

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/21/2026
NAME OF PROVIDER OR SUPPLIER Swan Health at Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff provided the necessary assistance with activities of daily living for Resident (R) 1 when staff failed to wash his face, provide baths, and trim his nails. Findings included:- R1's Electronic Medical Record (EMR) documented the following diagnoses of acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), epilepsy (brain disorder characterized by repeated seizures), spastic quadriplegic cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), seborrheic dermatitis (a common, chronic skin condition that primarily affects areas rich in sebaceous glands, such as the scalp, face, and trunk), and dysphagia (swallowing difficulty). R1's admission Minimum Data Set (MDS) dated [DATE] documented a staff assessment for mental status that showed a score of three, indicating severely impaired cognition. R1's MDS documented he was dependent on staff with all activities of daily living (ADL). R1 was at risk of developing a pressure ulcer and had moisture associated skin damage (MASD). The MDS documented a turning and repositioning program, nutrition and hydration interventions to manage skin problems, and applications of ointments/medications other than to the feet. R1's Activities of Daily Living Self-Care Care Plan initiated on 06/08/2026 directed that R1 was totally dependent on staff for dressing and personal hygiene and oral care. The plan of care further directed that R1 required a skin inspection every shift to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. R1's Care Plan lacked direction of care with grooming related to R1's personal hygiene preference to have his face washed and cocoa butter applied daily or addressing trimming of the fingernails. Review of R1's Bath Sheets documented the following:05/31/2026 documented no concerns.06/03/2026 documented no concerns.06/08/2026 documented no concerns.06/14/2026 documented no concerns. There was no evidence that R1 received any baths other than those listed above, indicating that between admission [DATE]) and discharge (06/30/2026), 32 days total, R1 only received five baths. Review of R1's Progress Notes from 05/29/26 through 06/30/26 lacked documentation that addressed R1's facial care, fingernails, or refusals for bathing/personal care. Review of R1's Admission paperwork from his admission to the acute hospital dated 06/30/2026 documented R1 admitted with very long fingernails. Review of the admission photograph revealed R1's right hand had fingernails that extended over the top of all five of R1's fingertips. On 07/20/2026 at 03:13 PM, R1's representative stated he had asked both facility staff and facility administration about R1 needing to have his nails trimmed. R1's representative stated he had asked the facility staff to wash R1's face and put on some cocoa butter cream every day. On 07/21/2026 at 11:11 PM, Certified Nurse Aide (CNA) N stated that she would let the nurse know if a resident needed their nails trimmed. CNA N further stated she did not trim fingernails because she did not feel comfortable doing that. On 07/21/2026 at 11:00 AM, Licensed Nurse (LN) H (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 175240	If continuation sheet Page 1 of 6

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that when the residents needed their nails trimmed, she notified Administrative Nurse E. LN H revealed that she did not see clipping fingernails as part of her job but said if a resident's nails appeared to be too long and needed to be trimmed due to being at risk of harming themselves, she would trim them. On 07/21/2026 at 12:10 PM, Administrative Nurse E stated that if a resident needed their nails trimmed, she would be notified, and she would trim the resident's nails. Administrative Nurse E further stated that CNAs and LNs could trim residents' nails, but if a resident was diabetic, only an LN could trim that resident's nails. Administrative Nurse E stated that R1's representative had come into R1's room and thrown away all of the creams that were ordered for R1. Administrative Nurse E stated R1's representative informed them the creams did not work and directed staff to use the cream that R1's representative had supplied. On 07/21/2026 at 12:58 PM, Consultant HH confirmed that regardless of what a family member requested, the facility still needed to address ADLs and fingernails. The facility's Nail Care policy, implemented on 07/01/26, documented the purpose of the procedure was to provide guidelines for the provision of care to a resident's nails for good grooming and health. The policy further directed that staff would routine cleaning and inspections of nails would be provided during Activities of Daily Living care on an ongoing basis. The policy identified routine nail care, to include trimming and filing, which would be provided on a regular schedule, and nail care would be provided between scheduled occasions as the need arose. The facility's Activities of Daily Living (ADLs) policy, implemented on 07/01/26, documented a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide adequate care and services related to skin issues when staff failed to address and treat Resident (R) 1's seborrheic dermatitis (a common, chronic inflammatory skin condition causing oily patches, stubborn dandruff, and yellow or white scales) on his face and scalp. Findings included:- R1's Electronic Medical Record (EMR) documented the following diagnoses of acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), epilepsy (brain disorder characterized by repeated seizures), spastic quadriplegic cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), seborrheic dermatitis (a common, chronic skin condition that primarily affects areas rich in sebaceous glands, such as the scalp, face, and trunk), and dysphagia (swallowing difficulty). R1's admission Minimum Data Set (MDS) dated [DATE] documented a staff assessment for mental status that showed a score of three, indicating severely impaired cognition. R1's MDS documented he was dependent on staff with all activities of daily living (ADL). R1 was at risk of developing a pressure ulcer and had moisture associated skin damage (MASD). The MDS documented a turning and repositioning program, nutrition and hydration interventions to manage skin problems, and applications of ointments/medications other than to the feet. R1's Activities of Daily Living Self-Care Care Plan initiated on 06/08/2026 directed that R1 was totally dependent on staff for dressing and personal hygiene and oral care. The plan of care further directed that R1 required a skin inspection every shift to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. R1's Care Plan lacked direction of care for seborrheic dermatitis. R1's Clinical Update from the hospital dated 05/18/2026 documented he had a history of seborrheic dermatitis and to monitor for worsening tachypnea (rapid shallow breathing), secretion burden, and fevers. The seborrheic dermatitis management per dermatology recommended Vanicream (a mild corticosteroid used topically to reduce inflammation, redness, and itching associated with skin conditions such as dermatitis) twice a day as needed, Ketoconazole (an antifungal medication used to treat dandruff and seborrheic dermatitis) two percent shampoo two to three times per week as needed, and ketoconazole cream to the red areas on R1's face. R1's Discharge Orders provided to the facility for R1's admission dated 05/29/2026 documented Vanicream apply topically to affected area if needed for dry skin, ketoconazole two percent cream apply topically to affected area two times a day as needed for itching or rash. R1's Orders tab documented the following orders:Ketoconazole external shampoo two percent, apply to scalp topically as needed for dandruff to scalp on bath days, ordered on 05/29/26.Ketoconazole external cream two percent, apply to affected areas topically as needed for itching or rash, ordered on 05/29/2026, discontinued on 06/02/2026. The Orders Note dated 05/29/2026 at 03:22 PM documented the Vanicream cream was discontinued, and A&D ointment (an over-the-counter skin protectant and emollient used to treat and prevent diaper rash, minor cuts, scrapes, and chafed skin) was ordered verbally. Review of R1's May Medication Administration Record (MAR) revealed no signatures indicating R1 had received Ketoconazole external cream or Ketoconazole external shampoo. Review of R1's May Treatment Administration Record (TAR) revealed no signatures indicating R1 had received A&D ointment. Review of R1's June MAR revealed no signatures indicating R1 had received Ketoconazole External Cream or Ketoconazole external shampoo. Review of R1's June TAR revealed no signatures indicating R1 had received A&D ointment. Review of R1's Face Sheet revealed R1 was photographed on 06/02/2026 with no reddened areas to his face, and his forehead appeared shiny in the photograph. Review of R1's Bath Sheets documented (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following:05/31/26 documented no concerns.06/03/26 documented no concerns.06/08/26 documented no concerns.06/14/26 documented no concerns. Review of R1's Progress Notes documented throughout that R1's skin was warm and pink with brisk capillary refill (less than three seconds) with no edema (swelling resulting from an excessive accumulation of fluid in the body tissues) present. The Skilled Assessments flow into the progress notes and reflected the same documentation. R1's Progress Notes lacked any identification of rashes or flaky skin during his stay at the facility. Review of R1's Admission paperwork from his admission to the acute hospital dated 06/30/2026 documented R1 admitted with significantly worse fungal facial rash than when R1 had originally been discharged on 05/29/2026. On discharge, 05/29/2026, R1 had some small areas, but this was well-controlled with the daily application of antifungal ointment and facial hygiene. Review of the admission photograph of R1 revealed a reddened area that spanned out from around R1's nose; multiple raised, reddened, circular areas throughout R1's face with an increase in areas on his chin and forehead. R1 had yellowed flakes at the bridge of his nose near both eyes. R1 had whitish-yellow areas under the base of his nose, and white flakes on his lips and circling his chin. In a second photograph of R1's right ear, a darker reddened circular outline with dry yellow flakes on the inside was visible on the outside of R1's ear near his canal. On the underside of R1's earlobe, there was a similar reddened area at the base that had patches of dry yellow flakes throughout that reddened area. On 07/20/2026 at 03:13 PM, R1's representative stated he had asked the facility staff to wash R1's face and put on some cocoa butter cream every day. R1's representative further stated that he had asked both facility staff and facility administration about getting R1 in to see a dermatologist (physician specializing in skin conditions). On 07/21/2026 at 11:10 AM, Certified Nurses Aide (CNA) M stated that when he gave a resident a bath, he would check over the resident's skin and let the nurse know if there were any skin concerns. CNA M stated that R1 had dry, flaky skin and hair. CNA M stated he had notified the nurse. On 07/12/2026 at 11:11 AM, CNA N stated that R1 had irritated skin and the nurse was notified about the concern. On 07/20/2026 at 02:43 PM, Administrative Nurse E, the wound care nurse, stated that R1's order for the Vanicream was just for dry skin with no specifications as to where it needed to go. Administrative Nurse E stated she spoke with the nurse practitioner and asked to discontinue the order. Administrative Nurse E revealed she did not know what that cream was used for, and when asked if she would call to clarify the order with the discharging facility, Administrative Nurse E stated she would not call because R1 was their patient once admitted and not the discharging hospital's. Administrative Nurse E stated that R1's father had come into the facility and thrown all of R1's topical creams away. On 07/20/2026 at 02:50 PM, Administrative Nurse D stated that she had provided cares for R1 and noticed red blotches on his skin, but did not think that it was a rash but more of a color variance. Administrative Nurse D stated R1 had reddened areas on his face since he was admitted to the facility. The facility's Skin Integrity-Foot Care policy, implemented on 07/01/26, documented it was the policy of the facility to ensure residents received proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide foot care to Resident (R) 1, who was dependent on staff for foot care and whose toenails were long. Findings included:- R1's Electronic Medical Record (EMR) documented the following diagnoses of acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), epilepsy (brain disorder characterized by repeated seizures), spastic quadriplegic cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), seborrheic dermatitis (a common, chronic skin condition that primarily affects areas rich in sebaceous glands, such as the scalp, face, and trunk), and dysphagia (swallowing difficulty). R1's admission Minimum Data Set (MDS) dated [DATE] documented a staff assessment for mental status that showed a score of three, indicating severely impaired cognition. R1's MDS documented he was dependent on staff with all activities of daily living (ADL). R1 was at risk of developing a pressure ulcer and had moisture associated skin damage (MASD). The MDS documented a turning and repositioning program, nutrition and hydration interventions to manage skin problems, and applications of ointments/medications other than to the feet. R1's Activities of Daily Living Self-Care Care Plan initiated on 06/08/2026 directed that R1 was totally dependent on staff for dressing and personal hygiene and oral care. The plan of care further directed that R1 required a skin inspection every shift to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. R1's Care Plan lacked direction of care for his toenails or feet. Review of the Podiatrist list for June lacked R1's name on the list of residents that were seen. Review of R1's Bath Sheets documented the following:05/31/26 documented no concerns.06/03/26 documented no concerns.06/08/26 documented no concerns.06/14/26 documented no concerns. Review of R1's Progress Notes from 05/29/26 through 06/30/26 lacked documentation that addressed R1's feet or toenails. Review of R1's Admission paperwork from his admission to the acute hospital dated 06/30/2026 documented R1 admitted with very long toenails. Review of the admission photograph revealed R1's right foot had a thick big toenail that appeared to extend past the top of his big toe considerably. R1's second toe and pinky toe also appeared to have toenails extending past the top of his toes considerably. On 07/20/2026 at 03:13 PM, R1's representative stated he had asked both facility staff and facility administration about R1 being seen by a podiatrist (doctor who specializes in foot care) for his toenails. On 07/21/2026 at 11:11 PM, Certified Nurses Aide (CNA) N stated that she would let the nurse know if a resident needed their nails trimmed. CNA N further stated she did not trim toenails and fingernails because she did not feel comfortable doing that. On 07/21/2026 at 11:00 AM, Licensed Nurse (LN) H stated that when the residents needed their nails trimmed, the podiatrist handled that, or she would notify Administrative Nurse E. LN H revealed that she did not see clipping toenails as part of her job. LN H stated if a resident's toenails appeared to be too long and needed to be trimmed due to being at risk of harming themselves, she would trim them. LN H further revealed that she could only trim a resident's toenails as long as the resident was not a diabetic. On 07/21/2026 at 12:10 PM, Administrative Nurse E stated that if a resident needed their toenails trimmed, she would be notified, and she would trim the resident's nails unless it was something that the podiatrist needed to attend to. Administrative Nurse E stated she could not recall if she trimmed R1's toes but felt that she had, stating it would be in the progress notes. Administrative Nurse E further stated that CNAs and LNs could trim residents' nails, but if a resident was diabetic, only a LN could trim that resident's nails. The facility's Skin Integrity-Foot Care policy, implemented on 07/01/2026, documented it was the (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy of the facility to ensure residents received proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. The policy directed that the facility would provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions. The policy further directed that if necessary, the facility would assist the resident in making appointments with a qualified person and arranging for transportation to and from such appointments. The policy directed staff that nursing assistants would inspect skin during baths and would report any concerns to the resident's nurse immediately after the task.		