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	12/30/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 141 residents. The sample included five residents, with three residents reviewed for dementia care. Based on record review and interviews, the facility failed to notify Resident (R) 1's provider of new or escalating behaviors. Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated 01/31/25 documented staff did not conduct a Brief Interview for Mental Status (BIMS) due to R1 being rarely or never understood. R1 wandered daily. R1 required substantial to maximal assistance with oral hygiene, toileting hygiene, showering, upper and lower body dressing, standing, and toilet transfers. R1 required dependence on staff for putting on shoes and personal hygiene. R1 required partial to moderate assistance with bed mobility, and he received antidepressant (a class of medications used to treat mood disorders) medications. The Quarterly MDS dated 10/23/25 documented staff did not conduct a BIMS due to R1 being rarely or never understood. R1 had physical behaviors directed towards others and wandering behaviors one to three days in the lookback period. R1 received antidepressant medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/31/25 documented R1 had a history and diagnosis of dementia with ongoing cognitive and physical impairments. R1 retained his ability to make his needs known. The EMR included a Functional Abilities CAA dated 02/03/25 which documented R1 required assistance with activities of daily living (ADL). The EMR included a Behavioral Symptoms CAA dated 02/03/25 which documented R1 exhibited wandering behavior due to advancing dementia. R1's 01/25/24 Care Plan revealed R1 had impaired cognitive ability and impaired thought processes due to dementia disease and included the following staff interventions:01/25/24- Staff allowed extra time for R1 to respond to questions and instructions. 01/25/24- Staff faced R1 and spoke clearly when they communicated with R1.01/29/25- The facility placed R1 on a secured unit.05/15/25- Staff used R1's preferred name, identified themselves at each interaction, reduced any distractions, provided necessary cues, and stopped then returned if R1 became agitated. The care plan lacked individualized interventions related to R1's behaviors and triggers for behaviors. R1's EMR revealed the following: A Behavior Note dated 07/03/24 at 09:11 PM documented R1 became more aggressive with staff on redirection from common areas. R1 kept self-propelling in his wheelchair through the TV and dining room and rolled over other residents' shoes and toes. When staff redirected R1, he became increasingly violent and tried to strike staff with a closed fist. R1 became increasingly restless and became a higher fall risk. R1 tried to ambulate without assistance and when staff tried to intervene, R1 became angry and tried to kick and punch staff. A Behavior Note dated 07/04/24 at 10:16 PM document R1 transferred himself without assistance and tried to stand up in the hallway. Staff redirected R1 back to his wheelchair several times and R1 sat in the TV room with a Certified Nurse Aide (CNA) for increased supervision for safety. R1 continued to be aggressive with direction and tried to hit and punch staff with a closed fist. A Behavior Note dated 07/09/24 at 09:08 PM documented R1 continued to be very restless and an increased fall risk. R1 needed increased supervision from staff for safety. R1's medical record lacked evidence the facility notified R1's physician about his behaviors from 07/03/24 to 07/09/24. A Behavior Note dated 10/13/24 at 07:00 AM documented R1 rolled around in his wheelchair that morning and shook both hands in the air, stating he was scared, he wanted to kill himself, and he did not know. Staff provided ineffective verbal redirection. R1 attempted to get out of his wheelchair while he stated he was scared. The nurse applied a gait belt and allowed R1 to ambulate down the hallway with the railings, but he remained anxious. R1's medical record lacked evidence the facility notified R1's provider of his suicidal/death statements on 10/13/24. A Behavior Note dated 10/23/24 at 01:02 PM documented R1 kept trying to stand up and walk. R1 verbalized he did not understand, he wanted to die. Staff redirected and helped R1 take a few steps then sat him back in his wheelchair. The note included the redirection remained ineffective. R1's medical record lacked evidence the facility notified R1's provider of his death statements on 10/23/24. A Behavior Note dated 09/08/25 at 06:22 PM documented R1 rolled up to another resident in his wheelchair and grabbed his

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(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 - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 141 residents. The sample included five residents, with three residents reviewed for dementia care. Based on record review and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to assess, identify, record, respond to, and reassess R1's specific behaviors and triggers to promote an environment which supported R1's individualized care needs. This deficient practice resulted in ongoing and escalating behaviors, including aggression towards other residents. Findings included: - R1 admitted to the facility on [DATE] and transferred to the hospital on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated 01/31/25 documented staff did not conduct a Brief Interview for Mental Status (BIMS) due to R1 being rarely or never understood. R1 wandered daily. R1 required substantial to maximal assistance with oral hygiene, toileting hygiene, showering, upper and lower body dressing, standing, and toilet transfers. R1 required dependence on staff for putting on shoes and personal hygiene. R1 required partial to moderate assistance with bed mobility, and he received antidepressant (a class of medications used to treat mood disorders) medications. The Quarterly MDS dated 10/23/25 documented staff did not conduct a BIMS due to R1 being rarely or never understood. R1 had physical behaviors directed towards others and wandering behaviors one to three days in the lookback period. R1 received antidepressant medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/31/25 documented R1 had a history and diagnosis of dementia with ongoing cognitive and physical impairments. R1 retained his ability to make his needs known. The EMR included a Functional Abilities CAA dated 02/03/25 which documented R1 required assistance with activities of daily living (ADL). The EMR included a Behavioral Symptoms CAA dated 02/03/25 which documented R1 exhibited wandering behavior due to advancing dementia R1's 01/25/24 Care Plan revealed R1 had impaired cognitive ability and impaired thought processes due to dementia disease and included the following staff interventions:01/25/24- Staff allowed extra time for R1 to respond to questions and instructions.01/25/24- Staff faced R1 and spoke clearly when they communicated with R1.01/29/25- The facility placed R1 on a secured unit.05/15/25- Staff used R1's preferred name, identified themselves at each interaction, reduced any distractions, provided necessary cues, and stopped then returned if R1 became agitated. The care plan lacked individualized interventions related to R1's behaviors and triggers for behaviors. R1's 02/07/24 Care Plan revealed R1 depended on staff for meeting emotional, intellectual, physical, and social needs due to his disease process and included the following staff interventions:02/07/24- Staff established and recorded R1's prior level of activity involvement and interests by talking to R1, his caregivers, and family on admission and as necessary.02/07/24- Staff invited R1 to scheduled activities.02/07/24- R1 preferred coloring, simple puzzles, and watching his preferred television channels.02/07/24- Staff reviewed R1's activity needs with his family/representative. R1's EMR revealed the following: A Behavior Note dated 07/03/24 at 09:11 PM documented R1 became more aggressive with staff on redirection from common areas. R1 kept self-propelling in his wheelchair through the TV and dining room and rolled over other residents' shoes and toes. When staff redirected R1, he became increasingly violent and tried to strike staff with a closed fist. R1 became increasingly restless and became a higher fall risk. R1 tried to ambulate without assistance and when staff tried to intervene, R1 became angry and tried to kick and punch staff. A Behavior Note dated 07/04/24 at 10:16 PM document R1 transferred himself without assistance and tried to stand up in the hallway. Staff redirected R1 back to his wheelchair several times and R1 sat in the TV room with a Certified Nurse Aide (CNA) for increased supervision for safety. R1 continued to be aggressive with direction and tried to hit and punch staff with a closed fist. A Behavior Note dated 07/09/24 at 09:08 PM documented R1 continued to be very restless and an increased fall risk. R1 needed increased supervision from staff for safety. A Behavior Note dated 10/13/24 at 07:00 AM documented R1 rolled around in his wheelchair that morning and shook both hands in the air, stating he was scared, he wanted to kill himself, and he did not know. Staff provided ineffective verbal redirection. R1 attempted to get out of his wheelchair while he stated