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	11/18/2025

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. The facility identified a census of 145 residents. The sample included six residents, with six reviewed for abuse and neglect. Based on observation, interview, and record review, the facility failed to ensure cognitively impaired Resident (R) 2 and R3 remained free from resident-to-resident physical abuse by R1. On 09/30/25 at 07:55 AM, Certified Nurse Aide (CNA) N left the facility dining area unsupervised to assist another staff member. When CNA N returned to the dining area, he observed R2 with blood on his face while R1 (who had a history of wandering into resident rooms and behaviors including wanting to fight) stood nearby with blood on his hands. There was blood splashed on the window and table, and pooling on the floor near R2. CNA N asked R1 if he had hit R2, and R1 stated he had. CNA N asked R1 to walk away and allowed R1 to leave the area unsupervised. R1 walked into R3's room and began punching R3 while R3 laid in his bed. Both R2 and R3 were transported to the hospital for emergency medical treatment. R2 was admitted to the hospital for a subdural hematoma, and R3 was admitted to the hospital for facial lacerations. The facility's failure to prevent physical abuse placed all the residents on R1's unit in immediate jeopardy (IJ).Findings Included: - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (a progressive mental disorder characterized by failing memory and confusion) with unspecified behaviors and other behavioral disturbances. R1's 08/18/25 admission Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS noted he had no upper or lower extremity impairments and required supervision but could complete his activities of daily living (ADL) independently. The MDS noted R1 displayed physically aggressive behaviors noted one to three days. R1's 08/28/25 Behavioral Care Area Assessment (CAA) noted he had a history of physical aggression and a care plan was implemented to minimize the risk associated with his behaviors. R1's 08/28/25 Functional Abilities CAA noted he was a new admission, required assistance with his ADLs, and a care plan was implemented to minimize the decline of his ADLs. R1's Care Plan initiated 08/19/25 indicated he had a behavioral problem related to his medical diagnoses. The plan instructed staff to assist with his ADLs as needed (08/19/25). The plan instructed staff to administer his medication as ordered (08/19/25), anticipate his needs (08/19/25), and discuss his behaviors (08/19/25). The plan instructed staff to explain and reinforce why his behaviors were inappropriate or unacceptable (08/19/25). The plan indicated he was placed on one-to-one staff supervision to promote safety on 09/30/25. The plan instructed staff to remove R1 from the common area to reduce stimulation and speak to him in a calming manner (09/30/25). A Communication Note completed 09/16/25 indicated R1's resident representative was notified that items were taken out of his room due to the potential they would be used as weapons. A Behavior Note completed 09/19/25 indicated R1 had unpredictable mood changes and extreme behaviors of wanting to fight. The note indicated he walked around smiling and became agitated in seconds. R1 did not take redirections and acted as if he could not hear staff when they spoke to him. The note lacked information on other interventions staff attempted with R1.A Behavior Note completed 09/27/25 revealed R1 spent his free time going into his peers' rooms and taking items. The note revealed R1 did not take redirections and acted as if he could not hear staff when they spoke to (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	him. The note lacked information on other interventions staff attempted with R1.An Alert Note completed 09/30/25 indicated R1 was sent out to an acute medical facility for severe agitation and aggression. The note indicated staff called local law enforcement to stay with R1 until emergency medical services arrived for transport. An Event Note for R2 completed 09/30/25 revealed R2 sustained multiple facial injuries while he was seated in the dining room. The note revealed staff observed a large amount of blood behind his wheelchair, on the table, and the window next to R2's wheelchair. R2 was bleeding from four areas on the left side of his face and was sent out to an acute medical facility for emergency medical assessment and treatment due to his injuries. An Event Note completed 09/30/25 revealed R3 was found in his bed with his head under the covers. The note revealed blood coming from the left side of his mouth. The note revealed he had swelling to the left side of his face and eye, with blood on the walls and his blanket. R3 was sent out to an acute medical facility for emergency medical assessment and treatment due to the severity of his injuries. A Facility Incident Report #0907 completed on 09/30/25 indicated R1 got into a physical altercation with R2 and R3, resulting in facial injuries on both residents. The report noted R2 and R3 were sent out to an acute medical facility for emergency medical evaluation and treatment.A Witness Statement completed by CNA N on 09/30/25 revealed on 09/30/25 at 07:55 AM, CNA N sat in the dining room with the residents and CNA N briefly exited the dining room to assist another staff member in the shower room. CNA N returned to the dining room after about five minutes to find R2 bleeding from his face as he sat in his wheelchair, as R1 stood next to him. The statement indicated CNA N asked R1 if he hit R2 and R1 admitted to hitting R2 and stated, He raped my daughter. The statement noted CNA N asked R1 to leave the immediate area, and then R1 walked into R3's room, where CNA N later observed R1 repeatedly hitting R3 with closed fists as he entered R3's room. The statement revealed CNA N separated the residents, and R1 stated, He raped my daughter. The statement revealed CNA N escorted R1 out of the room and stayed with him until help arrived. A Witness Statement completed by Certified Medication Aide (CMA) N on 09/30/25 revealed on 09/30/25, CMA R entered the dining room to find R2's face bleeding and then went into R3's room. The statement revealed that CMA R had to physically remove R1 from R3's room. A Witness Statement completed by Licensed Nurse (LN) G on 09/30/25 revealed LN G was called to the secured unit due to an emergency on 09/30/25. When LN G entered the dining R2 was bleeding as he sat in his wheelchair. The statement indicated blood was splashed on the window, table, and floor behind his wheelchair. R2 was unresponsive but blinking his eyes at times. LN G also observed R3 in his bed with facial swelling on the left side of his face and eye, with blood on the blanket and wall next to his bed. On 10/02/25 at 12:15 PM, CMA R stated R1 did not display daily behaviors and had no behaviors before his incident on 09/30/25. He stated R1 was usually easily redirectable and kept to himself. He stated R1 kept yelling out, They raped my daughter, during the incident with R2 and R3. He stated that both R2 and R3 had to be sent out due to their injuries. On 10/02/25 at 12:05 PM, Consultant GG stated R3 admitted to the hospital with a subdural hematoma (bleeding around the brain) and a six-millimeter mid-line shift (displacement of the brain structures that can result in increased pressure on the brain). He stated R3's prognosis did not look good. On 10/02/25 at 02:28 PM, R2's Resident Representative indicated he was admitted to an acute medical facility on 09/30/25 for a subdural hematoma and fluid buildup in his lungs. He stated he was told that R2 was not expected to live during the medical facility's first assessment. On 10/02/25 at 02:34 PM, Administrative Nurse D stated R1 exhibited no behaviors on the morning of the incident with R2 and R3, before the incident occurred. She stated R1 was immediately placed on one-to-one supervision until his eventual discharge. She stated all residents in the secured area were screened immediately after the incident occurred for potential abuse and psychosocial concerns. She stated all three residents involved were sent out for emergency medical assessment. She stated that the facility immediately began in-service training for all available staff. The facility's Abuse, Neglect, and Exploitation policy, revised 06/2024, documented that the resident has a right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. The policy indicated it was the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	responsibility of the facility to treat each resident with respect, kindness, dignity, and care, to keep them free from abuse and neglect, and to take swift action to investigate and adjudicate alleged resident abuse and neglect. Mental abuse included, but was not limited to, verbal or non-verbal conduct which caused or has the potential to cause humiliation, intimidation, fear, shame, agitation, degradation, harassment, or threats of punishment or deprivation. The policy indicated that all staff were to be educated to identify, prevent, and intervene when potential abuse was identified. On 10/02/25 at 03:26 PM, Administrative Staff A was provided the IJ template and notified of the facility's failure to protect R2 and R3 from R1's physical abuse, which placed all residents in the immediate area in immediate jeopardy. The facility identified, implemented, and completed the following corrective actions related to the incident: 1. The facility immediately assessed R1, R2, and R3 for physical harm. (09/30/25)2. R1 was immediately placed under one-to-one supervision, and his behavioral care plan was updated. (09/30/25)3. The facility immediately notified all three resident representatives and the medical provider. (09/30/25)4. The facility sent R1, R2, and R3 out for immediate acute medical intervention. (09/30/25)5. The facility immediately initiated in-service staff training related to abuse prevention, behavioral health services, dementia care, and unit supervision to be completed by staff before the next available shift on 09/30/25 and completed on 10/01/25. 6. The facility screened all in-house cognitively intact residents for potential abuse or witnessed altercations. (09/30/25)7. The facility screened all residents who resided on the affected secured unit for abuse or psychosocial concerns. (09/30/25)8. Administrative Nurse D completed EMR audits for all residents on the affected unit for potential abuse. (09/30/25)9. The facility's Quality Assurance Committee completed a meeting on 09/30/25. 10. The facility will interview five random staff members about behavioral management five times weekly for four weeks, three times weekly for four weeks, and then randomly thereafter. (09/30/25)11. The facility will review all resident-to-resident interactions for the last 30 days to validate root-cause analysis and causative factors. (09/30/25)12. The facility will monitor all residents with known periods of aggression and interventions to reduce the risks of recurring altercations and implement additional measures in the daily clinical meetings and risk meetings. (09/30/25)13. All results will be reported to the Quality Assurance Committee. This deficient practice was deemed past non-compliance due to the corrective actions completed on 10/01/25, prior to the surveyor entering the facility. The citation remains at a J scope and severity to represent R2 and R3's actual harm.