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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swan Health at 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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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). 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 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