

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Overland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 Indian Creek Parkway Overland Park, KS 66207	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 38 residents. The sample included six residents with three residents reviewed for abuse/neglect. Based on record review and interviews, the facility failed to submit completed investigations within the required five working-day timeframe following reported allegations to the State Agency (SA) for Residents (R) 1 and R2. Findings included:- R1 admitted to the facility on [DATE] and discharged to home on [DATE]. R2 admitted to the facility on [DATE] and transferred to the hospital on [DATE]. Review of the facility's notifications to the State Agency (SA) revealed the following: The facility reported intake number 2715968 to the SA on 01/13/26. The intake documented on 01/12/26 at 03:00 PM. The facility received an email from R1's representative that on 01/12/26 between the hours of 02:00 AM and 03:00 AM, R1 put on her call light to request urgent medical assistance, and staff failed to respond in a timely manner. As a result, R1 remained unattended while in acute physical distress and R1 told her representative in the morning when she called. The facility talked to R1, and she did not remember what time she vomited. The facility did not submit the completed investigation to the State Agency within the required five working days. The facility reported intake number 2744352 to the SA on 02/16/26. The intake documented on 01/31/26, R2 had a clogged catheter and staff pushed R2 into the lobby for discharge, so a new admission could have R2's room. R2's representative canceled transportation for his discharge and R2 went to the hospital at his representative's request. The facility did not submit the completed investigation to the State Agency within the required five working days. On 02/26/26 at 02:16 PM, Administrative Nurse D stated she did not submit the completed investigations for R1 or R2 to the State Agency. On 02/26/26 at 02:22 PM, Administrative Staff A stated Administrative Nurse D interviewed staff and he assumed Administrative Nurse D sent the investigation on R1 to the State Agency. He stated he did not send the completed investigation to the SA on R1. He stated the facility had five working days to send the completed investigation to the SA. Administrative Staff A stated he did not send the completed investigation on R2 because he thought Administrative Nurse D did that one. The facility's Abuse Policy and Procedure, not dated, directed the Administrator or Director of Nursing (DON) completed an investigation of the incident including a written summary of the findings no later than five working days of the reported occurrence. The summary included interview notes; incident report, and written, signed, and dated statements from the accused witnesses and the person reporting the incident. The policy directed a thorough investigation was critical to developing effective prevention strategies. The facility maintained a written record of all investigations of reported abuse, neglect, mistreatment, misappropriation, exploitation, or deprivation of goods and/or services. The policy directed any investigation and follow-through abided by facility policies and State and Federal laws and regulations. The policy did not address the required timeframe to submit completed investigations to the SA.</p>

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: 175542	If continuation sheet Page 1 of 3

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 38 residents. The sample included six residents with three residents reviewed for abuse/neglect. Based on record review and interviews, the facility failed to conduct a complete investigation to rule out abuse and neglect after receiving allegations from representatives for Resident (R) 1 and R2. Findings included:- R1 admitted to the facility on [DATE] and discharged to home on [DATE]. R2 admitted to the facility on [DATE] and transferred to the hospital on [DATE]. Review of the facility's notifications to the State Agency (SA) revealed the following: The facility reported intake number 2715968 to the SA on 01/13/26. The intake documented on 01/12/26 at 03:00 PM. The facility received an email from R1's representative that on 01/12/26 between the hours of 02:00 AM and 03:00 AM, R1 put on her call light to request urgent medical assistance, and staff failed to respond in a timely manner. As a result, R1 remained unattended while in acute physical distress and R1 told her representative in the morning when she called. The facility talked to R1 and she did not remember what time she vomited. The facility did not provide a copy of a completed investigation to the State Agency or to the onsite surveyor as requested on 02/26/26. The facility reported intake number 2744352 to the SA on 02/16/26. The intake documented on 01/31/26, R2 had a clogged catheter and staff pushed R2 into the lobby for discharge, so a new admission could have R2's room. R2's representative canceled transportation for his discharge and R2 went to the hospital at his representative's request. The facility did not provide a copy of a completed investigation to the State Agency or to the onsite surveyor as requested on 02/26/26. Upon request for the completed investigations into 2715968 and 2744352, the facility provided only staff witness statements. On 02/26/26 at 01:08 PM, Administrative Nurse D stated R1's representative said the facility neglected R1 when she threw up at night. She stated due to R1's representative's insistence that R1 threw up and staff did not chart on it, she reported the allegation to the SA. Administrative Nurse D stated she reported R2's representative's concerns with his discharge and catheter. On 02/26/26 at 02:16 PM, Administrative Nurse D stated R1's representative emailed her directly and she reported the allegations. She stated she tracked down staff that worked for three days prior to the alleged date to make sure R1 did not throw up on a different night. Administrative Nurse D stated she spoke to R1 and reviewed her chart. She stated she let Administrative Staff A know the investigation was ready to go with the witness statements in a folder. She stated she followed up with a couple of other residents regarding the allegations but did not fill out any documentation. She stated she finished her part of R1's investigation within a couple of days, then let Administrative Staff A know she was finished because she thought the facility only had a certain amount of time for an investigation. Administrative Nurse D stated R2's representative emailed Administrative Staff A with her allegations. She stated she reached out to two nurses who were mentioned in the complaint and got their recollection of events. She stated Administrative Staff A looked at the cameras for R2's discharge. She stated she did not submit the completed investigations for R1 or R2 to the SA. On 02/26/26 at 02:22 PM, Administrative Staff A stated R1's representative reported R1 vomited, and the facility did not clean the vomit up. He stated he checked R1's room and it looked fine and did not smell. He stated R1's representative escalated the concerns later with more complaints. Administrative Staff A stated Administrative Nurse D interviewed staff and he assumed Administrative Nurse D sent the investigation to the SA. He stated he did not send the completed investigation to the SA on R1. He stated the facility had five working days to send the completed investigation to the SA. Administrative Staff A stated he received notification that R2's representative was not happy with catheter care, and she believed he was left in distress in the hallway during discharge. He notified Administrative Nurse</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D, who reviewed R2's catheter care notes and did not find any issues. Administrative Staff A stated he reviewed the video and R2 was not in distress and was always supervised. He stated he completed a brief note on the video but that was all he did on the investigation. Administrative Staff A stated he did not send the completed investigation on R2 because he thought Administrative Nurse D did that one. The facility's Abuse Policy and Procedure, not dated, directed the Administrator or Director of Nursing (DON) completed an investigation of the incident including a written summary of the findings no later than five working days of the reported occurrence. The summary included interview notes; incident report, and written, signed, and dated statements from the accused witnesses and the person reporting the incident. The policy directed a thorough investigation was critical to developing effective prevention strategies. The facility maintained a written record of all investigations of reported abuse, neglect, mistreatment, misappropriation, exploitation, or deprivation of goods and/or services. The policy directed any investigation and follow-through abided by facility policies and State and Federal laws and regulations.</p>		