STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39752

The facility identified a census of 155 residents. The sample included three residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to ensure Resident (R)1 received the necessary assistive care and services with ADL to maintain her highest practicable ability and promote independence. This placed R1 at risk for injury, pain, and decreased ability to perform ADL.

Findings included:

- R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of displaced intertrochanteric (where the hip and thigh bone meet) fracture of the right femur (thigh bone), displaced intertrochanteric fracture of the left femur, unsteadiness on feet, muscle weakness, dementia (a progressive mental disorder characterized by failing memory, confusion), fractures of the upper end of the left humerus (upper arm bone), history of falling, restless leg syndrome, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Admission Minimum Data Set (MDS) dated [DATE] documented that a Brief Interview for Mental Status (BIMS) could not be completed. The staff interview revealed R1 had short- and long-term memory concerns. R1 was independent with her ADL including walking and transfers.

The Care Area Assessment (CAA) for Falls dated 01/17/24 documented R1 triggered for falls related to her use of antidepressants (a class of medications used to treat mood disorders).

The CAA for Communication dated 01/17/24 documented R1 had a diagnosis of dementia with ongoing cognitive impairments. R1 had difficulty communicating and following conversations related to her dementia diagnosis.

The Five Day MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. R1 needed some help with self-care and indoor mobility (ambulation). R1 had a limitation in her functional range of motion on one side for the upper and lower extremities. R1 required substantial to maximal assistance for toileting. R1 was dependent on staff for lower body dressing. R1 was dependent on staff for sit-to-stand activity, transfers, and propelling a wheelchair.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan initiated on 03/28/24 directed that R1 was to be one-on-one at night until released by therapy or orthopedics (medical practice specializing in bones). Staff were directed to assist R1 with ADLs as needed, and if R1 was restless at night, staff were to bring R1 to the common area as tolerated. Staff were directed to assist R1 to the toilet upon waking, before and after meals, at bedtime, and as needed. Staff were directed to assist with ADLs as needed. R1's Care Plan lacked further directions for ADLs related to assistance required or any weight-bearing restrictions R1 had. R1's Physician Orders tab documented a Physician Order dated 04/16/24 that R1 was cleared to weight bear as tolerated for transfers. There were no further orders active or discontinued related to the R1's weight-bearing status in 2024. A review of R1's acute hospital discharge packet scanned under the Misc tab documented progress notes signed by the physician on 03/08/24 which recorded R1 had a cephalomedullary nail (a locked hip screw-surgically placed for the treatment of femur fractures). The plan documented R1 was non-weight bearing to her bilateral lower extremities. R1's Skilled Note dated 03/13/24 at 01:31 PM documented R1 was nonambulatory due to fractures and required total assistance with all ADLs. R1's Physical Therapy: Evaluation and Plan of Treatment dated 03/13/24 at 03:01 PM documented that therapy staff attempted to clarify R1's weight-bearing status from the orthopedic doctor, but had not received a return call yet. Staff determined R1 remained non-weight bearing to her lower extremities until confirmation could be obtained from the orthopedic physician. R1's Skilled Note dated 03/14/24 at 01:27 PM documented an order clarification from the orthopedic physician for non-weight bearing status to the right lower extremity and weight bearing as tolerated only for transfers on R1's left lower extremity. R1's Skilled Note dated 03/14/24 at 06:28 PM documented R1 used a wheelchair and required the assistance of one staff member with transfers and ADLs. R1's Skilled Note dated 03/15/24 at 05:14 AM documented R1 required extensive assistance with toileting and peri care. R1 was weight-bearing as tolerated to her right lower extremity. R1's Skilled Note dated 03/16/24 at 05:51 AM documented R1 required extensive assistance with toileting and peri care. R1 was weight-bearing as tolerated to the right lower extremity and had an unsteady gait and feet. R1's Skilled Note dated 03/20/24 at 02:24 AM documented R1 required total assistance with peri care. R1 had one one-on-one in the room to assist with bed positioning and care for safety. R1 had bilateral hip precautions in place and weight bearing as tolerated on the right hip. R1's Physical Therapy: Therapy Progress Report dated 03/26/24 at 02:28 PM documented a team communication and or collaboration with therapists and primary caregivers to facility development and follow-through on R1's plan of treatment. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physical Therapy: Therapy Progress Report dated 04/09/24 at 11:47 AM documented R1 continued to have non-weight bearing status to the right lower extremity and weight bearing as tolerated with transfers only for the left lower extremity. R1's Orthopedic: Physical Therapy appointment date of 04/16/24 documented R1 was okay to weight bear as tolerated for transfers. R1's Physician Orders tab documented a Physician Order dated 04/16/24 that R1 was cleared to weight bear as tolerated for transfers. R1's EMR lacked evidence there were any orders entered for weight-bearing status until this 04/16/24 order. R1's Physical Therapy: Treatment Encounter Note(s) dated 05/06/24 at 10:12 AM documented R1 had precautions of bilateral lower extremities weight bearing as tolerated for transfers only. R1 worked with physical therapy for sit-to-stand transfers with weight bearing as tolerated with minimal assistance of one staff member and cueing to try and shift her weight forward onto the metatarsal heads to work on stability when standing in preparation for walking with R1 received approval and indications that R1 is ready to ambulate. On 05/06/24 at 11:35 AM R1 sat in the commons area in a recliner with her feet elevated. R1 appeared clean and well-groomed. On 05/06/24 at 11:41 AM Certified Nurse Aide (CNA) M stated R1 was only to stand and pivot but was otherwise supposed to be non-weight bearing. CNA M stated R1's weight-bearing status was communicated to staff by word of mouth. CNA M stated that R1 wanted to walk to the bathroom in the common area on 05/03/24 and did want to use the wheelchair. CNA M went on to say she walked R1 to the bathroom because that was what R1 wanted. CNA M stated R1 would get up and walk when she indicated she needed to go to the bathroom. On 05/06/24 at 12:05 PM, R1's representative stated that on 05/03/24 staff walked R1 to the bathroom in the commons area. R1's representative questioned staff about the incident because R1 had restrictions with walking and weight-bearing and the staff continued to walk R1 to the bathroom even after R1's representative pointed it out. R1's representative stated staff opened R1's chart and said there were no weight-bearing restrictions listed in R1's chart. R1's representative stated that when staff assisted R1 back to the recliner, R1 appeared to be in pain. R1's representative stated that about 20 minutes after R1 returned from the bathroom, staff came back and confirmed that there were orders limiting R1's weight-bearing status to transfers only. On 05/06/24 at 02:35 PM, Licensed Nurse (LN) G stated that R1 had no weight-bearing or ADL restrictions. LN G stated R1 required the assistance of one staff member. LN G stated R1 was released to walk in April 2024. LN G stated that R1 was never non-weight bearing. On 05/06/24 at 03:30 PM Administrative Nurse D stated that R1's weight-bearing status should have been placed in R1's Physician Orders when she returned after each hospitalization related to her hip repairs. Administrative Nurse D confirmed that there were no orders indicating R1's weight-bearing status either in February or March after R1's hip repairs. Administrative Nurse D revealed staff failed to make sure R1 maintained her non-weight bearing status. Administrative Nurse D further stated that staff walked R1 to the bathroom in the commons area when they should have assisted her in a wheelchair. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Activities of Daily Living revised 02/12/24 documented that residents would receive assistance as needed to complete ADL. The policy documented that a resident would be given the appropriate treatment and services to maintain and improve his or her ability to carry out the activities of daily living. The policy also documented the facility would utilize appropriate safety measures and any necessary equipment to maintain resident safety. The facility failed to ensure R1 received the necessary assistive care and services with ADL to maintain her highest practicable ability and promote independence. This placed R1 at risk for injury, pain, and decreased ability to perform ADL.