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	10/21/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 154 residents. The sample included three residents. Based on observation, record review, and interviews, the facility failed to ensure cognitively impaired Resident (R) 1 remained free from physical abuse. On 10/09/24 at approximately 08:25 AM, Licensed Nurse (LN) G overheard Certified Nurse Aide (CNA) M tell R1 she could not have any sugar because she was diabetic (a condition when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and R1 became upset. LN G turned around and observed R1 hit CNA M in the stomach. LN G observed CNA M react to R1 by making a fist and punching R1 in the left upper arm. LN G immediately notified Administrative Nurse D who removed CNA M from the building and suspended her pending investigation. R1 complained of left upper arm pain. Staff assessed the area and identified R1 had a blue bruise on her left upper arm. R1 continued to complain of left upper arm pain and required as-needed (PRN) pain medication. The facility's failure to ensure R1 remained free from staff-to-resident physical abuse placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, generalized muscle weakness, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. R1 had no behaviors in the assessment period. R1's activity preferences documented it was very important to be with groups of people, take care of her personal belongings, choose her own bedtime, and have family involved in discussions with her care. The Quarterly MDS dated [DATE], documented R1 was unable to complete the BIMS interview. R1 had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue); physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, and rejection of care one to three days in the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/16/24, documented R1 had a history and diagnosis of dementia with ongoing cognitive impairments. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan revised 04/17/23, documented R1 had the potential to be physically and verbally aggressive related to dementia and poor impulse control. The care plan directed when R1 became agitated, staff intervened before the agitation escalated, guided R1 away from the source of distress, engaged calmly in conversation, and if R1's became aggressive, staff calmly walked away and approached later. LN G's notarized Witness Statement on 10/09/24, stated at 08:25 AM, LN G was at the medication cart passing morning medications when she heard CNA M yell at R1 that the resident could not have sugar because the resident was diabetic. LN G then heard R1 and CNA M arguing and R1 stated Stop that. LN G stated she turned toward CNA M and R1 and observed R1 hit CNA M in the stomach with a closed fist. LN G observed CNA M hit R1 in her left upper arm with a closed fist. LN G stated she told CNA M that she could not hit R1 and CNA M asked why R1 could hit her but she could not hit R1. CNA M walked away from the area and LN G immediately notified Administrative Nurse D. LN G's notarized Witness Statement on 10/21/24, stated on 10/09/24 at 08:25 AM, she was at the medication cart administering morning medications when she heard CNA M tell R1 the resident could not have sugar because the resident was diabetic. She then heard CNA M and R1 arguing and R1 stated Stop that. LN G stated as she turned around, she observed R1 hit CNA M in the stomach then CNA M hit R1 back with a closed fist in R1's left upper arm. LN G stated she had a clear view of the incident as she was within a few feet of CNA M and R1. The facility's Investigation dated 10/11/24, documented on 10/09/24 around 08:25 AM, R1 sat in the dining room eating breakfast. R1 went to reach for a sugar packet and LN G overheard CNA M yell at R1 that the resident could not have the sugar because the resident was diabetic. LN G heard R1 arguing with CNA M. LN G stood at the medication cart and turned to face the argument in the dining room. At that time, she observed R1 hit CNA M in the stomach with a closed fist then CNA M hit R1 with a closed fist in her left upper arm. LN G immediately moved CNA M away from R1 and notified Administrative Nurse D about the incident. Administrative Nurse D walked CNA M off the unit and out of the facility, suspending CNA M pending investigation. Staff completed a skin assessment on R1 and found what appeared to be the start of a bruise on her left upper arm which had not been there previously. R1 exhibited signs of pain and staff gave her pain medication. Staff notified R1's provider and he ordered an x-ray of her left arm and shoulder. The x-ray did not reveal any acute findings. R1's EMR revealed the following: A Skin Integrity Update on 10/09/24, documented a blue-colored bruise to R1's upper left arm below her left shoulder. An Event Note on 10/09/24 at 10:30 AM, documented on 10/09/24 at approximately 08:25 AM, LN G observed CNA M hit R1 in the left upper arm with a closed fist. LN G immediately removed CNA M and notified Administrative Nurse D who removed CNA M from the facility. Staff completed a skin assessment on R1 and found what appeared to be the start of a bruise on her left upper arm which previously was not there. R1 exhibited signs of pain and received pain medication. Staff notified R1's family, the provider, and law enforcement. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Physician/Physician's Assistant (PA)/Nurse Practitioner (NP) progress note on 10/09/24 at 03:44 PM, documented a staff member struck R1 in the left arm. R1 sat upright in her wheelchair and told Consultant GG her left arm hurt. R1 had a contusion (bruise) to the left arm and received Tylenol (pain medication) for discomfort. An Event Note on 10/10/24 at 08:45 AM, documented alleged abuse occurred between R1 and a nursing staff member. Administrative Nurse D removed the staff member from the unit and escorted her out of the building. Staff completed a skin assessment on R1 which revealed what appeared to be the start of a bruise on her left upper arm and R1 complained of pain to the left upper arm. R1 received pain medication for the pain. The facility notified local law enforcement who came to the facility and interviewed R1 and LN G then received contact information for CNA M. On 10/21/24 at 12:28 PM, R1 lay in bed on her right side, facing the wall. She did not respond to knocking or talking. On 10/21/24 at 12:30 PM, observation of the area where the incident occurred revealed a table in the dining room, right beside the nurse's station. The medication cart was located within 10 feet of the table with a clear view of where R1 sat on 10/09/24. On 10/21/24 at 12:30 PM, LN G stated on 10/09/24, she stood at the medication cart while R1 sat in her wheelchair at the dining room table and CNA M stood beside her. She stated she had a clear view of the table from the medication cart. LN G stated she heard CNA M yelling at R1and CNA M's tone of voice upset R1. LN G stated she turned around and saw R1 hit CNA M in the stomach then CNA M punched R1 in her left upper arm. LN G stated she told CNA M she could not hit the resident and CNA M asked why. LN G stated she notified Administrative Nurse D immediately. She stated immediately after the incident, R1 complained that her arm hurt, and she cried. LN G stated even when they removed R1's shirt to assess her skin, R1 cried and appeared upset and angry. She stated R1 commented that she was hit and her arm hurt. On 10/21/24 at 12:43 PM, CNA M stated on 10/09/24, R1 sat at the dining room table with R2 who was a diabetic. She stated she served R1 and R2 breakfast and R1 tried to put sugar in R2's oatmeal. She stated she told R1 to give her the sugar because R2 could not have sugar as she was diabetic. CNA M stated R1 said to leave her alone and she could do what she wanted then started hitting CNA M. She stated she tried blocking CNA M from hitting her when LN G turned around and told CNA M not to hit R1. CNA M stated she backed away and said she was not hitting R1 and was only blocking R1 from hitting her. She stated when she started her shift that morning, R1 had her shirt off and there was no bruising. CNA M stated she did not touch R1 or her left arm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/24 at 12:55 PM, Administrative Nurse D stated LN G notified her on 10/09/24 of what happened between CNA M and R1 and she immediately went to the unit to remove CNA M. She stated she walked CNA M to the timeclock and CNA M stated she did not do it. Administrative Nurse D stated CNA M told her R1 hit her and out of frustration, CNA M brushed her off. She stated she informed CNA M there had been an allegation and it had to be investigated. Administrative Nurse D stated she notified corporate and Administrative Staff A. She stated staff completed a skin assessment which revealed R1 already had bruising started which lined up with what LN G said happened. R1 complained of pain to that arm and the facility completed an x-ray on her left arm. She stated all of the residents on that unit received skin assessments and any residents with a BIMS score of ten or higher were interviewed. Administrative Nurse D stated the facility called law enforcement and an officer came out to take LN G's statement; he talked to R1 even though she was confused, and then he left. She stated the facility terminated CNA M and banned her from returning to the facility. On 10/21/24 at 02:30 PM, Consultant GG stated he saw R1 on 10/09/24 and she appeared visibly shaken. He stated R1 had bruising on her left arm developing already and she made a statement that the place was crazy or there was a ruckus. On 10/21/24 at 02:35 PM, Administrative Staff A stated Administrative Nurse D notified her of the incident on 10/09/24 via phone as she was out of the building. She stated Administrative Nurse D informed her of the interventions and parts of the investigation she had done, and Administrative Staff A guided her on what else she needed to do. Administrative Staff A stated CNA M should have gotten the nurse and removed herself when R1 had behaviors. The facility's Abuse- Identification of Types policy, dated 10/04/22, directed the resident had the right to be free from abuse, neglect, and exploitation of resident property. The policy directed the risk for abuse may increase when a resident exhibits a behavior that may provoke a reaction by staff, residents, or others such as physically aggressive behavior. On 10/21/24 at 02:43 PM, Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed that the facility's failure to ensure R1 remained free from staff-to-resident physical abuse placed R1 in immediate jeopardy. The facility completed the following corrective actions by 10/10/24: The facility suspended CNA M immediately pending investigation on 10/09/24. The facility completed a skin assessment on R1 which revealed a bruise on R1's left upper arm on 10/09/24. The facility notified the State Agency (SA) and law enforcement on 10/09/24. Law enforcement obtained witness statements at the facility on 10/09/24 and provided a case number. The provider saw R1 on 10/09/24 following the incident. The facility completed an x-ray on 10/09/24 on R1's left arm/shoulder with no positive findings. The facility completed skin assessments on all residents on that unit on 10/09/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility interviewed all residents on that unit with a BIMS of 10 or higher for safety and abuse on 10/09/24. Staff received abuse education on 10/09/24. Social Services visited with R1 daily for three days, starting on 10/09/24. The facility terminated CNA M on 10/10/24 and banned her from returning. Because all corrective actions were completed prior to the onsite survey, the deficient practice was cited as past non-compliance, and the scope and severity remained a J.