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	05/28/2024

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 155 residents. The sample included three residents reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on observations, record review, and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to ensure staff utilized resident-specific interventions for behaviors. This deficient practice created an environment that affected R1's ability to maintain his highest practicable level of physical, mental, and psychosocial well-being. Findings included: - R1 was admitted to the facility on [DATE]. The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), unsteadiness on feet, generalized muscle weakness, repeated falls, and dementia with agitation. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. R1 had physical behaviors directed toward others and other behavioral symptoms not directed toward others one to three days in the assessment period. R1 rejected care and wandered for one to three days during the assessment period. It was very important to R1 to have books, newspapers, and magazines to read; very important to be around animals or pets; very important for R1 to go outside to get fresh air; very important for R1 to participate in religious services; somewhat important for R1 to listen to music she likes; somewhat important for R1 to do her favorite activities. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of zero which indicated severe cognitive impairment. R1 had no behaviors in the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/03/24, documented R1 had a history and diagnosis of dementia with ongoing cognitive impairments. The Behavioral Symptoms CAA dated 01/03/24, documented R1 rejected care, wandered, and grabbed people related to her dementia disease. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Communication CAA dated 01/03/24, documented R1 had difficulty communicating related to her dementia disease. R1's Care Plan, dated 05/30/23, documented R1 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to the disease process. The plan documented interventions, dated 05/30/23, that all staff conversed with R1 while providing care, staff invited R1 to scheduled activities, and staff thanked R1 for attendance at activity functions. The plan documented interventions on 06/14/23 that R1 preferred jazz, classical, and pop, and she enjoyed being in a band and playing the clarinet; R1 preferred to watch Downtown [NAME] on television. R1's Care Plan, dated 05/31/23, documented R1 had a behavior problem of being combative with care due to dementia disease. R1's Care Plan documented interventions, dated 05/31/23, for staff to anticipate and meet R1's needs, explain all procedures to R1 before starting, and allow R1 time to adjust to changes. The plan documented an intervention, dated 07/03/23, that when staff observed R1 trying to take off her gait belt, staff intervened and redirected or engaged R1 with meaningful activities such as walking with her. The facility's reportable investigation, dated 05/29/24, documented on 05/23/24 around 03:30 PM, Activity AA was coloring with a resident at a table in the unit's common area when R1 was pushed to the table by Certified Nurse Aide (CNA) N so she could join in the coloring activity. Consultant GG was present in the unit and stated that R1 went to reach for coloring supplies and Activity AA quickly began smacking R1's hands several times and stated to R1 [expletive] [expletive], leave it alone, your husband just left, do not be bad, you are so bad. Consultant GG stated at this time, R1 tried to stand up from her wheelchair, and Activity AA grabbed R1 by her right arm. Consultant GG stated she stepped in and told Activity AA she could not grab R1's arms. Consultant GG made sure R1 was safe and left R1 with CNA N. A head-to-toe skin assessment and pain evaluations were completed on R1 with no noted injuries or pain. Activity AA was removed from the unit and suspended pending investigation. Consultant GG's notarized Witness Statement on 05/23/24, stated at approximately 03:30 PM, Activity AA was coloring at the table with a resident. CNA N brought R1 to the table. Consultant GG stated R1 grabbed the coloring supplies with Activity AA quickly smacking her hands multiple times, used cuss words, and said Leave it alone, your husband just left, do not be bad, you are so bad. Consultant GG stated R1 attempted to stand from her wheelchair and Activity AA grabbed R1's right arm. She stated she stepped in and told Activity AA she could not grab R1's arms. Consultant GG stated she made sure R1 was safe and requested help from CNA N. CNA N's notarized Witness Statement on 05/23/24, documented that after R1 used the bathroom, she propelled her to the table with Activity AA. CNA N stated she assisted another resident and did not witness the incident with R1 and Activity AA. She stated Activity AA told her that Consultant GG accused her of hitting R1 and Activity AA stated she tapped it and told R1 to sit down. On 05/28/24 at 12:58 PM, R1 sat in the recliner in the television area and watched television. She fidgeted with her shirt. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 11:35 AM, Consultant GG stated on 05/23/24 she was on the unit assisting a resident and sat at a table by the window. She stated Activity AA was at a table coloring with a resident and CNA N brought R1 to the table. Consultant GG stated R1 had trouble controlling her movements and she stood up to get markers and coloring sheets when she observed Activity AA swatting at R1's hands and saying [exlpeteive], [expleteive], I said no. Consultant GG stated R1 stood up and Activity AA grabbed her arm and told her to sit down. Consultant GG stated she told Activity AA not to grab R1 like that and Activity AA asked what should she do. Consultant GG stated she told Activity AA to ask for help if she was uncomfortable. She stated she asked CNA N for help and then left the unit. Consultant GG stated she was in the line of sight of the table but Activity AA's back was to her and she could not say 100 percent if any contact was made with R1 during the swatting but it was the arm grab that got her attention. Consultant GG stated R1 seemed upset with the arm grab. She stated she believed there was something in place on R1's Care Plan about standing and ways to redirect her. On 05/28/24 at 11:41 AM, Activity AA stated on 05/23/24, she was getting done coloring and R1 was getting agitated. She stated she cussed but it was not at her and that she tapped the table to get R1's attention but did not hit her. Activity AA stated R1 was lurching forward and she was a high fall risk so she tried to get her to sit back down. She stated she put one hand under R1's elbow and the other hand on top of her arm to assist her back down. Activity AA stated R1 did not seem upset with her touching her arm but she seemed upset that Activity AA gathered up the supplies R1 wanted. She stated R1 was already agitated which was usual for her after her husband leaves. On 05/28/24 at 12:43 PM, Activity AA stated she had access to care plans, and sometimes the care plans addressed behaviors and care plans. R1's behaviors included outbursts, fits, sprinting down the hallway, and falling. She stated R1 liked to do activities, but she was destructive. Activity AA stated staff usually sat and talked with R1 but that day she was unable to be redirected. She stated after her husband left, she got very agitated. Activity AA stated staff tried to redirect R1 when she stood up, gave R1 something for her hands to stay busy, played music, and just distracted her to get her to sit down. On 05/28/24 at 01:01 PM, CNA M stated she did not have access to care plans. She stated R1's behaviors included pacing, hallucinations, wandering, screaming, refusing care, and being combative at times. CNA M stated staff redirected R1 by talking to her, watching television, giving her magazines, giving her snacks, and toileting. She stated if R1 stood up, staff put a gait belt on her and walked her to the bathroom or redirected her. CNA M stated if staff grabbed R1's arms, R1 became resistive. On 05/28/24 at 01:07 PM, Licensed Nurse (LN) G stated the care plan had triggers, behaviors, and interventions for behaviors. She stated CNAs had access to the care plans and staff discussed resident behaviors. LN G stated R1 liked moving and she started running down the hallways but she was a high fall risk. She stated if R1 was in the recliner, she was fine but if she was placed in a chair then she walked down the hallway trying to find an exit. LN G stated staff redirected her and knew she liked to watch television. She stated staff talked to R1 to get her to sit down but grabbing her arms agitated her more. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 01:34 PM, Administrative Nurse D stated CNAs had access to care plans which included behavioral care plans that were specific to the resident. She stated she expected staff to review the care plan to see what they could do to calm R1 down including redirection or providing a meaningful activity depending on the state R1 was in. Administrative Nurse D stated R1 was upset on 05/23/24 because her husband left her there when she thought she was going home. She stated it depended on R1's mood if staff were able to touch her with redirection. On 05/28/24 at 01:57 PM, Activity Z stated activity personnel had access to the care plans and she believed behaviors were on there. She stated Activity AA was the unit coordinator on that unit and she knew where to go for information to help with the residents. Activity Z stated Activity AA should have known what interventions worked for R1. She stated she never received any complaints about Activity AA. The facility's Care of the Cognitively Impaired (Dementia Care), dated 08/29/22, directed the facility to provide dementia treatment and services which may include, but were not limited to the following: ensuring the necessary care and services were person-centered and reflected the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; and utilizing individualized, non-pharmacological approaches to care. The facility failed to provide dementia care and services for R1 when the facility failed to ensure staff utilized resident-specific interventions for behaviors. This deficient practice created an environment that affected R1's ability to maintain his highest practicable level of physical, mental, and psychosocial well-being.