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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swan Health at 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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review, observations, and interviews, the facility failed to provide the necessary care and services related to indwelling catheter care for Resident (R) 1 when staff removed the catheter, failed to reinsert a catheter and monitor to ensure adequate urine output. Additionally, staff failed to obtain physician involvement. R1 subsequently developed a change in condition and was diagnosed with urine retention, urinary tract infection, and acute kidney injury. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of 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) with seizures (violent involuntary series of contractions of a group of muscles) or convulsions (involuntary series of contractions of a group of muscles), encephalopathy (a broad term for any brain disease that alters brain function or structure), and cerebrovascular disease (a group of conditions that affect the blood vessels supplying blood to the brain). The Quarterly Minimum Data Set (MDS) dated 03/31/2026, documented the Brief Interview for Mental Status (BIMS) was not conducted as R1 was rarely or never understood. The MDS documented R1's short-term and long-term memory were not assessed. The MDS documented R1's cognitive skills for daily decision making were severely impaired. The MDS documented R1 was dependent on staff for activities of daily living (ADL). The MDS documented R1 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). The MDS further documented R1 had no speech and recorded rarely or never for R1's ability to make himself understood.The Cognitive Loss / Dementia Care Area Assessment (CAA) dated 06/28/2025, documented R1 had a tracheostomy (trach- opening through the neck into the trachea through which an indwelling tube may be inserted) and had decreased communication. The CAA documented R1 was able to follow simple, one step commands with occasional cues. The Urinary Incontinence and Indwelling Catheter CAA dated 06/28/2025, documented R1 had a catheter due to neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). R1's 11/25/2024 Care Plan documented R1 had an indwelling catheter due to neurogenic bladder and documented the following interventions:11/25/2024 - R1 had Foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.11/25/2024 - Staff was directed to check tubing for kinks each shift.11/25/2024 - Staff was directed to monitor and document for pain or discomfort due to catheter.11/25/2024 - Staff were directed to monitor, record, or report to provider for signs and symptoms of urinary tract infection (UTI-an infection in any part of the urinary system): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. R1's 11/25/2024 Care Plan documented R1 had an ADL self-care performance deficit related to cerebrovascular accident (CVA- stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) with left sided weakness and documented the following interventions:11/25/2024 -R1 was totally dependent on staff to provide bed bath twice/week and as necessary.11/25/2024 -R1 was totally dependent on staff for personal hygiene and oral care.11/25/2024-R1 was totally dependent on (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 0690 Level of Harm - Actual harm Residents Affected - Few	staff for and turning in bed every two hours and as necessary.R1's Care Plan lacked documentation regarding R1's chronic UTIs. A N Adv Skilled Evaluation note dated 05/23/26 (at 10:49 PM) documented under the genitourinary (GU) section staff were unable to replace R1's catheter, provider was aware. The note lacked evidence of provider's response. The B&B - Bladder Elimination task, dated 05/23/2026 at 03:37 PM, documented an incontinent episode for R1. The task lacked further urine output documentation on 05/23/26. The Monitor Output in Foley Catheter task, dated 05/23/2026 at 03:37 PM, documented not applicable. The task lacked further urine output documentation on 05/23/26. A N Adv Skilled Evaluation note dated 05/23/2026 at 10:49 PM, documented under the genitourinary (GU) section staff were unable to replace R1's catheter, provider was aware. The note lacked evidence of provider's response. The Monitor Output in Foley Catheter task dated 05/24/26 at 10:13 AM, documented not applicable. A separate entry on 05/24/2026 at 09:46 PM recorded 2000 (milliliters) under amount. The task lacked further urine output documentation on 05/24/2026. The B&B - Bladder Elimination task, dated 05/24/2026, documented an incontinent episode for R1 at 10:13 AM and 09:46 PM. The task lacked further urine output documentation on 05/24/2026. A N Adv Skilled Evaluation note dated 05/24/2026 at 11:24 AM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's Foley catheter. The note lacked evidence that the provider was contacted. A N Adv Skilled Evaluation note dated 05/24/26 at 11:48 PM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's catheter. The note lacked evidence that the provider was contacted. The Monitor Output in Foley Catheter task, lacked documentation on 05/25/2026. The B&B - Bladder Elimination task, lacked evidence of documentation on 05/25/2026. A N Adv Skilled Evaluation note dated 05/25/2026 at 01:21 PM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's catheter. The note lacked evidence that the provider was contacted. A N Adv Skilled Evaluation note dated 05/25/2026 at 01:23 PM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's catheter. The note lacked evidence that the provider was contacted. A N Adv Skilled Evaluation note dated 05/26/2026 at 10:22 AM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's catheter. The note lacked evidence that the provider was contacted. A Monitor Output in Foley Catheter task, dated 05/26/2026 at 11:02 AM, documented not applicable. A separate entry on 05/26/2026 at 09:37 PM documented not applicable. The task lacked further urine output documentation on 05/26/2026. A B&B - Bladder Elimination task, dated 05/26/2026, documented an incontinent episode for R1 at 11:02 AM and 09:38 PM. The task lacked further urine output documentation on 05/26/2026. A Monitor Output in Foley Catheter task, dated 05/27/2026 at 11:15 AM, documented not applicable. The task lacked further urine output documentation on 05/27/2026. A B&B - Bladder Elimination task, dated 05/27/2026, documented an incontinent episode for R1 at 11:15 AM. The task lacked further urine output documentation on 05/27/2026. A N Adv Skilled Evaluation note dated 05/27/2026 at 12:17 AM, revealed blank documentation under the GU section. The note lacked evidence of staff intervention related to R1's catheter. The note lacked evidence that the provider was contacted. An eINTERACT SBAR Summary for Providers note dated 05/27/2026 at 01:02 PM, documented the change in condition reported was urinary incontinence. The note revealed blank documentation under the GU/Urine status evaluation section. The note recorded under the primary care provider feedback section to send R1 to the hospital. A No Type Specified note dated 05/2720/26 at 02:16 PM, documented R1 was discharged to the hospital for catheter replacement at 02:20 PM on a stretcher and was escorted by two medical transport personnel. A No Type Specified note dated 05/27/2026 at 07:41 PM, documented the emergency room (ER) physician contacted the facility for more details on what, when, and how the Foley catheter was discontinued. The note documented that the nurse was unable to give a relevant reason. The note further documented no progress note was placed at the time of the incident. R1's EMR lacked evidence of any notes, documented between 05/23/2026 at (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	10:49 PM and 05/27/2026 at 01:02 PM, that showed any staff intervention related to R1's Foley catheter being out, any documentation of staff contacting the provider, or orders given from the provider. Review of R1's hospital discharge records revealed a History Physical- Adult note dated 05/27/2026 at 06:57 PM. The note documented R1 had a known history of CVA with residual aphasia (condition with disordered or absent language function), trach, percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) dependence, and was bed-bound. The note further documented R1 came to the ER for urinary retention. The note documented R1 had a chronic Foley catheter, due to comorbidities. The note further recorded R1's family visited him at the facility and noted R1 did not have a Foley in place. Per documentation, nursing was notified and could not get the catheter placed after six attempts. The note recorded R1 had possibly been without the catheter for two to three days. Hospital documentation recorded R1 was seen by urology and a catheter was placed. The note documented R1 did have urine flowing from his catheter, but it was bloody with no clots noted. The note further recorded R1 was noted to have an acute kidney injury (AKI - a sudden and temporary loss of kidney function, causing toxins and waste to build up in the blood) and a UTI. Review of R1's hospital discharge records revealed an Infect Disease Consult Note dated 05/29/2026 at 12:41 PM. The note documented R1 presented to the ER for Foley catheter placement. The note recorded R1's family noted R1 did not have a catheter at the facility. The note further recorded the Foley catheter was placed by urology which required urethral dilation (a minor medical procedure used to stretch and widen a narrowed urethra) due to stricture (an abnormal narrowing or constriction of a bodily passage, tube, or hollow organ). The note recorded that more than two liters of urine was drained following placement. The note documented R1 was diagnosed with a UTI. Review of R1's Treatment Administration Record (TAR) dated 05/01/2026 to 05/31/2026, revealed staff documented performing a flush of R1's Foley catheter on 05/25/2026. Review of R1's Treatment Administration Record (TAR) dated 05/01/2026 to 05/31/2026 revealed staff documented performing urinary catheter care on 05/24/2026 for AM and PM shifts, 05/25/2026 for AM and PM shifts, and on 05/26/2026 for AM shift. The order for urinary catheter care was discontinued on 05/26/2026 at 04:54 PM. Review of the record with Administrative Nurse D confirmed staff identity initials recorded on the TAR, from 05/24/2026 to 05/26/2026, for staff that documented performing catheter care and Foley flush during the time R1's catheter was not in place. On 06/09/2026 at 04:29 PM, R1 rested in bed in his room. R1 had trach and Foley catheter in place. The Foley catheter bag was covered and hung from the side of R1's bed. On 06/09/2026 at 03:08 PM, Licensed Nurse (LN) G confirmed she had worked at least one shift between 05/24/2026 and 05/27/2026. LN G stated she came in the morning after R1's catheter came out. She stated it came out on the previous night shift. LN G stated the night nurse said they could not get it back in place and left it for day shift. LN G stated she went and got LN J to assist her with replacing R1's catheter. She stated neither of them were able to replace the catheter. She stated R1's sister came in and asked about R1's catheter being out, and she told her what had happened. LN G stated she told R1's sister R1's urethra was damaged and they could not put the catheter back in. She stated R1's sister asked if R1 could see a urologist. LN G stated she told R1's sister yes. LN G stated she was then off for several days and when she came back R1 was in the hospital, and his catheter had been replaced. LN G stated she contacted the provider and asked if they could not get the catheter back in if they should send R1 out. She stated she got orders for a condom catheter and that is what they used. LN G stated she made a nurses note under the progress note section related to her contacting the provider and what the provider's response was. LN G stated she did not know why catheter care was documented on her shift. She stated she did not perform catheter care during the shifts she worked, as R1 did not have a catheter in place. She stated she cleaned him up good, but he did not have a catheter to do catheter care on. On 06/09/2026 at 03:16 PM, LN H stated she had worked on the 05/26/2026 and 05/27/2026. She stated she was the nurse that contacted the provider to send the resident to the ER. She stated she had received in report that R1's Foley catheter had come out several days before on (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	night shift. LN H stated it may have been out four to five days but was not for sure exactly how many days. LN H stated R1's sister was at the facility and saw the catheter was no longer in and asked about it. She stated the sister had spoken to the administrator and was concerned that R1's wound may worsen if the catheter was not replaced due to incontinence. She stated she attempted to put his catheter in but was unsuccessful. She stated she was told by other staff that two other nurses had also previously attempted to replace R1's catheter but were unable to. She stated R1's sister wanted R1 sent out if they were unable to replace the catheter. LN H stated she was unsure as to how or why R1's catheter came out due to there not being any progress notes recorded related to the incident. She stated the ER doctor contacted her and asked about R1's catheter and she was unable to give him any details due to there being no documentation from previous staff. She stated it made staff look foolish that she was unable to provide information to the ER doctor due to lack of documentation. She stated everything she knew about what happened with R1's catheter prior to her shifts was hearsay from other staff as there were no notes to read and she could not confirm what had been done previously. LN H confirmed her initials were recorded on the TAR as providing catheter care on 05/26/2026. She stated if she charted that it must have been a mistake. She stated R1 did not have a Foley in either day she worked, and she could not have done catheter care. She stated R1 had been incontinent on her shift twice and she cleaned him up after each time but did not perform catheter care as he did not have one. LN H stated she got the order for catheter care discontinued because there was no point in documenting against catheter care when R1 did not have a catheter in place. On 06/09/2026 at 03:30 PM, LN I stated she had worked a night shift between 05/24/2026 and 05/27/2026. She stated she was not that familiar with R1. She stated she did not know if R1 had an order for a continuous catheter. She stated she was not 100% sure if R1 had a catheter, and she was only providing general information. She stated she did know that R1 had a history of urinary retention. On 06/09/2026 at 03:37 PM, LN J confirmed his initials and stated he worked a shift between 05/24/2026 and 05/27/2026. LN J stated LN G asked him to assist her with replacing R1's catheter. He stated R1's catheter had come out on the previous night shift and LN G had difficulty getting it put back in place. He stated when he tried, there was a lot of resistance, and he did not want to force it. He stated he recommended LN G contact the doctor to see if R1 could be sent out to have a specialist do it. LN J stated he was unsure if LN G contacted the doctor, but stated he believed she did. LN J stated he did not remember documenting that he had done catheter care on R1 when he worked his shift. He stated he did not have that assignment, and he did not do catheter care on R1 that day a R1 did not have one in place. LN J stated LN G should have put in a note documenting that information if she contacted the doctor. LN J stated it would be difficult for staff to know what was going on with a resident if other staff were not documenting when they contacted providers. He stated unless he had the resident himself, he would have a hard time knowing what had occurred on previous shifts if there was no documentation. On 06/09/26 at 04:00 PM, LN K confirmed she had worked a night shift between 05/24/2026 and 05/27/2026. She stated she had only heard about R1's situation in passing. She stated she knew R1 had gone out to the hospital. She stated if her initials were documented as performing catheter care then it must have been her. She stated she did not recall anything out of the ordinary with him the night she worked. LN K stated she did not recall if R1 had a catheter or not the night she worked. LN K stated when she documented doing catheter care, she must have considered it as regular peri care and clicked it. On 06/09/2026 at 04:49 PM, Administrative Nurse D stated she was on vacation from 05/21/2026 to 06/01/2026. Administrative Nurse D stated R1's catheter came out; staff tried to put it back in and were unable to. She stated from what she understood, R1's Foley came out on night shift, they notified the nurse practitioner, and no new orders were given. Administrative Nurse D stated R1 was sent out on 05/27/2026 and returned on 05/30/2026. Administrative Nurse D stated R1 had urinary retention and neurogenic bladder. Administrative Nurse D stated she reviewed the TAR for the dates of 05/2420/26 through 05/26/2026 and saw where staff had documented performing catheter care over those days. She stated staff should not have (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	documented performing catheter care if R1 did not have a catheter in place. She stated staff should have contacted the doctor and should have put a progress note in after documenting that if he did not have it in place. Administrative Nurse D stated if there was an order to hold the catheter and monitor, then that should have been put in. She further stated staff should be putting in notes if no new order was given, or any order given. She stated they should document any change in conditions and notes documenting family was notified. Administrative Nurse D stated if the catheter was out, staff should have notified the MDS coordinator to have them change the Foley catheter output task. She stated staff should have monitored urine output through a different task if the catheter was no longer in place. Administrative Nurse D stated R1 was found to have had a UTI at the hospital. She stated she believed R1 may have had a history of chronic UTIs. Administrative Nurse D stated it would be difficult for other nurses to know what was going on with a resident fi there was no documentation from previous shifts. The facility's Urinary Continence and Incontinence- Assessment and Management policy, with a revision date of August 2022, documented the staff and practitioners will appropriately screen for and manage individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. If an indwelling catheter is needed, staff will monitor and report complications such as evidence of a symptomatic infection.