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	05/14/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide adequate supervision and failed to ensure staff responded appropriately to door alarms to prevent the elopement of two cognitively impaired residents. Around 04:30 PM on 05/03/26, Resident (R) 1 and R2 exited the facility without staff knowledge or supervision. Certified Nurse Aide (CNA) M heard a door alarm and reset the alarm without checking to see what triggered the door alarm. At 05:20 PM, the facility learned R1 and R2 were with a community member at a store down the street from the facility. The facility staff did not realize R1 and R2 were out of the facility for approximately 45 minutes. The community member brought R1 and R2 back to the facility in her personal vehicle. This deficient practice placed R1 and R2 in immediate jeopardy. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (a progressive mental disorder characterized by failing memory and confusion). R1's Quarterly Minimum Data Set (MDS) dated [DATE], documented a BIMS score of three, which indicated severe cognitive impairment. R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/25/25, documented R1 had a BIMS score of three related to deficits in memory recall, repetition, temporal orientation, and fluctuating behavior. R1's Care Plan, revised on 04/15/24, documented R1 was at risk for elopement related to cognitive decline. The care plan documented the following interventions:03/08/24- Staff completed an Elopement Risk Assessment.03/08/24- Staff encouraged R1 to participate in activities to divert her from exit-seeking behavior.04/15/24- Staff added R1 to the Elopement Book.04/15/24- Staff provided for safe wandering as R1 was an elopement risk. R2's EMR documented diagnoses of Alzheimer's disease and dementia. R2's Quarterly MDS dated 02/18/26, documented a BIMS score of four, which indicated severe cognitive impairment. R2's Cognitive Loss/Dementia CAA dated 06/02/25, documented R2 had a history of dementia with ongoing cognitive impairments that required 24-hour a day care for her safety and well-being. R2's Care Plan, last revised 02/11/26, documented R2 was at risk for elopement. The care plan documented the following interventions:05/10/23- Staff completed an Elopement Risk Assessment.05/10/24- Staff encouraged R2 to participate in activities to divert her from exit-seeking behavior.04/15/24- Staff added R2 to the Elopement Book.04/15/24- Staff provided for safe wandering as R2 was an elopement risk. The facility's Investigation dated 05/08/26, documented on 05/03/26 at approximately 05:20 PM, the facility received a phone call from a community member who stated she believed she had two of the facility's residents with her at a store down the street from the facility. The facility verified the two resident names as R1 and R2 of the facility. The community member stated R1 and R2 were with her at the store since between 04:30 PM to 04:45 PM. The community member brought R1 and R2 back to the facility in her personal vehicle at 05:30 PM. Upon return, the facility assessed R1 and R2 and found no injuries or pain. The investigation revealed R1 and R2 exited the dining room together around 04:30 PM, and Licensed Nurse (LN) G told them she would see them for dinner, to which they agreed and proceeded to walk out of the dining room. CNA M turned off the alarm that sounded when the lobby door opened, without (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	looking through the door. Both R1 and R2 were dressed appropriately for dignity and the weather that day. According to the Kansas State University Historical Weather website, the temperature on 05/03/26 was 83.1 degrees Fahrenheit (F) at 04:00 PM, 82.8 degrees F at 05:00 PM, and 79.4 degrees F at 06:00 PM. Review of Google Maps revealed the distance from the facility to the store R1 and R2 walked to was 0.1 miles. CNA M's notarized Witness Statement, dated 05/03/26, stated she passed drinks and silverware, and at about 05:20 PM, she realized that R1 and R2 were missing from their room. She stated she searched the residents' rooms and realized R1 and R2 were not in the building. CNA M stated the facility located R1 and R2 at 05:30 PM, and they attended dinner. She stated around 04:30 PM, R1 and R2 sat in the dining room, and they left the dining room to go to their room after getting their medications. CNA N's notarized Witness Statement, dated 05/03/26, stated at about 05:20 PM, she answered the phone, and a woman stated she had two women with her that she believed resided at the facility. CNA N stated the woman said they were at the store down the hill from the facility. CNA N stated she took down the residents' names, the community member's information, and vehicle description, and an estimated time the community member planned to bring the residents back. She stated she notified LN H, and together, they notified LN G. LN G's notarized Witness Statement, dated 05/03/26, stated she saw R1 and R2 in the dining room at 04:30 PM, seated and drinking coffee. She stated that both R1 and R2 stood up from where they were seated and started walking out of the dining room. LN G stated she told them she would see them at dinner, and they both agreed with a nod, then walked out. LN G stated at around 05:30 PM, CNA N alerted her about the phone call. She and other staff members waited for R1 and R2 outside as the community member dropped them off. LN G stated she performed a skin assessment on R1 and R2 with no bruising or wounds noted on either resident. LN H's notarized Witness Statement, dated 05/03/26, stated CNA N answered the phone and a community member told her she had two of the facility's residents, R1 and R2. She stated CNA N notified her, and she and CNA N notified LN G. LN H stated she told LN G to do a head count of their residents. The facility completed a head count and accounted for all residents except R1 and R2. LN H stated the community member brought R1 and R2 back in her own car, and LN G performed a pain and skin assessment on them. LN H stated she immediately notified Administrative Nurse D. In an observation on 05/14/26 at 11:01 AM, the facility's front door opened into a driveway with an awning over it, with the driveway curving down slight hills, to two exits onto the road. There was parking available between the two exits and additional parking around the south side of the building. The North driveway exit had uneven ground and depressions in it. The street in front of the facility that led to the store was a busy residential street with no posted speed limit. The East side of the street, which was the closest side to the facility, had no sidewalk, and the street went down a hill and had areas of uneven ground on the side of the street, near the curb. The street that ran in front of the store was a busy [NAME] street with a posted speed limit of 35 miles per hour (mph). In an observation on 05/14/26 at 12:12 PM, R1 and R2 sat in chairs at the same table in the dining room. In an observation on 05/14/26 at 12:15 PM, the double doors between healthcare and the front lobby opened when pushed, and a door alarm sounded immediately upon pushing, and the staff had to enter a code to clear the alarm. On 05/14/26 at 12:17 PM, Administrative Staff B stated if a resident went through the double doors from healthcare, the alarm sounded, and she announced Attention, Dr. Walker three times. She stated she could usually talk to the resident and get them back through the double doors. During an interview on 05/14/26 at 12:40 PM, Administrative Nurse D stated CNA M said she heard the door alarm and reset it, without looking to see who set it off. Administrative Nurse D stated R1 and R2 wore pants and a shirt on 05/03/26. During an interview on 05/14/26 at 01:45 PM, CNA O stated on 05/03/26, around dinner time, she saw R1 and R2 sitting in the dining room. She stated R1 and R2 happened to slip by and get out of the door, and she did not hear the alarm going off because she was down the hall getting residents for dinner. CNA O stated she realized R1 and R2 were missing from their room between 05:00 PM and 05:20 PM before the facility received the phone call, and she looked room-to-room for them. She stated she was in the hall (continued on next page)

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