval of CCO or designee if the physician cannot be immediately reached, and it was felt a higher level of care was immediately necessary to safeguard a patient's health and safety. The facility's Enteral Nutrition policy, dated [DATE], directed staff monitored for signs and symptoms of enteral feed intolerance every four hours which included abdominal distention, abdominal pain/cramping, vomiting, and/or new onset diarrhea. The facility's Abuse/Neglect/Exploitation of Children/Elderly and Vulnerable Adults policy, last revised February 2020, defined neglect as when a resident was deprived of or allowed to do without necessary food, clothing, shelter, or medical treatment. The facility failed to ensure R1 remained free from neglect when they failed to provide the necessary monitoring and treatment for R1's PEG tube complications which included abdominal distention, redness and swelling at the PEG tube site, and discoloration of R1's abdomen. R1 transferred to the hospital on [DATE] where she died the same day. This deficient practice placed R1 in immediate jeopardy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility received the Immediate Jeopardy [IJ] Template on [DATE] at 04:42 PM. The facility submitted a removal plan to the state agency which included the following: The facility educated all LN in an in-service provided by Administrative Nurse D prior to their next scheduled shift on PEG tubes, notification of changes, and abuse/neglect/exploitation. Administrative Nurse D rounded on all 23 residents with PEG tubes on [DATE] to ensure proper placement. Administrative Nurse D or designee rounded daily using the PEG Tube Nursing Audit Tool. Administrative Nurse D reviewed the information from the audits and reported findings to the Quality Committee Quarterly. The surveyor verified the implementation of the IJ removal plan while onsite on [DATE] at 10:00 AM. The deficient practice remained at a scope and severity of G to represent the actual harm to R1.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 39752 The facility identified a census of 29 residents and 11 residents with trust accounts. The sample included three residents who were reviewed for misappropriation. Based on observation, record review, and interviews, the facility failed to ensure residents with trust accounts managed by the facility remained free from misappropriation when Administrative Staff B misappropriated funds from the resident trust fund account. This deficient practice placed all residents with trust accounts managed by the facility at risk for misappropriation, financial instability, and impaired rights. Findings included: - The facility's undated RFMS [Resident Funds Management Systems] Investigation, documented on 12/11/24 the facility initiated an investigation after finding credit card fraud on the company credit card attributed to Administrative Staff B. The facility noted several large checks from the resident funds account written to Administrative Staff B with withdrawals not matching up with the written checks. On 12/16/24, Administrative Staff C flew in to assist with the audit of the facility's RFMS account. On 12/17/24, the facility identified several withdrawals from Resident (R) 2, R3, and R4's accounts without receipts signed by the residents. The facility also noted several checks written out of the RFMS account that were not attached to any specific resident. On 12/18/24, Administrative Staff B came to the facility to give an account of discrepancies. She stated she could not remember details but stated the money was accounted for. The facility placed Administrative Staff B on suspension pending further investigation. On 12/19/24, the facility implemented new policies and procedures related to withdrawals from the resident trust account. On 12/30/24, Administrative Staff B resigned from the facility effective immediately. On 01/16/25, the facility reimbursed the missing funds to the resident trust account. On 01/16/25, the facility notified the State Agency (SA) of the issues. On 01/22/25, the facility notified law enforcement. The following checks were written by and made out to Administrative Staff B, from the resident trust account: Check #1831 on 12/14/23 was written and cashed/deposited for $500.00. The For line listed resident petty cash. Check #1835 on 05/01/24 was written and cashed/deposited for $400.00. The For line listed resident petty cash. Check #1838 on 06/28/24 was written and cashed/deposited for $150.00. The For line was left blank. Check #1840 on 07/16/24 was written and cashed/deposited for $500.00. The For line listed resident petty cash. Check #1841 on 07/23/24 was written and cashed/deposited for $450.00. The For line was left blank. Check #1843 on 08/12/24 was written and cashed/deposited for $250.00. The For line was left blank. Check #1844 on 08/19/24 was written and cashed/deposited for $300.00. The For line was left blank. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R2's RFMS Statement, Withdrawal Receipts, and Withdrawal Record revealed the following: A transaction on 03/07/24 for $136.60 for personal needs items. A Withdrawal Receipt dated 03/06/24, for $136.60 was not signed by R2 or Administrative Staff B and lacked evidence of a Withdrawal Record for 03/06/24. A transaction on 05/28/24 for $4.00 for personal needs items but lacked evidence of a Withdrawal Receipt or a Withdrawal Record for the transaction. A transaction on 10/31/24 at $150.00 for personal needs items. A Withdrawal Receipt dated 10/30/24, for $150.00 was not signed by R2 or Administrative Staff B. A Withdrawal Record dated 10/30/24, was signed by Administrative Staff B but was not signed by R2. A transaction on 11/20/24 at $100.00 for personal needs items. A Withdrawal Receipt dated 11/19/24, for $100.00 was not signed by R2 or Administrative Staff B. A Withdrawal Record dated 11/19/24, was signed by Administrative Staff B but was not signed by R2. A review of R3's RFMS Statement, Withdrawal Receipts, and Withdrawal Records revealed the following: A transaction on 06/03/24 for $1200.00 for personal needs items. A Withdrawal Receipt dated 05/29/24, for $1200.00 was not signed by R3 or Administrative Staff B. A RFMS Withdrawal Record dated 05/29/24, for $1200.00 was not signed by R3 or Administrative Staff B. A transaction on 07/01/24 for $50.00 for personal needs items. A Withdrawal Receipt dated 06/28/24, for $50.00 was not signed by R3 or Administrative Staff B. A Withdrawal Record dated 06/28/24, was not signed by R3 or Administrative Staff B. A transaction on 07/25/24 for $450.00 for personal needs items. A Withdrawal Receipt dated 07/24/24, for $450.00 was not signed by R3 or Administrative Staff B. A RFMS Withdrawal Record dated 07/24/24, was signed by Administrative Staff B but not by R3. A review of R4's RFMS Statement, Withdrawal Receipts, and Withdrawal Record revealed the following: A transaction on 08/29/24 for $120.00 for personal needs items. A Withdrawal Receipt dated 08/28/24, was not signed by R4 or Administrative Staff B. A Withdrawal Record dated 08/28/24, was not signed by R4 or Administrative Staff B. On 02/27/25 at 04:53 PM, R3 lay in bed and yelled out for help. On 02/27/25 at 04:55 PM, R4 lay in bed and pulled the blanket down from his face to converse with the surveyor. On 02/27/25 at 04:58 PM, R2 lay in bed and watched television. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Highcrest Hospital of Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103rd Street Overland Park, KS 66212	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/25 at 04:17 PM, Administrative Staff A stated in November 2024, Accounts and Receivables asked her to help balance the corporate credit card. She stated she asked Administrative Staff B to make a spreadsheet with receipts for the purchases, but Administrative Staff B never made the spreadsheet. Administrative Staff A stated she asked Administrative Staff B to review the receipts with her before Administrative Staff B went on vacation on 12/09/24, but she left for the day before it was done. She stated she went to Administrative Staff DD and discovered Administrative Staff B had charged personal lunches and dinners on the corporate credit card. She stated she wondered if the corporate credit card was off, what else could have been off? Administrative Staff A stated she started an investigation on 12/11/24 and had Administrative Staff C fly out to help with the investigation. She stated on 12/17/25, the facility noticed there were several large checks written out to Administrative Staff B that did not match any resident's account and the resident funds were compromised. Administrative Staff A stated that Administrative Staff B came in on 12/18/24 to give a statement and stated that the records were all there and that the facility did not know what they were looking at. Administrative Staff A stated she placed Administrative Staff B on suspension on 12/18/24 and the facility started writing new policies on 12/19/24. She said the facility wanted to give Administrative Staff B another chance to account for the funds, but she had no further statement and quit on 12/30/24. Administrative Staff A stated the facility reported the incident to the SA on 01/16/25. She stated she believed Administrative Staff B did bad bookkeeping but since there were no traces of where the money went, the facility paid the money back. She stated the withdrawal receipts should have had the resident and Administrative Staff B's signature on each transaction. On 02/27/25 at 04:27 PM, Administrative Staff C stated during the investigation, the facility reimbursed any transaction that was withdrawn without the resident's signature. She stated it took a while to look at everything and she wanted to get everything for an audit from Social Security. Administrative Staff C stated after the audit, the facility reported the incident to the SA. She stated there was some withdrawn money without receipts and checks that were cashed with nothing to back them up. On 03/03/25 at 11:38 AM, Administrative Staff DD stated the facility currently had Administrative Staff C helping with resident funds remotely and, if a resident needed money, she told Administrative Staff C who sent a receipt from their account and then Administrative Staff DD and Administrative Staff A gave the money to the resident and had them sign the receipt then they both signed it as well. The facility's Abuse/Neglect/Exploitation of Children/Elderly and Vulnerable Adults policy, last revised February 2020, defined exploitation when a person who stood in a position of trust and confidence with a person and knowingly by deception or intimidation, obtained or used or endeavored to obtain or use, a vulnerable person's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable person of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable person. The facility's Resident Trust/Personal Need Fund Notification and Authorization policy, revised 04/01/24, directed requests for less than $100.00 were honored the same day, and requests for $100.00 or more were honored within three banking days. No funds were disbursed without the appropriate written authorization of the resident or legal representative, if applicable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175240	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highcrest Hospital of Overland Park	6505 W 103rd Street Overland Park, KS 66212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to prevent misappropriation of resident trust funds from the resident trust account and from R2, R3, and R4's trust accounts. This deficient practice placed all residents with trust accounts managed by the facility at risk for misappropriation, financial instability, and impaired rights.

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NAME OF PROVIDER OR SUPPLIER Highcrest Hospital of Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 6505 W 103rd Street Overland Park, KS 66212	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42966 The facility identified a census of 29 residents and 11 residents with trust accounts. The sample included three residents who were reviewed for misappropriation. Based on observation, record review, and interviews, the facility failed to report the suspicion of misappropriation of resident funds to the State Agency (SA) and law enforcement within the required timeframe. This deficient practice placed all residents with trust accounts managed by the facility at risk for unidentified and ongoing misappropriation. Findings included: - The facility's undated RFMS [Resident Funds Management Systems] Investigation, documented on 12/11/24 the facility initiated an investigation after finding credit card fraud on the company credit card attributed to Administrative Staff B. The facility noted several large checks from the resident funds account written to Administrative Staff B with withdrawals not matching up with the written checks. On 12/16/24, Administrative Staff C flew in to assist with the audit of the facility's RFMS account. On 12/17/24, the facility identified several withdrawals from Resident (R) 2, R3, and R4's accounts without receipts signed by the residents. The facility also noted several checks written out of the RFMS account that were not attached to any specific resident. On 12/18/24, Administrative Staff B came to the facility to give an account of discrepancies. She stated she could not remember details but stated the money was accounted for. The facility placed Administrative Staff B on suspension pending further investigation. On 12/19/24, the facility implemented new policies and procedures related to withdrawals from the resident trust account. On 12/30/24, Administrative Staff B resigned from the facility effective immediately. On 01/16/25, the facility reimbursed the missing funds to the resident trust account. On 01/16/25, the facility notified the State Agency (SA) of the issues. On 01/22/25, the facility notified law enforcement. On 02/27/25 at 04:53 PM, R3 lay in bed and yelled out for help. On 02/27/25 at 04:55 PM, R4 lay in bed and pulled the blanket down from his face to converse with the surveyor. On 02/27/25 at 04:58 PM, R2 lay in bed and watched television. On 02/27/25 at 04:17 PM, Administrative Staff A stated she started an investigation on 12/11/24 and had Administrative Staff C fly out to help with the investigation. She stated on 12/17/25, the facility noticed there were several large checks written out to Administrative Staff B that did not match any resident's account and the resident funds were compromised. Administrative Staff A stated that Administrative Staff B came in on 12/18/24 to give a statement and stated that the records were all there and that the facility did not know what they were looking at. Administrative Staff A stated she placed Administrative Staff B on suspension on 12/18/24 and the facility started writing new policies on 12/19/24. She said the facility wanted to give Administrative Staff B another chance to account for the funds, but she had no further statement and quit on 12/30/24. Administrative Staff A stated the facility reported the incident to the SA on 01/16/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 04:27 PM, Administrative Staff C stated after the audit, the facility reported the incident to the SA. She stated there was some withdrawn money without receipts and checks that were cashed with nothing to back them up. The facility's Abuse/Neglect/Exploitation of Children/Elderly and Vulnerable Adults policy, last revised February 2020, defined exploitation when a person who stood in a position of trust and confidence with a person and knowingly by deception or intimidation, obtained or used or endeavored to obtain or use, a vulnerable person's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable person of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable person. The policy directed the facility was obligated to immediately report to the SA and law enforcement any suspected or actual abuse, neglect, or exploitation inflected upon an elder. The facility failed to report the suspicion of misappropriation of resident funds to the SA and law enforcement within the required timeframe. This deficient practice placed all residents with trust accounts managed by the facility at risk for unidentified and ongoing misappropriation.