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	05/06/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 32 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure Residents (R) 19 and R8 remained free from unnecessary psychotropic (alters mood or thought) medications and chemical restraint (use of medication to control behaviors). This deficient practice placed both residents at risk for sedation and chemical restraint. Findings Included: - The Medical Diagnosis section within R19's Electronic Medical Records (EMR) included diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, dysphagia (difficulty swallowing), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R19's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS noted she had bilateral (both sides) upper and lower extremity impairments. The MDS noted she was dependent on staff assistance for transfers, bathing, bed mobility, dressing, toileting, and personal hygiene. The MDS noted she had no psychiatric or mood disorders. The MDS indicated she did not take antianxiety (a class of medications that calm and relax people) or antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications. R19's Psychotropic Drug Use Care Area Assessment (CAA) completed 02/04/25 noted she took psychotropic medications and was at risk for side effects. The CAA noted she took antipsychotic drugs and noted that care plan interventions were implemented. R19's Care Plan initiated on 02/27/25 indicated she was totally dependent on staff assistance for all her activities of daily living (ADL) related to her medical diagnoses. The plan noted she took medications with Black Box Warnings (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The plan instructed staff to monitor for medication side effects and adverse reactions to the medications. The plan noted that the pharmacy would make medication recommendations and follow up as indicated. The plan noted she would be monitored by her medical provider, and the pharmacist would consider dosage reduction when clinically appropriate for her psychotropic medications. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's EMR under Physician Orders indicated an order (dated 01/28/25) for staff to administer 12.5 milligrams (mg) of Seroquel (antipsychotic medication) via her gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The EMR revealed she had the medication upon her admission on 01/28/25. R19's EMR under Physician Orders indicated an order (dated 01/28/25) for staff to administer Lorazepam (an antianxiety medication), one milligram every six hours as needed for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The order lacked a stop date and was documented as indefinite. A review of R19's Medication Regimen Review (MRR) completed 03/14/25 revealed the Consultant Pharmacist (CP) notified the facility that R19's Lorazepam medication required a duration of use past the 14-day period. The medical provider responded to the note with a 30-day duration for anxiety on 03/21/25. R19's Lorazepam received no other orders for the continuation past the 30-day stop period. A review of R19's Medication Regimen Review (MRR) completed 03/14/25 revealed the CP notified the facility that R19's Seroquel medication could not be used for depression. The medical provider noted R19 failed a gradual dose reduction. The MRR did not acknowledge that depression was not an accepted CMS indication for antipsychotic medications. On 05/06/25 at 07:00 AM, R19 rested in her bed. R19 received her morning medication without issue. On 05/6/25 at 01:20 PM, Licensed Nurse (LN) I stated that antipsychotic medication should not be given for depression. She stated the medication was to be given for mental disorders. She stated PRN psychotropic medications required a 14-day stop date and a physician's rationale for continued use. She stated that nursing staff were expected to monitor the orders and report irregularities to the medical provider and the director of nursing. She stated the pharmacy was expected to also find these issues and report them. On 05/06/25 at 01:32 PM, Administrative Nurse D stated all PRN psychotropic medications should have the initial 14-day stop date. She stated the durations were not usually put into the orders due to the pharmacy setting the durations for the medications. She stated that antipsychotic medications were not meant to be used for depression. She stated that antipsychotics were to be used for behavioral and mood disorders. The facility's Psychotropic Medication Use policy, revised 07/2022, indicated the facility was not to give psychotropics unless necessary to treat a specific condition and deemed beneficial to the resident. The policy noted that the facility would identify the risks versus benefits of the medication's use and utilize non-pharmacological interventions. The policy noted that the facility would ensure continual medication monitoring and adjust the dosage to meet the therapeutic needs of the resident. The policy noted that PRN psychotropic medication would be given a 14-day stop date and renewed only upon physician evaluation. 41037 - R8's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of paraplegia (the loss of muscle function, sensation, or both) and insomnia (inability to sleep). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R8 had received hypoglycemic (a class of medication used to lower blood sugar) medication, opioid (a class of controlled drugs used to treat pain) medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. R8's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/15/25 documented R8 received antipsychotic medication related to his diagnosis of paraplegia. R8's Care Plan, dated 03/26/25, documented the nursing staff would request the physician to review and evaluate R8's medications. R8's EMR under the Orders tab revealed the following physician orders: Diazepam (antipsychotic) oral tablet two milligram (mg) (valium) give one tablet by mouth every eight hours as needed (PRN) for mild muscle spasms (involuntary muscular contraction) dated 02/10/25. The as needed antipsychotic medication lacked a 14-day stop date or a physician-ordered specific duration. Diazepam oral tablet, give two mg tablets (four mg) by mouth as needed for moderate muscle spasms. May have four mg at bedtime as needed, dated 02/10/25. The as needed antipsychotic medication lacked a 14-day stop date or a physician-ordered specific duration. Quetiapine (antipsychotic) fumarate tablet 25mg (Seroquel) give 12.5 mg tablet by mouth at bedtime for insomnia dated 03/10/25. Review of R8's EMR under the Misc tab revealed Monthly Medication Review (MMR) dated 01/16/25 with a recommendation for R8's as needed Valium needed a clinical rationale documentation in R8's clinical record for the continuance of the medication with a duration the medication should be continued. The physician response dated 02/11/25 rationale was chronic spasticity para status and the duration was lifetime. MMR dated 03/17/25 documented R8 had received antipsychotic medication Seroquel that lacked an acceptable indication for use. The physician's response dated 03/21/25 documented a diagnosis of psychosis (any major mental disorder characterized by a gross impairment in reality perception). The facility was unable to provide physician documentation for the use of an antipsychotic medication with a non-approved indication upon request. On 05/06/25 at 07:46 AM, R8 laid on his right on his bed. Staff delivered his breakfast tray to his room. R8 consumed a drink from his tray to swallow his pain medication without difficulty. On 05/6/25 at 01:20 PM, Licensed Nurse (LN) I stated that antipsychotic medication should not be given for insomnia. She stated the medication was to be given for mental disorders. She stated PRN psychotropic medications required a 14-day stop date and a physician's rationale for continued use. She stated nursing staff were expected to monitor the orders and report irregularities to the medical provider and the director of nursing. She stated the pharmacy was expected to also find these issues and report them. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 01:32 PM, Administrative Nurse D stated that all PRN psychotropic medications should have the initial 14-day stop date. She stated the durations were not usually put into the orders due to the pharmacy setting the durations for the medications. She stated that antipsychotic medications were not meant to be used for insomnia. She stated that antipsychotics were to be used for behavioral and mood disorders. The facility's Psychotropic Medication Use policy, revised 07/2022, indicated the facility was not to give psychotropic unless necessary to treat a specific condition and deemed beneficial to the resident. The policy noted that the facility would identify the risks versus benefits of the medication's use and utilize non-pharmacological interventions. The policy noted that the facility would ensure continual medication monitoring and adjust the dosage to meet the therapeutic needs of the resident. The policy noted that PRN psychotropic medication would be given a 14-day stop date and renewed only upon physician evaluation.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to complete the Care Area Assessment (CAA) analysis of findings, related to a Comprehensive Minimum Data Set (MDS), for two residents, Residents (R) 12 and R20, in order to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. This placed these residents at risk for impaired care and decreased quality of life due to unidentified care needs. Findings included: - R12's Admission MDS dated [DATE] 23 triggered the CAA for functional abilities (self-care mobility), urinary incontinence and indwelling catheter, pressure ulcer, and nutritional status. All triggered CAA's lacked completion with an analysis of findings. R20's Admission MDS dated [DATE] triggered the CAA for functional abilities (self-care mobility), urinary incontinence and indwelling catheter, pressure ulcer, psychotropic (alters mood or thought) drug use, falls, and nutritional status. All triggered CAA's lacked completion with an analysis of findings. On 05/06/25 at 09:03 AM, Administrative Nurse E was unavailable for interview by phone. On 05/06/25 at 10:30 AM, Administrative Nurse D stated she was not able to answer the question about R12 and R20's MDS lacking the analysis of their CAAs. The Facility's MDS Assessment Coordinator policy, last revised November 2019, documented a registered nurse (RN) would be responsible for conducting and coordinating the development and completion of the resident assessment (MDS).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45668 The facility identified a census of 32 residents. Based on observation, record review, and interview, the facility failed to provide consistent Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week. This placed all the residents who resided in the facility at risk of a lack of assessment and inappropriate care. Findings included: - A review of the facility's submitted Payroll Based Journaling (PBJ - Staffing Data Report) from 04/01/24 through 03/31/25 indicated the facility triggered for no RN coverage on 12 occasions (04/05/24, 4/12/24, 04/19/24, 06/08/24, 07/20/24, 07/21/24, 08/03/24, 08/17/24,11/11/24, 11/17/24, 11/23/24, and 12/09/24). Upon review of the facility's working schedules and daily posted staffing revealed that no accounted RN hours for eight of the twelve days triggered (04/05/24, 04/12/24, 04/19/24, 06/08/24, 07/20/24, 07/21/24, 08/03/24, and 08/17/24). The facility was not able to provide documentation for the eight missing days of RN coverage as requested on 05/06/25. On 05/06/25 at 10:35 AM, Administrative Nurse D stated that both Administrator A and she came in to cover call-offs and weekend shifts for nursing. She stated the hours may not have been reflected correctly on the PBJ documentation. On 05/06/25 at 10:35 AM, Administrator A stated she was not able to pull punches or timecards for the missing days due to the changeover to a newer system and had no way to pull the needed data for the coverage. The facility's Department Supervision, Nursing policy, revised 08/2022, indicated the facility was to ensure a registered nurse was on duty at least eight consecutive hours every 24 hours, seven days a week.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45668 The facility identified a census of 32 residents. The sample included 12 residents. Based on record review and interview, the facility failed to update its daily posted staffing form to provide accurate daily staffing information. Findings included: - On 05/04/25 at 10:05 AM, an inspection of the facility revealed posted staffing documentation on the wall in the cafeteria area. An inspection of the documentation revealed the document was dated 04/29/25. At 10:05 AM, Licensed Nurse (LN) H stated the form should be updated daily by the nursing administrators, but had not been updated since last week. On 05/05/25 at 0745 AM, an inspection of the posted staffing form revealed a date of 04/29/25. On 05/06/25 at 01:32 PM, Administrative Nurse D stated the form was to be updated daily with the correct information on it. She stated that Administrator A updated and posted the forms daily. On 05/06/25 at 01:32 PM, Administrator A stated she had been off since last week and wasn't able to update the forms. The facility's Posting Direct Care Daily Staffing Numbers policy, revised 08/2022, indicated that staffing hours must be maintained for facility records for a minimum of 18 months and posted daily. The policy indicated the records must be made available upon request.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 32 residents. The sample included 12 residents, with five sampled residents reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure the Consultant Pharmacist's (CP) recommended a Centers for Medicare and Medicaid (CMS) approved indication related to Resident (R) 19's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. This deficient practice placed R19 at risk of unnecessary medication administration and related complications. Findings Included: - The Medical Diagnosis section within R19's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, dysphagia (difficulty swallowing), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R19's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. The MDS noted she had bilateral upper and lower extremity impairments. The MDS noted she was dependent on staff assistance for transfers, bathing, bed mobility, dressing, toileting, and personal hygiene. The MDS noted she had no psychiatric or mood disorders. The MDS indicated she did not take antipsychotic medications. R19's Psychotropic (alters mood or thought) Drug Use Care Area Assessment (CAA) completed 02/04/25, noted she took psychotropic medications and was at risk for side effects. The CAA noted she took antipsychotic drugs and noted that care plan interventions were implemented. R19's Care Plan initiated on 02/27/25 indicated she was completely dependent on staff assistance for all her activities of daily living (ADL) related to her medical diagnoses. The plan noted she took medications with Black Box Warnings (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The plan instructed staff to monitor for medication side effects and adverse reactions to the medications. The plan noted that the pharmacy would make medication recommendations and follow up as indicated. The plan noted she would be monitored by her medical provider, and the pharmacist would consider dosage reductions when clinically appropriate for her psychotropic medications. R19's EMR under Physician Orders indicated an order (dated 01/28/25) for staff to administer 12.5 milligrams (mg) of Seroquel (antipsychotic medication) via her gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) at bedtime for depression. The EMR revealed she had the medication upon her admission on 01/28/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R19's Medication Regimen Review (MRR) completed 03/14/25 revealed the CP notified the facility that R19's Seroquel medication could not be used for depression. The medical provider noted R19 failed a gradual dose reduction. The MRR did not acknowledge that depression was not an accepted CMS indication for antipsychotic medications. On 05/06/25 at 07:00 AM, R19 rested in her bed. R19 received her morning medication without issue. On 05/06/25 at 01:20 PM, Licensed Nurse (LN) I stated that antipsychotic medication should not be given for depression. She stated the medication was to be given for mental disorders. She stated that nursing staff were expected to monitor the orders and report irregularities to the medical provider and the director of nursing. She stated the pharmacy was expected to also find these issues and report them. On 05/06/25 at 01:32 PM, Administrative Nurse D stated that antipsychotic medications were not meant to be used for depression. She stated that antipsychotics were to be used for behavioral and mood disorders. She stated the pharmacist was expected to make recommendations about which medications were appropriate related to psychotropic medication use. The facility's Medication Regimen Review policy, revised 01/2021, indicated the facility's CP was to complete monthly medication reviews for each resident and report irregular findings. The policy indicated the CP was to make recommendations to the facility for medication findings based on medication indications, durations, side effects, potential complications, or adverse reactions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 32 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician was notified of blood sugars outside the physician ordered parameters for Resident (R) 12 and the facility failed to ensure antihypertensive (medication used to treat high blood pressure) medication was administered per the physician ordered parameters for R16. These deficient practices placed these residents at risk for unnecessary medication administration and possible adverse reactions. Findings included: - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid) and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R12 had received diuretic (a medication to promote the formation and excretion of urine) medication and anticoagulant (a class of medications used to prevent the blood from clotting) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R12 had received diuretic medications, anticoagulant medications, and insulin (medication to regulate blood sugar) during the observation period. R12's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/14/24 lacked completion with analysis of findings. R12's Care Plan, dated 03/26/25, documented nursing staff would review the pharmacy consult recommendations and follow up as indicated. R12's EMR under the Orders tab revealed the following physician orders: Blood glucose monitoring four times a day for DM. Notify the physician if blood sugar was less than (<) 30 or greater than (>) 350 dated 02/11/25. Novolog (insulin) flex pen subcutaneous solution pen injector 100 units/milliliters (ml) (insulin aspart) inject 10 units subcutaneously with meals for blood sugar 250 and greater dated 02/28/25. Review of R12's Medication Administration Record (MAR) from 02/01/25 to 05/05/25 (94 days) his blood sugar was outside the physician ordered parameters on the following 12 dates: 02/20/25, 02/27/25, 03/03/25, 03/08/25, 03/25/25, 03/26/25, 04/03/25, 04/06/25, 04/13/25, 04/18/25, 05/04/25, and 05/05/25. R12's clinical record lacked documentation of physician notification. On 05/06/25 at 07:37 AM, R12 laid asleep on his bed with no distress noted. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/26/25 at 01:20 PM, Licensed Nurse (LN) I stated the physician should be notified of any blood sugars outside the ordered parameters LN I stated a note should be entered into the resident's EMR of the notification and their response to the notification. On 05/06/25 at 01:23 PM, Administrative Nurse D stated she expected the physician to be notified of any blood sugars that were outside the ordered parameters. Administrative Nurse D stated that a note should be in the residents' EMR of the physician notification and the physician's response. The facility was unable to provide a policy related to following a physician's order. 45668 - The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of chronic respiratory failure, hypoxia (inadequate supply of oxygen), hypertension (high blood pressure), and muscular dystrophy (MD - group of inherited disorders that involve muscle weakness and loss of muscle tissue and worsen over time). R16's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of eleven, indicating intact cognition. The MDS noted no upper or lower extremity impairments. The MDS noted he required substantial to moderate assistance from staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS noted he had a diagnosis of hypertension. The MDS noted that he received oxygen therapy services. R16's Functional Abilities Care Area Assessment (CAA) completed 06/11/24 indicated he required moderate to substantial staff assistance with his activities of daily living. The CAA noted staff were to anticipate his needs and care plan interventions were implemented to minimize the risks of falls, weight loss, incontinence, and skin breakdown. R16's Care Plan initiated on 11/26/24 indicated he required staff assistance for dressing, bathing, transfers, toileting, and personal hygiene. The plan noted he took medications with Black Box Warnings (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The plan instructed staff to monitor for medication side effects and adverse reactions to the medications. The plan noted he had hypertension. R16's EMR under Physician's Orders revealed an order for staff to administer 25 milligrams of Metoprolol (antihypertensive medication) by mouth two times daily for hypertension. The parameters instructed staff to hold the medication if systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg). A review of R20's Medication Administration Record (MAR) from 03/01/25 to 05/06/25 revealed that Metoprolol was given outside the ordered parameters on ten occasions (03/14/25, 03/16/25, 03/18/25, 03/24/25, 03/26/25, 03/30/25, 04/27/25, 04/30/25, 05/01/25, and 05/03/25). The EMR lacked documentation showing why the medication was given outside of parameters. On 05/06/25 at 01:20 PM, Licensed Nurse (LN) I stated blood pressure medication parameters should be followed for each medication. She stated medication should be held if outside the parameters, and document the reason why the medication was held or given. (continued on next page)

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	175240	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swan Health at Overland Park	6505 W 103rd Street Overland Park, KS 66212

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 01:32 PM, Administrative Nurse D stated that staff were expected to follow the physician's orders related to the parameters. She stated medications should not be given outside the parameters unless instructed by the physician. She stated staff should provide documentation if given orders to give it out of parameters in the progress notes. The facility's Medication Monitoring policy, revised 04/2019, indicated that medications would be given per the physician's orders and instructions. The policy noted that the pharmacy was to report irregular medication findings, and the facility was to take action to correct potential errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45668 The facility reported a census of 32 residents. Based on observations, record review, and interviews, the facility failed to ensure safe medication storage with three of the five medication carts. This deficient practice placed the residents at risk for diversion and ineffective medication regimen. Findings Included: - On 05/04/25 at 10:00 AM, an inspection of the facility revealed three unlocked and unsupervised medication carts on the facility's 200 hallway. An inspection of the medication carts revealed resident medications, stock medications, and medicated ointments stored in the carts. On 05/04/25 at 10:06 AM, Licensed Nurse (LN) G stated she was away from the medication cart for only five minutes, but stated she should have locked them before leaving them. She secured the medication carts. On 05/04/25 at 10:07 AM, LN I stated all the carts were to be locked when staff were away from them. LN I secured the other two carts and returned to the nurse's desk. On 05/06/25 at 01:32 PM, Administrative Nurse D stated staff were expected to lock the medication and treatment carts when not in use or supervised. The facility's Medication Labeling and Storage policy, dated 02/2023, indicated the facility was expected to store and ensure all medications and biologicals remained locked and secured to prevent tampering or exposure to the environment.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41037 The facility identified a census of 32 residents, with one resident on puree textured diets. Based on observations, interviews, and record review, the facility failed to follow nutritionally approved recipes during the preparation of the facility's puree-based meals. This deficient practice placed one resident at risk for complications related to nutritional impairment. Findings included: - On 05/05/25 at 10:59 AM, Dietary Staff CC placed one serving of cooked parmesan chicken into the food processor machine and then started the machine. Dietary Staff CC then poured water into the food processor with the chicken. Dietary Staff CC checked the consistency. Dietary Staff CC washed the food processor bowl. Dietary Staff CC placed one serving of cooked spaghetti with marinara sauce into the food processor and then started the machine. Dietary Staff CC then poured water into the food processor with the spaghetti and then added the thickener into the processor bowl. Dietary Staff CC washed the food processor bowl, then placed one serving of cooked peas into the food processor and started the machine. Dietary Staff CC then poured water into the food processor with the peas, checked the consistency, and then added the thickener into the food processor with the peas. Dietary Staff CC washed the food processor bowl. On 05/05/25 at 11:09 AM, Dietary Staff CC stated he did not follow the recipes because he had prepared the altered diets for a long time. On 05/06/25 at 10:55 AM, Dietary Staff BB stated water should never be used as an additive in the food when the food texture was altered. Dietary Staff BB stated that AM Dietary Staff CC should have followed the recipe when he prepared the pureed diet for the residents. The facility was unable to provide a policy related to altered diet preparation.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 45668 The facility identified a census of 32 residents. The sample included 12 residents. Based on interviews and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 32 residents residing in the facility. Findings Included: - On 05/05/25, Administrative Staff A provided a Facility Assessment updated 03/01/25. A review of the assessment revealed the following: The assessment identified the required staffing needs per day but failed to identify the specific staffing needs for days, nights, and weekend shifts. On 05/05/25, a review of the facility's Payroll Based Journaling (PBJ - Staffing Data Report) from 04/01/24 to 03/31/25 revealed excessively low weekend staffing triggered in all four quarters. On 05/06/25 at 01:30 PM, Administrative Nurse D stated the facility assessment did not separate the hours required by shift but just showed the required hours as a total. She stated the facility assessment was updated annually to reflect the yearly changes the Centers for Medicare and Medicaid Services (CMS) put out. The facility's Facility Assessment policy, revised 10/2018, indicated the facility would conduct and document a facility-wide assessment to determine what resources were necessary to care for the residents during day-to-day operations.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45668 The facility reported a census of 32 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - A review of the facility's submitted PBJ data from 04/01/24 through 03/31/25 indicated the facility triggered for excessively low weekend staffing for Fiscal Year (FY) Quarter Three 2024, FY Quarter Four 2024, FY Quarter One 2025, and FY Quarter Two 2025. A review of the facility's working schedule, time sheets/punches, and posted staffing hours indicated no gaps or loss of hours. An inspection of the working schedule revealed weekend call-offs documented with administrative nurse coverage. On 05/05/25, a review of the Facility Assessment updated 03/01/25 revealed the facility did not differentiate the required nursing hours for day, evening, and weekend shifts for staffing. On 03/12/25 at 11:34 AM, Licensed Nurse (LN) I stated the facility staffing was fine on evenings and weekends. She stated the facility usually had extra staff on duty to assist with resident care and the occasional call-off. On 03/12/25 at 01:30 PM, Administrative Nurse D stated that the facility was staffed heavily on weekends and at times outside of the regular nursing hours. She stated the facility had occasional call-offs, but the administrative nurses covered the shifts. The facility's Reporting Direct Care Staffing Information (PBJ) policy, revised 08/2022, indicated the facility was to report complete and accurate direct care staffing information to the Centers for Medicare and Medicaid Services (CMS).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41037 The facility identified a census of 32 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program, including antibiotic stewardship for residents in the facility. Findings included: - Review of the Infection Control Log for tracking and trending infections from May 2024 through April 2025, lacked evidence of tracking and identification of possible infection outbreaks at the facility. The infection log lacked identification of the facility-acquired infections. On 05/06/25 at 09:06 AM, Administrative Nurse D, the facility's Infection Preventionist, stated she did not track the antibiotic use in the facility to monitor for a possible infection outbreak. The facility's Infection Prevention Plan policy, dated 2025, documented the Infection Prevention and Control Program was designed to improve the quality of care for patients while reducing the risk of acquired Healthcare-Associated Infections (HAIs) for patients, staff, and visitors. The Infection Prevention Program coordinates prevention, surveillance, investigation, and control of infectious agents and reports information to external agencies as required. Infection prevention was a collaborative effort by all departments, services, and personnel throughout the facility to optimize patient safety and reduce the risks for disease transmission to patients, visitors, and staff.