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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 147 residents. The sample included 31 residents, with three residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide a dignified care environment for Residents (R) 127, R137, R4, R91, R8, and R11. This deficient practice placed the residents at risk for impaired dignity and quality of life. Findings Included: - On 05/12/25 at 07:23 AM, R127 (a severely cognitively impaired resident) stood in the first room right off the dining room. R127 had her pants and briefs pulled down and was feeling the inside of her briefs. R127 was not in her bedroom. On 05/12/25 at 07:23 AM, R127 stood in the first room right off the dining room. R127 had her pants and briefs pulled down and was feeling the inside of her briefs. R127 was not in her bedroom. On 05/13/25 at 08:04 AM, R137 (a severely cognitively impaired resident) walked down the hallway to the dining room. R137 pushed her left hand down the front of her shirt, causing her whole upper sweater to come down with her upper chest exposed. She then exited the dining room. No staff in the dining room to assist her with her shirt. On 05/14/25 at 12:10 PM, R127 walked holding herself between her legs. R127 walked into the first bedroom right off the dining room, pulled down her pants and briefs, and was feeling in the inside of her briefs. R127 was not in her bedroom. On 05/14/25 at 12:10 PM, R127 walked holding herself between her legs. R127 walked into the first bedroom right off the dining room, pulled down her pants and briefs, and was feeling in the inside of her briefs. R127 was not in her bedroom. On 05/14/25 at 12:35 PM, R4 sat at the dining room table next to the emergency exit. Staff walked up to her, placed a clothing protector on her without asking or speaking to her, and then left her alone. On 05/14/25 at 12:45 PM, R91 (a severely cognitively impaired resident) sat in the dining room at the table next to the wall column. R8 (a severely cognitively impaired resident) at to the left of R91 at the table. Staff placed R8's tray on the table in front of her. R91 began grabbing R8's food off her tray. R8 abruptly stood up and took her tray to her room, stating, I can't stand this. R8 returned to the table with her tray once R91's meal was served. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/25 at 02:55 PM, R11 (a severely cognitively impaired resident) sat at the dining room table closest to the window. R11 received her ice cream from the facility's Ice Cream Social activity. Upon receiving her ice cream, R11 was immediately pulled away from the table by direct care staff and taken to her bed without staff talking to her or asking if she wanted to take her ice cream. On 05/15/25 at 09:03 AM, Licensed Nurse (LN) G stated that residents should not be in any other resident's room. She stated they should not have their clothing off or pulled down. She stated staff were expected to ensure each resident had a safe and dignified environment. She stated staff were expected to ask the resident's permission before providing care or moving them. On 05/15/25 at 09:17 AM, Certified Nurse's Aide (CNA) M stated the residents were expected to be fully clothed while out on the unit or in others' rooms. She stated staff were to ensure residents were treated with dignity and ask their permission before caring. On 05/15/25 at 02:42 PM, Administrative Nurse D stated that residents should never have themselves exposed in another resident's room or public areas. She stated staff were expected to engage in conversation with each resident and ask their permission before performing care. The facility's Behavioral Health Services dated 03/11/25 documented that the facility would provide behavioral health care and services that create an environment that promotes emotional, psychosocial well-being, resident needs, and includes individualized approaches to care.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 147 residents. The sample included 31 residents, with two residents sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 25's food preferences were met, due to nursing staff taking dietary items away from the tray. This deficient practice placed R25 at risk for impaired physical, mental, and psychosocial well-being. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment in reality perception), hypertension (high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), acquired absence of right great toe, acquired absence of left great toe, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), foot drop (inability or difficulty in moving the ankle and toes upward), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), retention of urine, history of falling, muscle weakness, unsteadiness on feet, encephalopathy (a broad term for any brain disease that alters brain function or structure), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R25 depended on staff for dressing upper and lower body, and bathing. The MDS documented R25 was independent with eating and required partial/moderate assistance with toileting. The MDS documented R25 was a diabetic. The Nutritional Status Care Area Assessment (CAA) dated 08/22/24 documented R25 Nutritional CAA triggered secondary a calculation used to estate body fat percentage based on height and weight()R25's CAA documented the risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. The care plan would be reviewed and updated to include interventions to address risk factors. R25's Care Plan revised 02/20/25 documented R25 had a nutritional risk related to diabetes and Alzheimer's Disease. R25's plan of care had a history of diabetic foot ulcers. R25's plan of care documented she had her left and right great toe amputation. R25's plan of care documented R25 would maintain her weight without significant weight changes. R25's plan of care directed staff to provide her diet as ordered by the physician and monitor and record her food intake. R25's EMR under Orders revealed the following: Double protein with all meals dated 03/14/25. Regular diet, easy-to-chewy texture, thin consistency with diabetic condiments dated 03/14/25. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/12/25 at 08:27 AM, Certified Nurses Aid (CNA) N took toast from R25's breakfast tray after asking Licensed Nurse (LN) G if R25 should get all her bread due to blood glucose readings. LN G stated she should take half the bread from R25's tray. CNA N took two halves of toast from R25's tray. On 05/14/25 at 12:36 PM, LN G took R25's bread stick from her meal tray after stating her blood sugar would be high. R25 grabbed for the bread. LN G put bread on the tray and placed the tray in the food warmer. R25 then grabbed the bread off R124's plate and ate half of R124's breadstick. LN G stated R124 was a good [NAME]. On 05/14/25 at 12:45 PM, LN G stated R25's blood glucose was high, and she got double portions. LN G stated she did not want to call the physician. LN G stated R124 was a good [NAME] and R25 got some bread. On 05/15/25 at 09:17 AM, CNA N stated she always asked the nurse what the residents who are diabetics s would have for each meal. She stated she would tell me if the blood sugars were high or low. She stated during each meal the diabetic's bread or dessert would be pulled from their tray. On 05/15/25 at 02:42 PM, Administrative Nurse D stated residents should get what was served on the resident's tray. She stated staff should never take food away from the resident. The facility's Resident Rights policy revised 09/10/24 documented at the time of admission and periodically throughout their stay, the facility would inform each resident, orally and in writing of their rights.

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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. The facility identified a census of 147 residents. The sample included 31 residents, with one reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R) 198's physician of changes related to his head injury from staff-assisted cares. This deficient practice resulted in a delay in acute medical treatment. Findings Included: - The Medical Diagnosis section within R198's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), acute femur (upper leg bone) fracture (broken bone), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R198's Significant Change Minimum Data Set (MDS) dated 10/25/24 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted no behaviors observed. The MDS noted one-sided upper extremity impairment and bilateral (both sides) lower extremity impairment. The MDS noted he used a wheelchair for mobility. The MDS noted he was dependent on staff assistance for bed mobility, toileting, bathing, lower body dressing, putting on footwear, and personal hygiene. The MDS noted he was always incontinent of bowel and bladder. The MDS noted he had fractures and other multiple traumas. R198's Cognitive Impairment Care Area Assessment (CAA) completed 07/12/24 noted he had behaviors related to his dementia diagnosis and required 24-hour daycare. The CAA noted he required total care. R198's Communication CAA completed 07/12/24 noted he had severe cognitive impairment that rendered him unclear with garbled speech. The CAA noted he was unable to voice his needs. R198's Care Plan initiated 07/01/24 indicated he was at risk for activities of daily living (ADL) self-care deficit and falls related to his medical diagnoses. R198's plan noted he had verbal and physically aggressive behaviors (07/12/24). The plan instructed staff to speak to him calmly and divert his attention. The plan noted he was dependent on staff assistance for his transfers, toileting, dressing, personal hygiene, bathing, and oral hygiene. The plan noted he required total assistance from two staff for repositioning and turning in bed (10/28/24). The plan noted he required total assistance from two staff for transfers but was changed to a Hoyer lift (full mechanical body lift) on 11/13/24. R198's EMR under Progress Notes revealed an Event Note completed 01/02/25 at 07:48 PM by Licensed Nurse (LN) K. The note indicated staff found R198 in his bed with a blood-soaked Band-Aid. The note revealed staff then reported the injury to LN K. The note revealed R198 did not have this injury the previous evening. LN K cleaned and assessed the wound to find a three-centimeter (cm) laceration on his forehead. The note revealed LN K believed the wound might need sutures and notified the medical provider. R198 was sent out to an acute care facility for evaluation and treatment. R198's EMR revealed no progress notes or nursing assessments completed at the time of R198's injury prior to LN K's discovery of the wound. The facility was unable to provide this documentation as requested on 05/15/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Related Injury report # 5074 completed 01/02/25 indicated staff found R198 around 04:30 PM with a blood-saturated Band-Aid on his forehead. The report noted R198 had a three-centimeter laceration on his forehead and the wound needed to be sutured. The report revealed R198 was unable to explain how he received the injury. The note revealed R198 was sent out to an acute care facility at 05:30 PM for evaluation and treatment. A Witness Statement completed by CNA PP on 01/03/25 indicated she was assisting with R198's Hoyer Lift transfer before his injury occurred. The statement indicated CNA's PP and CNA Q transferred R198 to his bed from his wheelchair. The statement then indicated CNA PP left the room to assist other residents. A Witness Statement completed by CNA Q on 01/03/25 indicated she assisted with R198's wheelchair-to-bed transfer via a Hoyer lift after lunch. The statement indicated CNA PP left the room to assist another resident and returned to check on R198. The statement revealed upon returning to the room CNA Q found R198's feet were on the floor. The statement revealed R198 placed his feet back on his bed and noticed that R198 was incontinent of bowel. The statement revealed CNA Q raised the bed and turned R198 towards the wall. The statement revealed CNA Q turned R198 back towards her, and R198 punched CNA Q in the mouth. The statement revealed CNA Q saw that R198's head was bleeding as R198 grabbed her shirt. The statement revealed CNA Q placed a Band-Aid on his forehead and told CNA PP that R198 punched her in her mouth. R198's EMR under the Interdisciplinary Team (IDT) note completed on 01/07/24 indicated R198's injury was caused when he struck his head on a wall outlet next to his bed while he was agitated during care. On 05/15/25 at 09:34 AM, CNA Q stated on 01/02/25 that she moved R198 back to his bed after lunch with another staff. She stated that both staff left the room to assist other residents. CNA Q stated she re-entered the room briefly and found R198 hanging off the side of his bed with his feet on the floor. She stated she pulled his feet back up on the bed and noticed he had a bowel movement. She stated she turned him on his side (facing the wall). She stated that upon turning him back, R198 grabbed her and punched her. She stated she noticed his head bleeding. She stated she reported the incident to CNA PP and put a Band-Aid on his head. On 05/15/25 at 09:34 AM, CNA PP stated she assisted CNA Q with R198's bed transfer on 01/02/25 but then left the room to assist other residents. She stated the unit nurse left early that day, so she was not sure who the accident was reported to or if R198 was assessed. She stated the facility completed annual abuse, neglect, and exploitation training. She stated that injuries and accidents a required to be reported to the nurse immediately. On 05/15/25 at 11:43 AM, LN K stated he started his shift with no knowledge or pass-down information related to R198's injury. He stated that the previous shift nurse left early. LN K stated the staff found R198 in his bed, resting, and noticed the head injury. LN K stated he notified Administrative Nurse D and the medical provider upon assessment of the wound's condition and recommended further evaluation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 02:44 PM, Administrative Nurse D stated she did not feel the accidents were abuse-related due to having witnesses for the accidents. She stated the first accident was related to a slip of the Sit-to-stand lift, and the second was due to his head hitting a wall outlet. She stated that the witness statements corroborated the observations at the time. She stated that staff received annual training related to abuse, neglect, and exploitation. She stated staff were expected to report falls, accidents, and injuries immediately to the on-duty nurse. The facility's Changes in Resident Condition or Status revised 11/2018 indicated the facility must immediately inform the resident's physician of accidents that require physician intervention related to physical, mental, or psychosocial changes.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a census of 147 residents. The sample included 31 residents, with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on interview and record review, the facility failed to issue Center for Medicare/Medicaid Services (CMS) Notification of Medicare Non-Coverage Form 10123 (NOMNC - the form used to notify Medicare A participants of their rights to appeal and the last covered date of participants of potential financial liability when a Medicare Part A episode ends) with the required information for Resident (R) 199. This failure placed the resident at risk for decreased autonomy and impaired decision-making. Findings included: - A review of R199's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 03/28/25 and ended on 04/16/25. R199 did not remain in the facility for custodial care and was discharged to home. R199's clinical record lacked evidence of a NOMNC issued for this Medicare Part A episode. Review of R199 EMR under the Assessment tab revealed a Discharge Summary Information dated 04/14/25 that documented R199 had met her therapy goals and would be discharged home. On 05/15/25 at 10:10 AM, Social Services Staff X stated the facility did not issue NOMNC notices to residents who had been discharged from the facility with Medicare A days remaining. On 05/15/25 at 11:40 AM, Administrative Nurse F stated the facility was not required to issue a NOMNC notice to a resident who was discharged to home or going to get therapy outside the facility. The facility's Denial or End of Benefits policy last reviewed 05/06/25 documented the denial or end of benefits process was in place to help the resident and family understand their options and needs that they might have regarding their care.

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	175158	A. Building B. Wing	05/15/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 148 residents. The sample included 29 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 37, R93, R248, and R90 were free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without an appropriate indication for use or a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued). The facility failed to ensure the physician provided the risk versus benefit statement for the continued use of antipsychotic medications. These deficient practices placed R37, R93, R248, and R90 at risk of unnecessary medication administration and related complications. Findings included: - R37's Electronic Medical Record (EMR) recorded diagnoses of psychosis (any major mental disorder characterized by gross impairment in perception), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). R37's Annual Minimum Data Set (MDS) dated 08/08/24 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R37 displayed the behaviors of inattention and disorganized thinking that were present and fluctuated. R37 required supervision for his functional abilities. R37's Delirium Care Area Assessment (CAA) dated 08/13/24 documented he had a history and diagnosis of dementia with ongoing cognitive impairments. R37 could be inattentive and had disorganized thinking related to his dementia disease. R37's Psychotropic Drug Use CAA dated 08/13/24 documented he triggered this CAA due to the use of psychotropic medication use. R37's care plan directed staff to monitor R37 for medication side effects. R37's Care Plan was last revised on 02/13/25 and directed staff to administer antipsychotic medications as ordered by the physician. The plan of care directed staff to consult with the pharmacy and the physician to consider a dosage reduction when clinically appropriate. The plan of care directed staff to discuss with the physician and family the ongoing need for the use of the medication. The plan of care directed staff to educate the resident, family, and caregivers about the risks, benefits, and side effects of psychotropic medication drugs being given. R37's Orders tab of the EMR documented a physician's order dated 06/25/24 for Seroquel (an antipsychotic medication) 25 milligram (mg) tablet by mouth one time a date for psychosis. This order was discontinued on 09/27/24. R37's Orders tab of the EMR documented a physician's order dated 09/27/24 for Seroquel 25 mg tablet to give 12.5 mg by mouth twice daily for psychosis. This order was discontinued on 09/28/24. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's Orders tab of the EMR documented a physician's order dated 09/28/24 for Seroquel 25 mg tablet by mouth twice daily for psychosis. This order was discontinued on 11/21/24. R37's Orders tab of the EMR documented a physician's order dated 11/21/24 for Seroquel 25 mg tablet by mouth two times a day for psychosis. A review of the Consultant Pharmacist's Recommendation to Physician reports from May 2024 to the present for R37 revealed that a GDR had not been attempted or recommended since November 2023. The reports also lacked a consultant pharmacist (CP) recommendation for an appropriate indication for the use of Seroquel or a physician's risk versus benefit for the continued use of the medication. On 05/13/25 at 08:34 AM, R37 sat at the dining table of a secured unit. R37 sat at a table with another male resident and took the other resident's ice cream. The certified nurse aide (CNA) intervened and moved R37 to another table. On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate indication for the use of antipsychotic medication was but knew that dementia should not be used. On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already being on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the GDRs done and the physician's risk versus benefit done on residents. Administrative Nurse D stated that dementia was not a good indication for the use of an antipsychotic. Administrative Nurse D stated dementia should not be used as a diagnosis for an antipsychotic without proper physician rationale. Administrative Nurse D stated that R248 was a fairly new resident, and recommendations had not been performed yet by the CP. The facility's Unnecessary Medication policy last revised on 04/22/25 documented the facility would ensure only medications required to treat the resident's assessed condition were being used, reducing the need for, and maximizing the effectiveness of medications were important considerations for all residents. As a part of medication management, it was important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility would assess the resident's underlying condition, current, symptoms, and expressions, and preferences and goals for treatment. This would assist the facility in determining if there were any indications for initiating, withdrawing, or withholding medications as well as the use of non-pharmacological approaches. The resident's medical record should show documentation of adequate indicators for a medication's use and the diagnosed condition for which a medication was described, when there were multiple prescribers, the continuation of a medication needed to be evaluated to determine if the medication was still warranted in the context of the resident's other medications and comorbidities. - R93's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by gross impairment in reality perception), insomnia (inability to sleep), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R93's admission Minimum Data Set (MDS) dated 04/24/25 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R93 displayed symptoms of delirium (sudden severe confusion, disorientation, and restlessness) that included inattention and disorganized thinking. R93's MDS documented she displayed both physical and verbal behaviors directed toward others. R93's MDS documented she utilized a Broda chair (specialized wheelchair with the ability to tilt and recline). R93's MDS documented she required set-up assistance for eating and substantial to being dependent on staff for her activities of daily living (ADL) and functional abilities. R93's MDS documented she was frequently incontinent of bladder and always incontinent of bowel. The MDS documented R93 received an antipsychotic, an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), and an antidepressant (a class of medications used to treat mood disorders) medication on a regular basis. R93's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/01/25 documented she used psychotropic medications. The facility administered the medications per physician orders and observed the resident for adverse effects. R93's Care Plan revised on 04/22/25 directed staff to administer her antipsychotic medications as ordered by the physician. The plan of care directed staff to consult with the pharmacy and the physician to consider a dosage reduction when clinically appropriate. The plan of care directed staff to discuss with the physician and family the ongoing need for the use of the medication. The plan of care directed staff to educate the resident, family, and caregivers about the risks, benefits, and side effects of psychotropic medication drugs being given. The plan of care directed staff to observe for and report as needed any adverse reactions to the antipsychotic medications. R93's Orders tab of the EMR documented an order dated 04/18/25 for brexpiprazole (Rexulti - an antipsychotic medication) 3 milligrams (mg) by mouth in the afternoon for psychosis. R93's Orders tab of the EMR documented an order dated 04/18/25 for Seroquel (an antipsychotic medication) 25 mg tablet by mouth twice daily for psychosis. A review of the Consultant Pharmacist's Medication Regimen Review (MRR) for April 2025 lacked a recommendation for an appropriate indication for the use of the antipsychotics Seroquel and brexpiprazole. On 05/13/25 at 08:17 AM, R93 laid in her bed resting. R93's bed was in the low position and the call light was within reach. On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate indication for the use of antipsychotic medication was but knew that dementia should not be used. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already being on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the GDRs done and the physician's risk versus benefit done on residents. Administrative Nurse D stated that dementia was not a good indication for the use of an antipsychotic. Administrative Nurse D stated dementia should not be used as a diagnosis for an antipsychotic without proper physician rationale. Administrative Nurse D stated that R248 was a fairly new resident, and recommendations had not been performed yet by the CP. The facility's Unnecessary Medication policy last revised on 04/22/25 documented the facility would ensure only medications required to treat the resident's assessed condition were being used, reducing the need for, and maximizing the effectiveness of medications were important considerations for all residents. As a part of medication management, it was important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility would assess the resident's underlying condition, current, symptoms, and expressions, and preferences and goals for treatment. This would assist the facility in determining if there were any indications for initiating, withdrawing, or withholding medications as well as the use of non-pharmacological approaches. The resident's medical record should show documentation of adequate indicators for a medication's use and the diagnosed condition for which a medication was described, when there were multiple prescribers, the continuation of a medication needed to be evaluated to determine if the medication was still warranted in the context of the resident's other medications and comorbidities. - R248's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (elevated blood pressure), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). R248's admission Minimum Data Set (MDS) was still in progress and had not been completed. R248's Care Area Assessment was still in progress and had not been completed. R248's Care Plan dated 05/05/25 directed staff to administer antipsychotic medications as ordered by the physician. R248's plan of care directed staff to observe R248 for side effects and the effectiveness of medications each shift. R248's Orders tab of the EMR documented a physician's order dated 05/05/25 for Aripiprazole (an antipsychotic medication) 5 milligram (mg) tablet by mouth once daily for dementia. This order lacked an approved indication for antipsychotic medication use. A Consultant Pharmacist (CP) review had not been completed yet as R248 was admitted to the facility on [DATE]. On 05/13/25 at 10:19 AM, R248 sat in his wheelchair in his room watching TV. R248's call light was within reach. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate indication for the use of antipsychotic medication was but knew that dementia should not be used. On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already being on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the GDRs done and the physician's risk versus benefit done on residents. Administrative Nurse D stated that dementia was not a good indication for the use of an antipsychotic. Administrative Nurse D stated dementia should not be used as a diagnosis for an antipsychotic without proper physician rationale. Administrative Nurse D stated that R248 was a fairly new resident, and recommendations had not been performed yet by the CP. The facility's Unnecessary Medication policy last revised on 04/22/25 documented the facility would ensure only medications required to treat the resident's assessed condition were being used, reducing the need for, and maximizing the effectiveness of medications were important considerations for all residents. As a part of medication management, it was important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility would assess the resident's underlying condition, current, symptoms, and expressions, and preferences and goals for treatment. This would assist the facility in determining if there were any indications for initiating, withdrawing, or withholding medications as well as the use of non-pharmacological approaches. The resident's medical record should show documentation of adequate indicators for a medication's use and the diagnosed condition for which a medication was described, when there were multiple prescribers, the continuation of a medication needed to be evaluated to determine if the medication was still warranted in the context of the resident's other medications and comorbidities.- R90's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Pain, hypertension (high blood pressure), insomnia (unable to sleep), cognitive-communication deficit(often stems from problems with attention, memory, executive functions), deficit, history of falling, muscle weakness, hyperlipidemia (an abnormally high concentration of fats and lipid in the blood), aphasia (a condition with disordered or absent language function), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS) dated 01/31/25, documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R90 needed substantial to maximal assistance with dressing and toileting. The MDS documented R90 required setup for eating. The MDS documented R90 received an antidepressant (a class of medications used to treat mood disorders), antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), hypnotic (a class of medications used to induce sleep), and an antianxiety (a class of medications that calm and relax people during the observation period. R90's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/31/25 triggered secondary to R90 receiving antipsychotic, antianxiety, and antidepressant medications. R90's CAA documented the contributing factors including diagnosis of depression and psychosis. The CAA documented risk factors including side effects, allergic reactions, and improper dosing. The CAA documented R90's care plan would be reviewed and updated to include interventions to address risk factors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R90's Care Plan revised 10/24/24 documented R90 used psychotropic medications. The plan of care for R90 documented nursing staff were to administer medication as the physician ordered and monitor for side effects and effectiveness. R90's plan of care documented nursing staff were to consult with the pharmacy, and the physician to consider dosage reduction when clinically appropriate at least quarterly. The facility was to review behaviors, interventions, and alternate therapies attempted and their effectiveness as per facility policy. The plan of care for R90 documented staff were to educate the resident, family, and caregivers about the risks, benefits, and side effects of psychotropic medication. R90's EMR under Orders documented the following physician's order: Seroquel (anti-psychotropic) oral tablet (Quetiapine Fumarate) give 75 milligrams (mg) three times a day for psychosis dated 11/14/24. Review of R90's EMR lacked evidence of a physician-documented rationale for including the risks versus benefits of R48's antipsychotic medication. On 05/14/25 at 07:32 AM, R90 laid on his bed, with the head of the bed elevated. On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate indication for the use of antipsychotic medication was but knew that dementia should not be used. On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the Gradual Dose Reduction (GDRs) done and the physician's risk versus benefit done on residents. Administrative Nurse D stated that psychosis in a dementia resident was not a good indication for the use of Seroquel. Administrative Nurse D stated R90 had many behaviors and the Seroquel seemed to help with his symptoms. On 05/19/25 at 10:40 AM, communication from the facility documented 07/25/23 a pharmacy consult was obtained and approved by the physician for a dose reduction for R90's Seroquel. A GDR was declined on 12/23 for R90's Seroquel. The facility's Unnecessary Medication policy last revised on 04/22/25 documented the facility would ensure only medications required to treat the resident's assessed condition were being used, reducing the need for, and maximizing the effectiveness of medications was an important consideration for all residents. As a part of medication management, it was important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility would assess the resident's underlying condition, current, symptoms, and expressions, and preferences and goals for treatment. This would assist the facility in determining if there were any indications for initiating, withdrawing, or withholding medications as well as the use of non-pharmacological approaches. The resident's medical record should show documentation of adequate indicators for a medication's use and the diagnosed condition for which a medication was described, when there were multiple prescribers, the continuation of a medication needed to be evaluated to determine if the medication was still warranted in the context of the resident's other medications and comorbidities.

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	175158	A. Building B. Wing	05/15/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. The facility identified a census of 147 residents. The sample included 31 residents, with 31 residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 46 for person-centered preferences. The facility also failed to develop a comprehensive care plan for R82 for respiratory therapy. These deficient practices placed these residents at risk for impaired care due to uncommunicated care needs. Findings included: - R46's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognitive processes), and lack of coordination. The Annual Minimum Data Set (MDS) dated 01/03/25 documented a Brief Interview of Mental Status (BIMS) score of 99 and a staff interview was conducted, which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum assistance with personal hygiene and dressing. The Quarterly MDS dated 04/16/25 documented a BIMS score of 99 and a staff interview was conducted, which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum assistance with personal hygiene and dressing. R46's Behavioral Symptoms Care Area Assessment (CAA) dated 01/08/25 documented he had a diagnosis of dementia with ongoing cognitive impairment. R46 could be socially inappropriate due to his dementia. R46's Care Plan, dated 01/26/22, documented staff anticipated and met his needs. The plan of care documented R46 required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The plan of care lacked direction to the staff of R46's person-centered choices for personal hygiene. On 05/12/25 at 12:46 PM, R46 sat asleep in his wheelchair in the common area. R46 had several days of facial hair on his face. On 05/13/25 at 08:09 AM, R46 sat asleep at the dining room table in his wheelchair. R46 had several days of facial hair on his face. On 05/14/25 at 03:01 PM, R46 was pushed in his wheelchair by staff into the common area. R46 continued to have several days of facial hair on his face and neck area. On 05/15/25 at 11:14 PM, R46 sat in his wheelchair in the common area. R46 had several days of facial hair on his face and neck area. R46 stated he was not trying to grow a beard and would prefer to be shaved on a daily basis. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 11:39 AM, Certified Nurse Aide (CNA) O stated the staff shaved the gentlemen on their shower days. CNA O stated he would not know where to find if a resident had preferred to be shaved on a daily basis. CNA O stated everyone had access to the resident's care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident) which should include a resident's preferences. On 05/15/25 at 11:42 AM, Licensed Nurse (LN) H stated that R46's shaving of facial hair would be provided twice weekly on his shower/bath day or if R46 requested to be shaved. LN H stated that R46 was an evening bath, and she was not sure if the evening staff offered R46 on a daily basis to be shaved. LN H stated his choice should be listed on R46's Care Plan. LN H stated the residents had dementia so they may say yes at one time and then not the next. LN H stated everyone had access to the resident's Kardex. On 05/15/25 at 02:43 PM, Administrative Nurse D stated she would expect each resident's preference for personal hygiene to be on their care plan. Administrative Nurse D stated the facility tried to get the residents' preferences at the time of admission, but sometimes the residents were unable to answer the questions asked of them due to their dementia or cognitive impairments. The facility's Comprehensive Care Plans and Revisions policy last reviewed on 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. - R82's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), abnormal findings of lung fields, and hypoxia (inadequate supply of oxygen). The Significant Change Minimum Data Set (MDS) dated 11/13/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS lacked documentation that R82 was on oxygen therapy and had an order for a bi-level positive airway pressure (BIPAP - a device that helps with breathing) during the observation period. The Quarterly MDS dated 04/10/25 documented a BIMS score of eight, which indicated moderately impaired cognition. The MDS lacked documentation that R82 was on oxygen therapy and had an order for a BIPAP during the observation period. R82's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 11/22/24 documented she required staff assistance with some of her activities of daily living. R82's Care Plan, last revised 11/20/24, documented the hospice provider had supplied her with an oxygen concentrator, wheelchair, nebulizer (a device that changed liquid medication into a mist easily inhaled into the lungs), bed frame, and a foam mattress. The care plan lacked direction for her oxygen therapy and the use of a BiPAP machine at bedtime. R82's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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	05/15/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BiPAP upon arrival to the facility while asleep or in bed. Mode: non-invasive ventilation continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep), dated 11/01/24. Check oxygen saturation every shift and titrate oxygen to keep stats above 90% every shift for CHF exacerbation, dated 11/01/24. The order lacked dosing instructions for the oxygen. On 05/13/25 at 08:21 AM, R82 sat at the dining room table with oxygen tubing in her nares. On 05/14/25 at 07:13 AM, R82's oxygen tubing laid directly on the dining room table unbagged. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated she would ask the charge nurse what R82's oxygen flow should be set at. CNA P stated that R82's oxygen tubing should be stored in a bag when not in use. CNA P stated respiratory care should be included in R82's care plan. On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated oxygen equipment should be stored in a bag when not in use, and it should not be left unbagged on the dining room table when not in use. LN I stated that R82 should have an order to administer oxygen which included the specific dose to be administered. LN I stated respiratory therapy and her use of a BiPAP should be included in the care plan. On 05/15/25 at 02:43 PM, Administrative Nurse D stated she would expect R82's BiPAP and oxygen equipment to be stored in a bag when not in use. Administrative Nurse D stated she would expect there to be a physician order for the use of oxygen therapy. Administrative Nurse D stated she would expect a resident's care plan to have respiratory therapy. Administrative Nurse D stated everyone had access to the care plans and Kardex. The facility's Comprehensive Care Plans and Revisions policy last reviewed on 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care.

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	175158	A. Building B. Wing	05/15/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility identified a census of 147 residents. The sample included 31 residents, with 31 residents reviewed for care plan for resident centered revisions. The facility failed to revise the care plan to include resident-centered functional abilities for Resident (R) 23. This placed the resident at risk for unmet care needs. Findings included: - R23's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), muscle weakness, and cerebrovascular accident (CVA - stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The admission Minimum Data Set (MDS) dated 10/15/24 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R23 had no behavioral symptoms during the observation period. The Quarterly MDS dated 04/10/25 documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented that R23 had no behavioral symptoms during the observation period. The MDS documented R23 had received antidepressant (a class of medications used to treat mood disorders) medication and antianxiety (a class of medications that calm and relax people) medication during the observation period. R23's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/23/24 documented she had ongoing cognitive impairment related to her history of strokes. R23's Care Plan dated 10/25/24 directed the staff to reassure her when she was resistive with activities of daily living (ADL), leave and return in five to 10 minutes later and try again as safety allowed. R23's EMR under the Progress Notes tab revealed the following: On 03/28/25 at 08:50 PM, a Behavior Note that documented R23 was verbally and physically aggressive toward the staff during the assistance of ADLs. R23 stated stop and go away to the staff. R23 continued to hit, pinch, and kick during the ADL assistance. Staff had redirected R23 with minimal effect and R23 continued the verbal and physical aggressive behavior toward the staff during their assistance with ADLs. On 03/29/25 at 01:28 PM a Behavior Note documented R23 was combative during a transfer from her bed into the wheelchair with assistance of two staff members. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/25 at 06:46 PM a Behavior Note documented R23 was verbally and physically aggressive toward staff during ADL assistance. R23 stated stop and quit it to the staff as they assisted her. R23 kicked, bite and pinched the staff during their assistance. Staff redirected R23 with minimal effect as they continued to provide care. On 03/29/25 at 05:50 PM an Event Note documented a staff member that had provided assistance to R23 and reported R23 had an open area on her right arm. A skin tear was noted on R23's right arm. On 04/21/25 at 06:40 PM a Behavior Note documented R23 was verbally and physically aggressive toward the staff as they provided her assistance with ADLs. R23 yelled leave me alone and she would get them. R23 continued to hit, pinch, and hit at the staff during their assistance. Staff attempted to redirect R23 with minimal effectiveness, and R23 continued to be aggressive toward the staff. On 04/22/25 09:01 PM a Behavior Note documented R23 was verbally and physically aggressive toward the staff as they provided her assistance with ADLs. R23 yelled quit it and leave me alone. R23 continued to hit, pinch, and hit at the staff during their assistance. Staff attempted to redirect R23 with minimal effectiveness, and R23 continued to be aggressive toward the staff. On 05/2/25 at 01:00 PM a Behavior Note documented R23 was combative toward staff when they attempted to administer her medication. R23 attempted to hit staff and bite down on the spoon and made it difficult for staff to administer R23 her medications. On 05/10/25 at 10:40 AM a Skin/Wound Note documented R23 had received a skin tear on her right forearm during staff assistance with ADLs. Staff reported R23 had been combative during assistance with ADLs, dressing, transfers, and grooming. On 05/11/25 at 01:42 PM a Behavior Note documented R23 was combative with transfers from her bed into the wheelchair. R23 had resisted toward staff during their assistance with ADLs. R23 would bite staff and grab at staff's arms during their assistance with ADLs. On 05/13/25 at 07:32 AM, R23 laid asleep on her right side on the bed. R23's bed was in the lowest position, asleep on her bed, on her left side with the bed in the low position. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated R23 had behaviors at times. CNA P stated she would attempt to reapproach later. CNA P stated it would be helpful to have other person-centered interventions to help with R23's behaviors. CNA P stated she had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident) . On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated when R23 became combative with staff during their assistance. LN I stated they were to leave and reapproach her later. LN I was not sure if there were any person-centered interventions on R23 care plan for staff to use when she became combative. LN I stated everyone had access to the resident's care plan and Kardex. On 05/15/25 at 02:43 PM, Administrative Nurse D stated the staff would try to redirect the resident when they became combative during staff assistance with ADLs. Administrative Nurse D stated she would not expect staff to care plan every behavioral intervention. Administrative Nurse D stated everyone had access to the resident's care plan and Kardex. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Comprehensive Care Plans and Revisions policy last reviewed 09/11/24 documented the facility would ensure the timeliness of each resident 's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. The facility would monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. When these changes occurred, the facility should review and update the plan of care to reflect the changes to care delivery.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. The facility identified a census of 147 residents. The sample included 31 residents, with six residents reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to provide the necessary assistance with personal hygiene for Resident (R) 46. This deficient practice placed R46 at risk for poor hygiene, decreased self-esteem, and impaired dignity. Findings included: - R46's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognitive processes), and lack of coordination. The Annual Minimum Data Set (MDS) dated 01/03/25 documented a Brief Interview of Mental Status (BIMS) score of 99 and a staff interview was conducted which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum assistance with personal hygiene and dressing. The Quarterly MDS dated 04/16/25 documented a BIMS score of 99 and a staff interview was conducted which indicated severely impaired cognition. The MDS documented R46 required substantial to maximum assistance with personal hygiene and dressing. R46's Behavioral Symptoms Care Area Assessment (CAA), dated 01/08/25 documented he had a diagnosis of dementia with ongoing cognitive impairment. R46 could be socially inappropriate due to his dementia. R46's Care Plan, dated 01/26/22, documented staff anticipated and met his needs. The plan of care documented R46 required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The plan of care lacked direction to the staff of R46's person-centered choices for personal hygiene. On 05/12/25 at 12:46 PM, R46 sat asleep in his wheelchair in the common area. R46 had several days of facial hair on his face. On 05/13/25 at 08:09 AM, R46 sat asleep at the dining room table in his wheelchair. R46 had several days of facial hair on his face. On 05/14/25 at 03:01 PM, R46 was pushed in his wheelchair by staff into the common area. R46 continued to have several days of facial hair on his face and neck area. 05/15/25 11:14 PM, R46 sat in his wheelchair in the common area. R46 had several days of facial hair on his face and neck area. R46 stated he was not trying to grow a beard and would prefer to be shaved on a daily basis. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 11:39 AM, Certified Nurse Aide (CNA) O stated the staff shaved the gentlemen on their shower days. CNA O stated he would not know where to find if a resident had preferred to be shaved on a daily basis. On 05/15/25 at 11:42 AM, Licensed Nurse (LN) H stated that R46's shaving of facial hair would be provided twice weekly on his shower/bath day or if R46 requested to be shaved. LN H stated that R46 was an evening bath, and she was not sure if the evening staff offered R46 on a daily basis to be shaved. LN H stated his choice should be listed on R46's care plan. LN H stated the residents had dementia so they may say yes at one time and then not the next. On 05/15/25 at 02:43 PM, Administrative Nurse D stated she would expect each resident's preference for personal hygiene to be on their care plan. Administrative Nurse D stated the facility tried to get the residents' preferences at the time of admission, but sometimes the residents were unable to answer the questions asked of them due to their dementia or cognitive impairments. The facility's Resident Rights policy last revised on 09/10/24 documented the facility must treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. The facility identified a census of 147 residents. The sample included 31 residents with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order to apply thrombo-embolic-deterrent hose (TED hose - specialized compression stockings designed to help manage swelling of the feet/legs) in the mornings for edema (swelling resulting from an excessive accumulation of fluid in the body tissues). This deficient practice placed R90 at risk for increased edema, pain, and skin-related difficulties. Findings Included: - R90's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of pain, hypertension (high blood pressure), insomnia (unable to sleep), cognitive-communication deficit(often stems from problems with attention, memory, executive functions), history of falling, muscle weakness, hyperlipidemia (an abnormally high concentration of fats and lipid in the blood), aphasia (condition with disordered or absent language function), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS) dated 01/31/25, documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R90 needed substantial to maximal assistance with dressing, toileting, and set up for eating. The MDS documented R90 received a diuretic (a medication to promote the formation and excretion of urine) during the observation period. The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 01/31/25 documented R90 triggered for urinary incontinence CAA triggered secondary to incontinence of bowel and bladder and dependence of staff for incontinent care. The CAA for R90 documented contributing factors included weakness, impaired mobility, and cognitive loss. R90's CAA documented the risk factors included skin breakdown, falls, and recurrent urinary tract infections (UTI). The CAA documented R90's plan of care would be reviewed and updated. R90's Care Plan dated 05/15/25 documented R90 received diuretic therapy medication related to edema. R90's plan of care documented R90 received diuretic medication as ordered by the physician. R90's EMR chart under Orders revealed the following orders: Lasix (diuretic) oral tablet 40 milligrams (mg) give one tablet by mouth two times a day for edema dated 06/01/23. TED stockings off bilateral lower extremities at bedtime for skin integrity dated 07/30/23. TED stockings on bilateral lower extremities on everyday shift for edema dated 03/14/24. On 05/12/25 at 07:45 AM, R90 sat at the dining room table. R90 had nonskid socks on, and R90 did not have TED stockings on his feet. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/25 at 08:25 AM, R90 sat in front of the nursing station. R90 had nonskid socks on, and R90 did not have TED hose stockings on his feet. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated that if a resident should have TED hose in the AM, it was all the nursing staff's obligation to ensure the TED hose were put on him. On 05/15/25 at 02:27 PM, Certified Nurse's Aide (CNA) QQ stated it was the CNA's duty to apply TED hose when helping get a resident up for the day. CNA QQ stated she had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident), and any special instructions for a resident would be communicated to her by the charge nurse. On 05/15/25 at 02:42 PM, Administrative Nurse D stated she could not say it was one person's duty to ensure the TED hose were placed as ordered for a resident. She stated all nursing departments could apply the TED hose. The facility's Skin Integrity and Pressure Ulcer /Injury Prevention and Management policy dated 03/31/23 documented skin observations occurred through points of care provided by CNAs and during ADL care, and any changes or open areas were reported to the nurse.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R122's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and muscle weakness. The admission Minimum Data Set (MDS) dated 05/08/24 documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R122 was not at risk of the development of pressure-related injuries. The MDS documented R122 had a pressure-reducing device on her bed. The Quarterly MDS dated 02/07/25 documented a staff interview was conducted and R122 had moderately impaired cognition. The MDS documented that R122 was not at risk of development of a pressure-relayed injury. The MDS documented R122 had a pressure-reducing device on her bed. R122's Pressure Ulcer Care Area Assessment (CAA), dated 05/16/24 documented she did not have a pressure injury. R122's Care Plan, dated 04/18/25 documented she had a pressure-reducing mattress on her bed. The plan of care documented staff would encourage her to wear heel protectors while in bed as tolerated. R122's EMR under the Orders tab revealed the following physician orders: Bilateral heels - heel suspension boots at all times when in bed every evening and night shift for skin integrity dated 03/18/25. Right heel - encourage non-weight bearing as much as possible, except for therapy and transfers as needed for wound healing dated 04/18/25. R122's EMR under the Assessment tab revealed a Skin Integrity Update assessment dated [DATE] that documented finding a blister (a bubble that forms on the skin, typically due to friction, burns, or other skin injuries) on R122's right heel. A Wound Observation Tool assessment dated [DATE] of R122's right heel documented was a stage three (full thickness tissue loss, subcutaneous (beneath the skin) fat may be visible, but bone, tendon, or muscle are not exposed), Slough (dead tissue, usually cream or yellow in color) may be present but does not obscure the depth of tissue loss, may include undermining and tunneling. On 05/13/25 at 07:23 AM, R122 laid on her bed asleep on her left side and her heels laid directly on the mattress. R122's suspension boot sat in the chair next to her bed and no extra pillow was noted on R122's bed or in the chair beside her bed. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated she did not always put R122's pressure-reducing boots on her heels, because R122 tried to get up and walk. CNA P stated she was worried R122 would fall. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated she was not sure what pressure-reducing devices were in place for R122 without checking. LN I stated the pressure-reducing devices should be in R122's care plan. LN I stated R122 would stand on her right heel to transfer. On 05/15/25 at 02:43 PM, Administrative Nurse D stated it was everyone's responsibility to ensure a resident had their pressure-reducing device in place. The facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy last revised 07/0924 documented a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and to prevent the development of pressure ulcers unless the individual's clinical condition demonstrated that the pressure ulcers were unavoidable. The facility identified a census of 147 residents. The sample included 31 residents, with five residents reviewed for treatment and services to prevent and heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure Resident (R) 9 and R122's offloading boots were applied to their heels to prevent pressure ulcers. This placed R9 and R122 at increased risk for pressure ulcer development. Findings Included: - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cellulitis (a common bacterial infection of the skin and underlying tissues) of left lower limb, intracapsular fracture (a bone fracture that occurs within the joint capsule, specifically in the hip, the femoral head and femoral neck) of left femur (thigh bone), unsteadiness on feet, muscle weakness, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), and Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) of right buttock, and left buttock. The Modification of Quarterly Minimum Data Set (MDS) for R9 dated 03/04/25 documented that a mental status interview should not be performed, R9 was rarely or never understood. The MDS documented R9 required supervision or touching with eating, dependent on staff for toileting, and substantial to maximal assistance by staff for bathing. The MDS documented R9 had a Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) or greater over a bony prominence. The MDS documented R9 was a t risk of pressure ulcers. The MDS documented R9 had three Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) and had a pressure-reducing device for bed. The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 01/16/25 documented R9 had no pressure ulcers. R9's Care Plan dated 01/13/25 documented R9 was at risk for unavoidable pressure injury development or decline of skin integrity. The plan of care for R9 documented staff were to clean and apply a moisture barrier after each incontinent episode. The plan of care for R9 documented staff were to encourage and assist with turning and repositioning. The plan of care documented R9 had a pressure redistribution mattress, and staff were to do wound treatments as the physician ordered. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's EMR under Orders revealed the following physician orders: Low air loss mattress, check functionality and setting, setting at auto firm mode, and on #3 every shift for wounds dated 02/18/25. Heel protectors were on at all times when in bed every shift for heel protection dated 01/20/25. On 05/12/25 at 07:22 AM, R9 laid in bed on his right side facing the door. R9 had nonskid socks on his feet. R9 did not have heel protectors on. On 05/13/25 at 07:25 AM, R9 laid on his bed. R9's heels laid directly on the mattress. R9 did not have heel protectors on. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated all nursing staff have access to the care plan. LN stated if placing boots on a resident was on the Treatment Administrative Record TAR the nurse would check the resident to ensure the heel protectors were in place. She stated placing heel protectors on residents was the responsibility of the nurses and the Certified Nursing Aide (CNA). On 05/15/25 at 02:27 PM, CNA N stated all CNAs have access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CNA N stated nursing would let us know if a resident required any special equipment. On 05/15/25 at 02:42 PM, Administrative Nurse D stated CNAs have access to the Kardex. She stated if a resident was to have heel protectors, the CNA or the nurse could put the heel protectors on the resident. Administrative Nurse D stated the expectation was that a nursing staff member apply heel protectors as ordered by the physician. The facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management dated 07/09/24 documented the facility would provide associates and LN with procedures to manage skin integrity, prevent pressure ulcer/injury, complete would assessment documentation and provide treatment and care of skin and would utilizing professional standards.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 147 residents. The sample included 31 residents, with four residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 89's braces to both knees were applied. This deficient practice placed the resident at risk for discomfort and decreased range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Findings included: - R89's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), pain, insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hyperlipidemia (condition of elevated blood lipid levels), history of falling, abnormal weight loss, unsteadiness of fee, and dementia (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS) dated [DATE] documented R89 had a memory problem and was never or rarely understood. The MDS documented R89 had impairment on both sides of her lower body. The MDS documented R89 was dependent on staff for all activities of daily living (ADL). R89's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/27/24 documented R89 had a long history and diagnosis of dementia with ongoing cognitive and physical impairments that continue to require 24-hour day care. R89 was unable to make her needs known in any manner, she was total care for by the nursing staff. R89's Care Plan dated 08/02/22 documented R89 had an ADL self-care performance deficit related to dementia. R89's plan of care documented R89 was dependent on staff for bed mobility. R89's plan of care documented R89 was to walk 75 feet, and R89 was to wear knee extension braces daily for as long as tolerated. A review of R89's clinical record documented no refusals of staff applying knee brace. On 05/12/25 at 07:44 AM, R89 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room waiting for breakfast. R89 did not have braces on her knees. On 05/13/25 at 08:10 AM, R89 sat in her Broda chair in the dining room eating breakfast. R89 did not have braces on her knees. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated all nursing staff have access to the resident's plan of care. She stated that if a resident was to have a brace or any special equipment, it would be the responsibility of all nursing staff to ensure the brace was applied. LN J stated if a resident refused a brace or special equipment, that would be documented in the resident's medical record. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 02:27 PM, Certified Nurse's Aide (CNA) QQ stated CNAs have access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CNA QQ stated if a resident required special equipment or devices, it was the responsibility of the CNA that the information would be verbally communicated by the nurse. On 05/15/25 at 02:42 PM, Administrative Nurse D stated she could not say it was one specific person's duty to ensure a brace or any other devices were placed on a resident. She stated the facility worked as a team, and anyone could apply the brace. The facility's Restorative Nursing policy dated 09/20/24 documented the facility would promote the residents' optimum function, a restorative program may be developed by proactively identifying, care planning, and monitoring of a resident's assessments and indicators. Nursing Assistants must be trained in the techniques that promote residents and involvement in restorative activities.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. - R34's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), history of cervical vertebra fracture (broken bone of the spinal column), history of falls, and unsteadiness on her feet. The Annual Minimum Data Set (MDS) dated 12/06/24 documented a Brief Interview of Mental Status (BIMS) score of 99 and a staff interview was conducted, which indicated severely impaired cognition. The MDS documented R34 was independent with walking 10 feet and 50 feet. R34 required partial to moderate assistance with walking 150 feet. The Quarterly MDS dated 04/23/25 documented a BIMS score of 99 and a staff interview was conducted, which indicated severely impaired cognition. The MDS documented that R34 was independent to walk 10 feet, required supervision to touch assistance to walk 50 feet, and required partial to moderate assistance to walk 150 feet. R34's Falls Care Area Assessment (CAA) dated 12/16/24 documented she was at risk for fall-related to her psychotropic (alters mood or thought) medication use during the observation period. R34's Care Plan, dated 12/05/22 documented staff would place her call light within reach. R34's EMR under the Assessment tab revealed the following Fall Risk Evaluation dated 05/01/25 that documented a score of 15, which indicated a resident's score above 10 was at risk for falls. On 05/13/25 at 07:27 AM, R34 sat reclined in a Broda chair (specialized wheelchair with the ability to tilt and recline) asleep. She was covered with a blanket. R34's call light was across the room on her bed, out of her reach. On 05/14/25 at 07:20 AM, R34 sat reclined in a Broda chair asleep. She was covered with a blanket. R34's call light was across the room on her bed, out of her reach. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated R34 was not able to recline the Broda chair or cover herself with a blanket. CNA P stated the call light should be within R34's reach. CNA P stated every resident on the unit was a high fall risk. On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated every resident on the unit was a high fall risk. LN I stated a call light should always be within reach when a resident was in the room. LN I stated R34 was not able to recline herself in the Broda chair or cover herself up with a blanket. On 05/15/25 at 02:43 PM, Administrative Nurse D stated she would expect the resident's call light to within reach when the resident was in their room. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Management last reviewed on 03/11/25 documented the facility would assess the resident upon admission and readmission, quarterly with change in the condition and with and fall event for any fall risks and would identify appropriate interventions to minimize the risk of injury related to falls.The facility reported a census 147 residents. The sample included 31 residents, with six reviews for accidents. Based on observations, interviews, and record review, the facility failed to promote a safe care environment free from accidents and hazards for Residents (R) 198, R9, and R34. These deficient practices placed the residents at risk for preventable falls and injuries. Findings Included: - The Medical Diagnosis section within R198's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), acute femur (upper leg bone) fracture (broken bone), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R198's Significant Change Minimum Data Set (MDS) dated 10/25/24 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted no behaviors observed. The MDS noted one-sided upper extremity impairment and bilateral (both sides) lower extremity impairment. The MDS noted he used a wheelchair for mobility. The MDS noted he was dependent on staff assistance for bed mobility, toileting, bathing, lower body dressing, putting on footwear, and personal hygiene. The MDS noted he was always incontinent of bowel and bladder. The MDS noted he had fractures and other multiple traumas. R198's Cognitive Impairment Care Area Assessment (CAA) completed 07/12/24 noted he had behaviors related to his dementia diagnosis and required 24-hour a day care. The CAA noted he required total care. R198's Communication CAA completed 07/12/24 noted he had severe cognitive impairment that rendered him unclear with garbled speech. The CAA noted he was unable to voice his needs. R198's Care Plan initiated 07/01/24 indicated he was at risk for activities of daily living (ADL) self-care deficit and falls related to his medical diagnoses. R198's plan noted he had verbal and physically aggressive behaviors (07/12/24). The plan instructed staff to speak to him calmly and divert his attention. The plan noted he was dependent on staff assistance for his transfers, toileting, dressing, personal hygiene, bathing, and oral hygiene. The plan noted he required total assistance from two staff for repositioning and turning in bed (10/28/24). The plan noted he required total assistance from two staff for transfers but was changed to a Hoyer lift (full mechanical body lift) on 11/13/24. R198's EMR under Progress Note revealed an Event Note completed on 11/01/24. The note revealed R198 suffered a laceration of his scalp during a staff-assisted transfer from his wheelchair to his bed. The note revealed that he was sent to an acute medical facility for evaluation and treatment for his head injury. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Skin Related Injury report #4946 completed 11/01/24 indicated R198 received a laceration to his scalp (top of head) during a transfer from his wheelchair to his bed. The report indicated he received sutures on his scalp due to a head injury. The report noted R198 was unable to explain how he got injured. The report lacked a root-cause analysis or description of how the injury occurred. The report indicated that witness statements were found. No witness statements were provided with this report. A review of Certified Nurse's Aide (CNA) Q's Corrective Action Form completed on 11/04/24 noted she received a written (final) warning counseling related to R198's accident on 11/04/24. The form indicated R198 became agitated and anxious while being transferred from a Sit-to-stand lift by CNA Q. The form indicated this caused a laceration to R198's head. The form indicated this action put the resident at risk for injuries. The form indicated CNA Q was provided additional training for the utilization of mechanical lifts. The form noted she was expected to complete training in safety and person-centered care related to distracting and reapproaching residents. The form noted she completed the training on 11/13/24. R198's EMR under Progress Notes revealed an Event Note completed 01/02/25 at 07:48 PM by Licensed Nurse (LN) K. The note indicated staff found R198 in his bed with a blood-soaked Band-Aid. The note revealed the oncoming direct care staff then reported the injury to LN K. The note revealed R198 did not have this injury the previous evening. LN K cleaned and assessed the wound to find a three-centimeter (cm) laceration on his forehead. The note revealed LN K believed the wound might need sutures and notified the medical provider. R198 was sent out to an acute care facility for evaluation and treatment. R198's EMR revealed no progress notes or nursing assessments completed at the time of R198's injury prior to LN K's discovery of the wound. The facility was unable to provide this documentation as requested on 05/15/25. A Skin Related Injury report # 5074 completed 01/02/25 indicated staff found R198 around 04:30 PM with a blood-saturated Band-Aid on his forehead. The report noted R198 had a three-centimeter laceration on his forehead and the wound needed to be sutured. The report revealed R198 was unable to explain how he received the injury. The note revealed R198 was sent out to an acute care facility at 05:30 PM for evaluation and treatment. A Witness Statement completed by CNA PP on 01/03/25 indicated she was assisting with R198's Hoyer Lift transfer before his injury occurred. The statement indicated CNA's PP and CNA Q transferred R198 to his bed from his wheelchair. The statement then indicated CNA PP left the room to assist other residents. A Witness Statement completed by CNA Q on 01/03/25 indicated she was assisting with R198's wheelchair-to-bed transfer via a Hoyer lift after lunch. The statement indicated CNA PP left the room to assist another resident and returned to check on R198. The statement revealed upon returning to the room CNA Q found R198's feet were on the floor. The statement revealed R198 placed his feet back on his bed and noticed that R198 was incontinent of bowel. The statement revealed CNA Q raised the bed and turned R198 towards the wall. The statement revealed CNA Q turned R198 back towards her, and R198 punched CNA Q in the mouth. The statement revealed CNA Q saw that R198's head was bleeding as R198 grabbed her shirt. The statement revealed CNA Q placed a Band-Aid on his forehead and told CNA PP that R198 punched her in her mouth. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA Q's Termination Form completed on 01/07/25 indicated CNA Q was terminated due to her failure to comply with company standards regarding her CNA position. The form noted the risk of poor resident outcomes and a burden to her coworker as the consequences of her actions. R198's EMR under Interdisciplinary Team (IDT) note completed on 01/07/24 indicated R198's injury was caused when he struck his head on a wall outlet next to his bed while he was agitated during care. On 05/15/25 at 09:11 AM, LN NN stated she worked with CNA Q during his accident on 11/01/24. She stated CNA Q brought R198 back to his room after lunch. She stated R198 was agitated and had behaviors with CNA Q. LN NN stated on the 11/01/24 incident, R198 punched CNA Q resulting in the Sit-to-stand to slip and strike him in the head. She stated the Sit-to-stand brakes were not locked. On 05/15/25 at 09:34 AM, CNA Q stated R198 was highly agitated during both accidents. She stated she was attempting to transfer him into his bed via the Sit-to-stand lift. She stated she bent down to look at him, and he punched her in the mouth. She stated the shock of this punch caused her to grab the lift, resulting in the lift arm striking his head (11/01/24). CNA Q stated on 01/02/25 that she moved R198 back to his bed after lunch with another staff. She stated that both staff left the room to assist other residents. She stated she re-entered the room briefly and found R198 hanging off the side of his bed with his feet on the floor. She stated she pulled his feet back up on the bed and noticed he had a bowel movement. She stated she turned him on his side (facing the wall). She stated that upon turning him back, R198 grabbed her and punched her. She stated she noticed his head bleeding. She stated she reported the incident to CNA PP and put a Band-Aid on his head. On 05/15/25 at 09:34 AM, CNA PP stated she assisted CNA Q with R198's bed transfer on 01/02/25 but then left the room to assist other residents. She stated the unit nurse left early that day, so she was not sure who the accident was reported to or if R198 was assessed. She stated the facility completed annual abuse, neglect, and exploitation training. She stated that injuries and accidents a required to be reported to the nurse immediately. On 05/15/25 at 11:43 AM, LN K stated he started his shift with no knowledge or pass-down information related to R198's injury. He stated that the previous shift nurse left early. LN K stated the staff found R198 in his bed, resting, and noticed the head injury. He stated he notified Administrative Nurse D and the medical provider upon assessment of the wound's condition and recommended further evaluation. On 05/15/25 at 02:44 PM, Administrative Nurse D stated she did not feel the accidents were abuse-related due to having witnesses for the accidents. She stated the first accident was related to a slip of the Sit-to-stand lift, and the second was due to his head hitting a wall outlet. She stated that the witness statements corroborated the observations at the time. She stated that staff received annual training related to abuse, neglect, and exploitation. She stated staff were expected to report falls, accidents, and injuries immediately to the on-duty nurse. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Fall Management policy last revised 04/07/22 documented residents would be assessed upon admission, readmission, quarterly, change in condition and with any fall utilizing the Fall Risk Assessment. During the admission and readmission process, a care plan would be developed and initiated by the admitting nurse for any residents assessed to be a risk for falls. Upon completion of the other interdisciplinary teams (IDT) admission and readmission assessments, the IDT will review any additional fall risk indicators and revise the resident's care plan as indicated.- R9 ' s Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cellulitis (a common bacterial infection of the skin and underlying tissues) of left lower limb, intracapsular fracture (a bone fracture that occurs within the joint capsule, specifically in the hip, the femoral head and femoral neck) of left femur, unsteadiness on feet, muscle weakness, Alzheimer ' s disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), and Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) of right buttock and left buttock. The Modification of Quarterly Minimum Data Set (MDS) for R9 dated 03/04/25 documented a Brief Interview for Mental Status (BIMS) should not be performed, R9 was rarely or never understood. The MDS documented R9 required supervision or touching with eating, dependent on staff for toileting, and substantial to maximal assistance by staff for bathing. The MDS documented R9 had one non-injury fall, one fall with injury, and no falls resulting in a fracture. R9's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/1/25 documented R9 had a history and diagnosis of dementia with ongoing cognitive impairments. R9 was unable to attend his assessment, resulting in a BIMS score of 99. R9's Care Plan dated 01/29/24 documented R9 was a fall risk, and staff were to assist him with his activities of daily living (ADL) as needed and place his call light within his reach. R9 ' s plan of care documented staff were to provide activities that minimize the potential for falls while providing diversion and distraction and utilize activities that interested residents at that time. R9 ' s plan of care documented staff were to toilet R9 upon waking, before, and after meals, and at bedtime. R9 ' s plan of care dated 05/03/24 documented staff were to ensure R9 was in the center of his bed. The plan of care documented a yellow star placed outside of the room on the shadow box along with yellow tape on any ambulation assistive devices to signal to all staff that they are a high fall risk. R9 ' s plan of care dated 01/03/25 documented staff were not to put R9 in his bed until he was fatigued. R9 ' s EMR note Event Note dated 01/02/25 documented at approximal 01:40 PM the nurse was called to R9 ' s room by a CNA. When the nurse entered the room, R9 was observed by the nurse to be on the floor, he was sitting on his buttocks in the middle of his room, with his back against the window. The nurse noted adequate lighting, and there was dried blood on the floor of R9 ' s floor. R9 attempted to clean the blood on the floor with a paper towel. R9 was wearing only his socks and no shoes. R9 ' s bed was in a high position, above the nurse ' s waist. The bed remote was on R9 ' s bed by the head of the bed. The nurse documented R9 was alert and appeared to be alert to himself with confusion per his normal baseline. The nurse documented R9 had bleeding on the right side of his eyebrow. The nurse documented no other injuries during the assessment. R9 was toileted and assisted back to his bed for a nap by the CNA after lunch. The nurse documented CNAs stated R9 ' s bed was placed in the lowest position when he was placed in his bed, but when R9 was found his bed was found to be in the highest position. The nursing staff informed the physician and received orders to send R9 to the emergency room (ER). R9 ' s guardian was called and informed of the transfer. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9 ' s EMR under Physicians Notes documented the resident took Eliquis (blood thinner) and had an open laceration. The physician ordered R9 to be sent to the ER for further evaluation and management with concerns related to fractures or intracranial bleed with the level of fall R9 obtained. The physician documented R9 needed suturing of a laceration. R9 ' s EMR under Event Note dated 01/02/25 at 05:49 PM documented R9 returned from the hospital with no evidence of acute intracranial pathology from the scan, R9 ' s laceration to the left eye was secured with sutures to be removed in seven days. R9 ' s EMR under Event Note dated 01/02/25 at 10:40 PM documented when the nurse was doing neuro checks on R9, R9's left leg had less movement and he grimaced. The nurse noted that the physician was called for an emergent (STAT) X-ray of the left hip order. The X-ray department stated they would not be in the facility until 01/03/25. The physician was notified and ordered to send R9 to the ER for evaluation. R9 ' s EMR under Alert Note dated 01/02/25 nurse noted R9 left the building to go to the ER. R9 ' s EMR under Event Note dated 01/03/25 documented an unwitnessed fall on 01/02/25 with head and hip injuries. R9 attempted to get out of bed after lunch. R9 ' s updated plan of care directed staff to ensure R9 did not lay down until he was ready for a nap. R9 ' s EMR under Admission/Readmission dated 01/10/25 at 02:16 PM documented R9 returned to the facility after his hospital stay. R9 ' s EMR lacked a bed control device assessment to ensure he was safe to operate his bed. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated if a resident had dementia, nursing ensured the resident did not have the bed control. She stated residents with dementia were not safe to operate their own bed. LN J stated that would be a fall risk. On 05/15/25 at 02:27 PM, Certified Nurse ' s Aide (CNA) QQ stated residents with dementia did not have their bed controls, the nursing staff put the bed control at the top of the resident ' s bed to ensure the resident did not raise the bed to a high position. CNA QQ stated residents that had dementia used beds that were put at the lowest position due to the resident being a fall risk. On 05/15/25 at 02:42 PM, Administrative Nurse D stated the Interdisciplinary Team (IDT) reviewed each fall and decided on an appropriate plan of care. Administrative Nurse D stated the team would start with the least restrictive plan, such as ensuring the resident was not laid down in his bed until he was fatigued. Administrative Nurse D stated taking the resident's bed control, which raises his bed up or down would be a restraint. Administrative Nurse D stated she was unsure what an assessment to ensure the resident was safe with a bed device was, she stated the facility does not have an assessment for devices. The facility's Fall Management last reviewed on 03/11/25 documented the facility would assess the resident upon admission and readmission, quarterly with change in the condition and with and fall event for any fall risks and would identify appropriate interventions to minimize the risk of injury related to falls.

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	175158	A. Building B. Wing	05/15/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Citation Text for Tag 0690, Regulation FF16 [NAME], [NAME] The facility identified a census of 147 residents. The sample included 31 residents, with three sampled residents reviewed for bowel and bladder incontinence and catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. Based on observation, record review, and interview, the facility failed to ensure staff provided appropriate treatment and services to prevent potential urinary tract infections (UTI - an infection in any part of the urinary system) for Resident (R) 11 when staff failed to ensure R11's catheter bag (a urine drainage bag that collects urine from a catheter, a tube inserted into the bladder to allow urine to drain) was drained each shift and as needed. This placed R11 at risk of complications, infection, and further urinary problems. Findings included: - R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), retention of urine (a condition in which you are unable to empty all the urine from your bladder), and chronic kidney disease (the kidneys are damaged and can't filter blood properly, leading to a buildup of waste and fluid in the body). R11's admission Minimum Data Set (MDS) dated 02/26/25 documented R11 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R11 displayed signs and symptoms of delirium (sudden severe confusion, disorientation, and restlessness) including inattention and disorganized thinking. The MDS documented R11 required the use of an indwelling catheter. R11's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 02/27/25 documented R11 had an indwelling catheter and was at risk related to psychotropic (altered mood or thought) medication and she needed assistance with toileting. R11's Care Plan was revised on 03/05/25 and directed staff to do catheter care every shift. The plan of care directed staff to position the catheter bag and tubing below the level of the bladder. The plan of care directed staff to observe R11 for pain and discomfort due to the catheter and document. The plan of care directed staff to observe for and report to the physician any signs and symptoms of a UTI. The plan of care lacked staff direction for the frequency of emptying the catheter bag. R11's Order tab of the EMR documented a physician's order dated 02/18/25 for an indwelling catheter to straight drainage. Size 18 French (French gauge is a system of measurement used to size catheters). Change the catheter for infection, obstruction, or when the closed system is compromised every shift and as needed for urinary retention. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Order tab of the EMR documented a physician's order dated 02/19/25 for catheter care every shift for urinary retention, keep the catheter bag placed below the level of the bladder. R11's Order tab of the EMR documented a physician's order dated 02/19/25 to change the catheter bag every seven day(s) for urinary retention/infection control. R11's Order tab of the EMR documented a physician's order dated 02/19/25 to record urine output every shift. R11's Order tab of the EMR documented a physician's order dated 02/19/25 to secure a catheter with an anchoring device to prevent tension check every shift and as needed, change the device when clinically indicated and as recommended by the manufacturer. On 05/14/25 at 12:15 PM, R11 sat at the dining table for lunch in her Broda Chair (specialized wheelchair with the ability to tilt and recline). R11's catheter bag hung from the side of her Broda chair and was visibly full of urine. The catheter tubing was also full of urine. On 05/14/25 at 02:35 PM, R11 sat at the dining table in her Broda chair and was verbally complaining of her back hurting and an unidentified Certified Nurse Aide (CNA) was rubbing R11's back. R11's catheter bag hung from the side of the Broda chair, and the catheter tubing and bag were visibly full of urine. On 05/14/25 at 03:16 PM, R11 was propelled back to her room by staff. The unidentified CNA exited R11's room and exited the secure unit to find another staff member to assist with putting R11 back in bed using the Hoyer (total body mechanical lift) lift. After R11 was transferred the staff assisted to empty R11's catheter bag. On 05/14/25 at 03:25 PM, CNA OO stated a resident's catheter bag should be emptied at least each shift and as needed. CNA OO stated the bag, and tubing should not be overfilled with urine that could back up into the bladder and cause pain or infection. On 05/15/25 at 02:08 PM, Licensed (LN) H stated that the catheter bag should be emptied at least every shift and emptied any time the bag appeared full. LN H stated the tubing, and bag should not ever be so full that urine could flow back into the bladder. LN H stated that urine back flowing into the bladder could cause infection or other complications. On 05/15/25 at 02:45 PM, Administrative Nurse D stated the catheter bag should be emptied at least once each shift but could need more depending on the resident's output. Administrative Nurse D stated the tubing, and bag should never be full as that was a big risk for infection and UTI. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Indwelling Urinary Catheter Management policy last revised 06/27/23 documented the facility would ensure residents admitted with a urinary catheter or were determined to need a catheter for a medical indication would have the following addressed; timely and appropriate assessments related to the indication for use of the indwelling catheter; insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; the response of the resident during the use of the catheter; and ongoing monitoring for changes in condition related to potential catheter-associated UTI's, recognizing, reporting, and addressing such changes. Maintain unobstructed urine flow by keeping the catheter and collection tube from kinking. Always keep the collecting bag below the level of the bladder. Do not rest the bag on the floor. Empty the collecting bag regularly using a separate, clean collecting container for each patient, avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container.

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	175158	A. Building B. Wing	05/15/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. The facility identified a census of 147 residents. The sample included 31 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure there was a physician indication for oxygen administration for Resident (R) 82 and failed to ensure the oxygen tubing was stored in a sanitary manner to and contamination. This placed R82 at increased risk for respiratory infection and complications. Findings included: - R82's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), abnormal findings of lung fields, and hypoxia (inadequate supply of oxygen). The Significant Change Minimum Data Set (MDS) dated 11/13/24 documented a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS lacked documentation that R82 was on oxygen therapy and had an order for a bi-level positive airway pressure (BIPAP- a device that helps with breathing) during the observation period. The Quarterly MDS dated 04/10/25 documented a BIMS score of eight 1 which indicated moderately impaired cognition. The MDS lacked documentation that R82 was on oxygen therapy and had an order for a BIPAP during the observation period. R82's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 11/22/24 documented she required staff assistance with some of her activities of daily living. R82's Care Plan, last revised 11/20/24, documented the hospice provider had supplied her with an oxygen concentrator, wheelchair, nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs), bed frame, and a foam mattress. The care plan lacked direction for her oxygen therapy and the use of a BiPAP machine at bedtime. R82's EMR under the Orders tab revealed the following physician orders: BiPAP upon arrival to the facility while asleep or in bed. Mode: non-invasive ventilation continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep), dated 11/01/24. Check oxygen saturation every shift and titrate oxygen to keep stats above 90% every shift for CHF exacerbation, dated 11/01/24. The order lacked dosing instructions for the oxygen. On 05/13/25 at 08:21 AM, R82 sat at the dining room table with oxygen tubing in her nares. On 05/14/25 at 07:13 AM, R82's oxygen tubing laid directly on the dining room table unbagged. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated she would ask the charge nurse what R82's oxygen flow was to set at. CNA P stated that R82's oxygen tubing should be stored in a bag when not in use. CNA P stated respiratory care should be included in R82's care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated oxygen equipment should be stored in a bag when not in use, and it should not be left unbagged on the dining room table when not in use. LN I stated that R82 should have an order to administer oxygen which included the specific dose to be administered. LN I stated respiratory therapy and her use of a BiPAP should be included in the care plan. On 05/15/25 at 02:43 PM, Administrative Nurse D stated she would expect R82's BiPAP and oxygen equipment to be stored in a bag when not in use. Administrative Nurse D stated she would expect there to be a physician order for the use of oxygen therapy. The facility's Oxygen Administration (Infection Control, Safety, and Storage) policy last reviewed on 04/08/25 documented to ensure that oxygen was administered and stored safely within the facility or in an outside storage area.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. The facility identified a census of 147 residents. The sample included 31 residents with one reviewed for competent staffing. Based on observation, record review, and interviews, the facility failed to ensure staff possessed the appropriate skills and knowledge to safely provide direct care and nursing services related to Resident (R) 198's care needs. These deficient practices resulted in preventable injuries and delayed medical treatment. Findings Included: - On 05/15/25 a review of Certified Nurses Aide (CNA) Q personnel file revealed she received a Corrective Action Form on 11/04/25. The counseling form was a final notice counseling related to an injury-related accident that occurred with R198 on 11/01/24. (See Citation F600) A Skin Related Injury report #4946 completed 11/01/24 indicated R198 received a laceration to his scalp (top of head) during a transfer from his wheelchair to his bed. The report indicated he received sutures on his scalp due to a head injury. The report noted R198 was unable to explain how he got injured. The report lacked a root-cause analysis or description of how the injury occurred. The report indicated that witness statements were found. No witness statements were provided with this report. A review of Certified Nurse's Aide (CNA) Q's Corrective Action Form completed on 11/04/24 noted she received a written (final) warning counseling related to R198's accident on 11/04/24. The form indicated R198 became agitated and anxious while being transferred from a Sit-to-stand lift by CNA Q. The form indicated this caused a laceration to R198's head. The form indicated this action put the resident at risk for injuries. The form indicated CNA Q was provided additional training for the utilization of mechanical lifts. The form noted she was expected to complete training in safety and person-centered care related to distracting and reapproaching residents. The form noted she completed the training on 11/13/24. A review of R198's EMR revealed he was involved had a second head injury on 01/02/25 while under the care of CNA Q. The facility investigation and incident witness statements revealed CNA Q turned R198 without additional staff assistance resulting in R198 hitting his head on a wall outlet during incontinence cares. (See Citation F600) A Skin Related Injury report # 5074 completed 01/02/25 indicated staff found R198 around 04:30 PM with a blood-saturated Band-Aid on his forehead. The report noted R198 had a three-centimeter laceration on his forehead and the wound needed to be sutured. The report revealed R198 was unable to explain how he received the injury. The note revealed R198 was sent out to an acute care facility at 05:30 PM for evaluation and treatment. R198's EMR revealed no assessments were completed at the time of injuries injury and the physician was not notified until the next shift found R198 with a bloody gauze on his forehead while in bed. The facility was unable to provide documentation showing R198 was assessed by a nurse at the time of his injury. (See Citation F600) (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA Q's Termination Form completed on 01/07/25 indicated CNA Q was terminated due to her failure to comply with company standards regarding her CNA position. The form noted the risk of poor resident outcomes and a burden to her coworker as the consequences of her actions. On 05/15/25 at 11:43 AM, LN K stated he started his shift with no knowledge or pass-down information related to R198's injury. He stated that the previous shift nurse left early. LN K stated his direct care staff found N198 in his bed, resting, and noticed the head injury. He stated he notified Administrative Nurse D and the medical provider upon assessment of the wound's condition and recommended further evaluation. He stated staff were required to report injuries immediately to the nurse, director of nursing, and medical provider. On 05/15/25 at 02:44 PM, Administrative Nurse D stated the staff were expected to report falls and injuries immediately to the nurse. She stated residents were to be assessed at the time of injury and the medical provider was to be notified. She stated the facility did not have an assessment for R198's injury on 01/02/25. She stated the direct care staff should have notified the on-duty nurse. She stated the nurse may have gone home early for the unit, and indicated that the facility still had other nurses covering the floor. The facility's Competent Staff policy 09/2022 indicated the facility was to ensure staff had sufficient competencies and skill sets to provide nursing services to ensure resident safety.

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** - R23's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), muscle weakness, and cerebrovascular accident (CVA - stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The admission Minimum Data Set (MDS) dated 10/15/24 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R23 had no behavioral symptoms during the observation period. The Quarterly MDS dated 04/10/25 documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented that R23 had no behavioral symptoms during the observation period. The MDS documented R23 had received antidepressant (a class of medications used to treat mood disorders) medication and antianxiety (a class of medications that calm and relax people) during the observation period. R23's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/23/24 documented. She had ongoing cognitive impairment related to her history of strokes. R23's Care Plan dated 10/25/24 directed the staff to reassure her when she was resistive with activities of daily living (ADL), leave and return five to 10 minutes later, and try again as safety allowed. R23's EMR under the Progress Notes tab revealed the following: On 03/28/25 at 08:50 PM, a Behavior Note that documented R23 was verbally and physically aggressive toward the staff during the assistance of ADLs. R23 stated to stop and go away to the staff. R23 continued to hit, pinch, and kick during the ADL assistance. Staff had redirected R23 with minimal effect and R23 continued the verbally and physically aggressive behavior toward the staff during their assistance with ADLs. On 03/29/25 at 01:28 PM a Behavior Note documented R23 was combative during a transfer from her bed into the wheelchair with the assistance of two staff members. On 03/29/25 at 06:46 PM a Behavior Note documented R23 was verbally and physically aggressive toward staff during ADL assistance. R323stated stop and quit it to the staff as they assisted her. R23 kicked, bit, and pinched the staff during their assistance. Staff redirected R23 with minimal effect as they continued to provide care. On 03/29/25 at 05:50 PM an Event Note documented a staff member who had provided assistance to R23 and reported R23 had an open area on her right arm. A skin tear was noted on R23's right arm. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/25 at 06:40 PM a Behavior Note documented R23 was verbally and physically aggressive toward the staff as they provided her assistance with ADLs. R23 yelled leave me alone and she would get them. R23 continued to hit, pinch and hit at the staff during their assistance. Staff attempted to redirect R23 with minimal effectiveness, and R23 continued to be aggressive toward the staff. On 04/22/25 at 09:01 PM a Behavior Note documented R23 was verbally and physically aggressive toward the staff as they provided her assistance with ADLs. R23 yelled quit it and leave me alone. R23 continued to hit, pinch and hit at the staff during their assistance. Staff attempted to redirect R23 with minimal effectiveness, and R23 continued to be aggressive toward the staff. On 05/2/25 at 01:00 PM a Behavior Note documented R23 was combative toward staff when they attempted to administer her medication. R23 attempted to hit staff and bite down on the spoon which made it difficult for staff to administer R23 her medications. On 05/10/25 at 10:40 AM a Skin/Wound Note documented R23 had received a skin tear on her right forearm during staff assistance with ADLs. Staff reported R23 had been combative during assistance with ADLs, dressing, transfers, and grooming. On 05/11/25 at 01:42 PM a Behavior Note documented R23 was combative with transfers from her bed into the wheelchair. R23 had resisted staff during their assistance with ADLs. R23 would bite staff and grab at staff's arms during their assistance with ADLs. On 05/13/25 at 07:32 AM R23 laid asleep on the right side of the bed. R23's bed was in the lowest position, asleep on her bed, on her left side with the bed in the low position. On 05/15/25 at 10:15 AM, Certified Nurse Aide (CNA) P stated R23 had behaviors at times. CNA P stated she would attempt to reapproach later. CNA P stated it would be helpful to have other person-centered interventions to help with R23's behaviors. On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated when R23 became combative with staff during their assistance. LN I stated they were to leave and reapproach her later. LN I was not sure if there were any person-centered interventions on R23 care plan for staff to use when she became combative. On 05/15/25 at 02:43 PM, Administrative Nurse D stated the staff would try to redirect the resident when they became combative during staff assistance with ADLs. Administrative Nurse D stated she would not expect staff to care plan every behavioral intervention. The facility's Residents Rights policy revised on 09/2024 documented the residents have a right to a dignified existence, self-determination, and communication with and access to personnel, and services inside and outside the facility. - R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), retention of urine (a condition in which you are unable to empty all the urine from your bladder), and chronic kidney disease (the kidneys are damaged and can't filter blood properly, leading to a buildup of waste and fluid in the body). (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's admission Minimum Data Set (MDS) dated 02/26/25 documented R11 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R11 displayed signs and symptoms of delirium (sudden severe confusion, disorientation, and restlessness) including inattention and disorganized thinking. The MDS documented R11 was dependent on staff for all activities of daily living (ADL)The MDS documented R11 required the use of an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). The MDS documented R11 was on hospice care. R11's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/27/25 documented she had a history and diagnosis of dementia with ongoing cognitive impairments that require 24-hour a day care. R11 needed staff assistance to total dependence on staff with ADL cares. R11's Care Plan revised on 02/19/25 directed staff when she became agitated to intervene before the agitation escalated, guide her away from the source of distress, and engage calmly in conversation. The plan of care directed staff to allow R11 extra time to respond to questions and instructions. The plan of care lacked person-centered staff direction on activities and services to direct staff for her dementia care needs. On 05/14/25 at 02:35 PM, R11 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining table awaiting activity staff to pass out ice cream to residents on the unit. Upon receiving the ice cream from the activity staff there was no interaction or further activity with the resident. On 05/15/25 at 02:18 PM, LN H stated the residents were not allowed to enter other residents' rooms or take their property. She stated that staff were expected to redirect and document the behaviors of each resident. She stated staff were expected to intervene when residents exhibited behaviors. On 05/15/25 at 02:27 PM, Certified Nurse's Aide (CNA) QQ stated that residents on the locked unit could walk around the unit under supervision but were not to go into other residents' rooms or take their property. She stated staff were expected to supervise the residents to ensure no behaviors or falls occurred. On 05/15/25 at 02:44 PM, Administrative Nurse D stated that staff were expected to monitor and intervene when resident behaviors occurred. She stated staff were expected to keep residents from entering peers' rooms and taking items from them. The facility's Residents Rights policy revised on 09/2024 documented the residents have a right to a dignified existence, self-determination, and communication with and access to personnel, and services inside and outside the facility. - R37's Electronic Medical Record (EMR) recorded diagnoses of psychosis (any major mental disorder characterized by a gross impairment in perception), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's Annual Minimum Data Set (MDS) dated 08/08/24 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R37 displayed the behaviors of inattention and disorganized thinking that were present and fluctuated. R37 required supervision for his functional abilities. R37's Delirium Care Area Assessment (CAA) dated 08/13/24 documented he had a history and diagnosis of dementia with ongoing cognitive impairments. R37 could be inattentive and have disorganized thinking related to his dementia disease. R37's Psychotropic Drug Use CAA dated 08/13/24 documented he triggered for this CAA due to the use of psychotropic medication use. A care plan directed staff to monitor R37 for medication side effects. R37's Care Plan was last revised on 02/13/25 and directed staff to allow extra time for him to respond to questions and instructions. The plan of care directed staff to face R37 and speak clearly when communicating with him. The plan of care directed staff R37 was on a secured unit. The plan of care directed staff to call R37 by his preferred name. The plan of care lacked person-centered staff direction on activities and services to direct staff for her dementia care needs. On 05/13/25 at 08:32 AM, R37 sat at the dining table at breakfast with another resident on the secured unit. R37 took the other residents' ice cream and started eating it. Certified Nurse Aide (CNA) MM intervened by taking the ice cream from R37 and moved him to another table away from R18. On 05/14/25 at 11:45 AM, CNA MM stated she had been on this secured unit for quite a while. R37 had a lot of behaviors toward other residents and was hard to redirect at times. CNA MM stated the area for dining and watching tv was very small on the secure unit and sometimes staff were not always able to do activities due to resident behaviors and the resident's lack of staying focused. On 05/15/25 at 02:18 PM, LN H stated the residents were not allowed to enter other residents' rooms or take their property. She stated that staff were expected to redirect and document the behaviors of each resident. She stated staff were expected to intervene when residents exhibited behaviors. On 05/15/25 at 02:44 PM, Administrative Nurse D stated that staff were expected to monitor and intervene when resident behaviors occurred. She stated staff were expected to keep residents from entering peers' rooms and taking items from them. The facility's Residents Rights policy revised on 09/2024 documented the residents have a right to a dignified existence, self-determination, and communication with and access to personnel, and services inside and outside the facility.The facility identified a census of 147 residents. The sample included 31 residents, with seven reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion). Based on interviews, record reviews, and observations, the facility failed to provide consistent dementia-related care services for Residents (R) 78, R91, R37, R11, R23, and R25 to promote the resident's highest practicable level of well-being. This deficient practice placed the residents at risk for decreased quality of life, isolation, and impaired dignity. - The Medical Diagnosis section within R78's Electronic Medical Records (EMR) included diagnoses of dementia, dysphagia (difficulty swallowing), major depressive disorder (major mood disorder), aphasia (difficulty speaking), and the need for assistance with personal cares. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R78's Significant Change Minimum Data Set (MDS) dated 02/12/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted she exhibited physical, verbal, and self-directed behaviors for one to three days during the assessment. The MDS noted her behaviors would significantly interfere with the care of her and others. The MDS noted her behaviors could put others at risk for privacy intrusion and physical injury. The MDS noted she exhibited wandering behaviors for one to three days during the assessment. The MDS noted she could independently complete her activities of daily living. The MDS noted she could ambulate independently by walking. R78's Dementia Care Area Assessment (CAA) completed 02/24/25 indicated R78 had ongoing cognitive and physical impairments. The CAA noted she required 24-hour care. The MDS noted she was less able to make her needs known and required more assistance with her activities of daily living (ADLs). R78's Behavioral Symptoms CAA completed 02/24/25 indicated she exhibited dementia-related symptoms of physical aggression, verbal aggression, and inappropriate behaviors. The CAA noted she was at risk for falls, ADL decline, incontinence, and impaired cognitive function. The CAA noted that a care plan was implemented to address her risks. R78's Care Plan initiated 02/14/22 indicated she was at risk for an ADL self-care deficit, falls, and a communication deficit related to her dementia diagnosis. The plan noted she had delusions (untrue persistent beliefs or perceptions held by a person, although evidence shows it was untrue), wandering, rummaging through belongings, and sleeping in peers' beds. The plan instructed staff to intervene to protect the rights and safety of others, divert her attention, develop coping methods, and provide redirection from peers. The plan instructed staff to monitor and report episodes of physical and verbal aggression toward others. On 05/14/25 at 11:50 AM, R78 exited her room and into the hallway. R78 was confused and asked which room her daughter was in. R78 headed down the hallway, going into R10's room. R78 exited R10's room and went into R8's room. On 05/14/25 at 12:15 PM, R78 came out of the room and into the hallway holding a green jacket and a white shoe. R78 walked toward the dining area and stopped in the hallway adjacent to the dining room. Licensed Nurse (LN) RR was at the nurse's station looking in the direction of both residents during the argument. R8 yelled out, This is my stuff, and yanked the items out of R78's hands. LN RR left the desk area and walked to the resident's R78 punched R8 in the right upper arm and grabbed her shirt. LN RR separated the residents and returned to the desk. R8 immediately went into her room to put her items up, and R78 followed her in. R78 exited R8's room and returned to the dining area. On 05/14/25 at 02:51 PM, R78 and R91 walked down the hallway holding hands. R78 led R91 into R119's room. R78 opened a drawer, looking through the items in the drawer, and closed it. Both residents exited the room and continued walking around the hallway. On 05/14/25 at 03:16 PM, R78 and R91 walked back into R119's room and took a stuffed bear from the dresser. Both residents returned to the hallway and entered R12's room. R12 attained a plastic trash bag and shoved it down the front of her pants. Both residents exited the room and walked down the hallway to the dining room. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/15/25 at 02:18 PM, LN H stated the residents were not allowed to enter other residents' rooms or take their property. She stated that staff were expected to redirect and document the behaviors of each resident. She stated staff were expected to intervene when residents exhibited behaviors and ensure the director of nursing was immediately notified. On 05/15/25 at 02:27 PM, Certified Nurses Aide (CNA) QQ stated that residents on the locked unit could walk around the unit under supervision but were not to go into other residents' rooms or take their property. She stated staff were expected to supervise the residents to ensure no behaviors or falls occurred. On 05/15/25 at 02:44 PM, Administrative Nurse D stated that staff were expected to monitor and intervene when resident behaviors occurred. She stated staff were expected to keep residents from entering peers' rooms and taking items from them. The facility was unable to provide a policy related to dementia care as requested on 05/19/25. The facility's Residents Rights policy, revised on 09/10/24, documented that the residents have a right to a dignified existence, self-determination, and communication with and access to personnel and services inside and outside the facility. - The Medical Diagnosis section within R91's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (difficulty swallowing), cognitive-communication deficit, insomnia (difficulty sleeping), and need for assistance with personal cares. R91's Quarterly Minimum Data Set (MDS) dated 02/05/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she exhibited wandering behaviors daily. The MDS noted she required patrial to moderate assistance for bathing, oral hygiene, personal hygiene, dressing, and toileting. The MDS noted she could ambulate independently by walking. R91's Behavioral Symptoms Care Area Assessment (CAA) completed 05/08/24 indicated she exhibited dementia-related behaviors related to wandering the unit and grabbing other residents. The CAA noted a care plan was implemented to address her risks. R91's Care Plan initiated 05/06/24 indicated she had cognitive impairment and exhibited behaviors related to her dementia diagnosis. The plan indicated she wandered the unit and exhibited behaviors of grabbing peers. The plan instructed staff to anticipate her needs and provide a safe environment for wandering. The plan instructed staff to provide diversions and distractions such as food, drink, toileting, or other meaningful activities. The plan instructed staff to reorient her when needed. On 05/14/25 at 12:45 PM, R91 sat in the dining room at the table next to the wall column. R8 sat to the left of R91 at the table. Staff placed R8's tray on the table in front of her. R91 began grabbing R8's food off her tray. R8 abruptly stood up and took her tray to her room stating, I can't stand this. R8 returned to the table with her tray once R91's meal was served. On 05/14/25 at 02:51 PM, R91 and R78 (severely cognitively impaired resident) walked down the hallway holding hands. R78 led R91 into R119's room. R78 opened a drawer, looking through the items in the drawer, and closed it. Both residents exited the room and continued walking around the hallway. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/25 at 03:16 PM, R91 and R78 walked back into R119's room and took a stuffed bear from the dresser. Both residents returned to the hallway and entered R12's room. R12 attained a plastic trash bag and shoved it down the front of her pants. R91 sat down at the first table in the dining room and pulled the trash bag out of her pants. R91 handed the bag to another resident at the table and stated, This is for you. On 05/15/25 at 02:18 PM, LN H stated the residents were not allowed to enter other residents' rooms or take their property. She stated that staff were expected to redirect and document the behaviors of each resident. She stated staff were expected to intervene when residents exhibited behaviors. On 05/15/25 at 02:27 PM, Certified Nurse's Aide (CNA) QQ stated that residents on the locked unit could walk around the unit under supervision but were not to go into other residents' rooms or take their property. She stated staff were expected to supervise the residents to ensure no behaviors or falls occurred. On 05/15/25 at 02:44 PM, Administrative Nurse D stated that staff were expected to monitor and intervene when resident behaviors occurred. She stated staff were expected to keep residents from entering peers' rooms and taking items from them. The facility was unable to provide a policy related to dementia care as requested on 05/19/25. The facility's Residents Rights policy, revised on 09/10/24, documented that the residents have a right to a dignified existence, self-determination, and communication with and access to personnel and services inside and outside the facility. - R25's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment in reality perception), hypertension (high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), acquired absence of right great toe, acquired absence of left great toe, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), foot drop (inability or difficulty in moving the ankle and toes upward), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), retention of urine, history of falling, muscle weakness, unsteadiness on feet, encephalopathy (a broad term for any brain disease that alters brain function or structure), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R25 depended on staff for dressing upper and lower body, and bathing. The MDS documented R25 was independent with eating and required partial/moderate assistance with toileting. The MDS documented R25 was a diabetic. The Behavioral Symptoms Care Area Assessment (CAA) dated 08/22/24 documented due to R25's dementia she could be impatient with peers' behaviors and may be verbally aggressive. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace at Overland Park	7541 Switzer Road Overland Park, KS 66214

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's Care Plan dated 10/05/22 documented R25, had the potential to be verbally aggressive related to dementia. R25 would verbalize understanding of the need to control verbally abusive behavior. R25's plan of care documented when R25 became agitated staff should intervene before agitation escalated and guide her away from the source of distress. On 05/13/25 at 12:28 PM, R25 was served her tray, R69 grabbed for R25's tray, R25 pushed R69's hand away from her plate. R25 ate her lunch with her arm guarding her tray. On 05/15/25 at 09:03 AM, Licensed Nurse (LN) G stated residents should never be able to grab another resident's food. LN G stated the nursing staff monitored to ensure residents did not grab another resident's belongings. On 05/15/25 at 09:17 AM, Certified Nurse's Aide (CNA) N stated nursing staff monitor the dining area to ensure residents do not take food from other residents. She stated residents should not grab at other residents' trays or take from other residents' trays. On 05/15/25 at 02:42 PM, Administrative Nurse D stated residents should not grab food from other residents' trays. She stated residents should not have to guard their trays during mealtime. The facility's Residents Rights policy revised on 09/2024 documented the residents have a right to a dignified existence, self-determination, and communication with and access to personnel, and services inside and outside the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 148 residents. The sample included 29 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that the Consultant pharmacist (CP) identified and reported Resident (R) 37 and R90's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without an appropriate indication for use. The facility failed to ensure the CP recommended a gradual dose reduction (GDR - tapering of a medication dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for R37 and R90's antipsychotic medication. The facility also failed to ensure the physician provided the risk versus benefit for the continued use of R90's antipsychotic medications. These deficient practices placed R37, and R90 at risk of unnecessary medication administration and related complications. Findings included: - R37's Electronic Medical Record (EMR) recorded diagnoses of psychosis (any major mental disorder characterized by a gross impairment in perception), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). R37's Annual Minimum Data Set (MDS) dated 08/08/24 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R37 displayed the behaviors of inattention and disorganized thinking that were present and fluctuated. R37 required supervision for his functional abilities. R37's Delirium Care Area Assessment (CAA) dated 08/13/24 documented he had a history and diagnosis of dementia with ongoing cognitive impairments. R37 can be inattentive and have disorganized thinking related to his dementia disease. R37's Psychotropic Drug Use CAA dated 08/13/24 documented he triggered this CAA due to the use of psychotropic medication use. A care plan directed staff monitored R37 for medication side effects. R37's Care Plan was last revised on 02/13/25 and directed staff to administer antipsychotic medications as ordered by the physician. The plan of care directed staff to consult with the pharmacy and the physician to consider a dosage reduction when clinically appropriate. The plan of care directed staff to discuss with the physician and family the ongoing need for the use of the medication. The plan of care directed staff to educate the resident, family, and caregivers about the risks, benefits, and side effects of psychotropic medication drugs being given. R37's 'Orders tab of the EMR documented a physician's order dated 06/25/24 for Seroquel (an antipsychotic medication) 25 milligram (mg) tablet by mouth one time a date for psychosis. This order was discontinued on 09/27/24. This order lacked an appropriate indication for use for a resident with a diagnosis of dementia. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's 'Orders tab of the EMR documented a physician's order dated 09/27/24 for Seroquel 25 mg tablet to give 12.5 mg by mouth twice daily for psychosis. This order was discontinued on 09/28/24. This order lacked an appropriate indication for use for a resident with a diagnosis of dementia. R37's 'Orders tab of the EMR documented a physician's order dated 09/28/24 for Seroquel 25 mg tablet by mouth twice daily psychosis. This order was discontinued on 11/21/24. This order lacked an appropriate indication for use for a resident with a diagnosis of dementia. R37's 'Orders tab of the EMR documented a physician's order dated 11/21/24 for Seroquel 25 mg tablet by mouth two times a day for psychosis. This order lacked an appropriate indication for use for a resident with a diagnosis of dementia. A review of the CP's Recommendation to Physician reports from May 2024 to the present for R37 revealed that a GDR had not been attempted or recommended since September 2023. The reports also lacked a CP recommendation for an appropriate indication for the use of Seroquel. A Physician Progress Note in the EMR dated 05/01/25 at 12:51 PM documented R37 continued with episodes of agitation and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R37 continued on Seroquel, 25 mg twice daily. There was a desire to reduce this medication but given the failed attempts in the past, he would continue with the same dose for now. The plan was for R37 to remain on Seroquel at this time for Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) associated agitation. All the available medical records and lab results had been reviewed. On 05/13/25 at 08:34 AM, R37 sat at the dining table of a secured unit. R37 sat at a table with another male resident and took the other resident's ice cream. The certified nurse aide (CNA) intervened and moved R37 to another table. On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate indication for use of an antipsychotic medication was but knew that dementia should not be used. On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already being on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the GDRs done and the physician's risk versus benefit done on residents. Administrative Nurse D stated that psychosis in a dementia resident was not a good indication for the use of Seroquel. Administrative Nurse D stated that R37 had many behaviors and the Seroquel seemed to help with his symptoms. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Area of Focus: Pharmacy recommendations dated 11/19/24 documented the Medication Regimen Review (MRR) was a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medications. The pharmacist must report any irregularities to the attending physician, the facility's medical record, and the director of nursing. These reports must be acted upon. The attending physician must document in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. The pharmacist's review considered factors such as: Whether the physicians and staff have documented objective findings, diagnoses, symptom(s), and/or resident goals and preferences to support indications for use; whether the medication dose, frequency, route of administration, and duration was consistent with the resident's condition, manufacturer's recommendations, and applicable standards of practice; whether the physician and staff have documented attempts for GDR or added any non-pharmacological approaches, in an effort to reduce or discontinue the medication.- R90's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Pain, hypertension (high blood pressure), insomnia (unable to sleep), cognitive communication deficit (often stems from problems with attention, memory, executive functions), history of falling, muscle weakness, hyperlipidemia (an abnormally high concentration of fats and lipid in the blood), aphasia (a condition with disordered or absent language function), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS) dated 01/31/25, documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R90 needed substantial to maximal assistance with dressing and toileting and set up for eating. The MDS documented R90 received an antidepressant (a class of medications used to treat mood disorders), antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), hypnotic (a class of medications used to induce sleep), and an antianxiety (a class of medications that calm and relax people during the observation period). R90's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/31/25 documented R90 was receiving antipsychotic, antianxiety, and antidepressant medications. The CAA documented the contributing factors included diagnoses of depression and psychosis. The CAA documented Risk factors include side effects, allergic reactions, and improper dosing. The CAA documented R90's care plan would be reviewed and updated to include interventions to address risk factors. R90's Care Plan revised 10/24/24 documented R90 used psychotropic medications. The plan of care for R90 documented nursing staff were to administer medication as the physician ordered and monitor for side effects and effectiveness. R90's plan of care documented nursing staff were to consult with the pharmacy, and the physician to consider dosage reduction when clinically appropriate at least quarterly. The facility was to review behaviors, interventions, and alternate therapies attempted and their effectiveness as per facility policy. The plan of care for R90 documented staff were to educate the resident, family, and caregivers about the risks, benefits, and side effects of psychotropic medication. R90's EMR under Orders documented the following physician's order: Seroquel (anti-psychotropic) oral tablet (Quetiapine Fumarate) give 75 milligrams (mg) three times a day for psychosis, dated 11/14/24. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the CP's Monthly Medication Reviews (MMR) from 04/2024 to 04/2025 revealed no recommendations noting the inappropriate indication of use related to R90's quetiapine fumarate medication. On 05/14/25 at 07:32 AM, R90 laid on his bed, with the head of the bed elevated. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated she did not do anything with the pharmacy reviews. She was unsure who would inform the physician about the correct indication for psychotropic medication. On 05/15/25 at 02:42 PM, Administrative Nurse D stated many of the residents came to the facility already being on antipsychotic medication. Administrative Nurse D stated it has been a team effort with the Interdisciplinary Team (IDT) to try to get the GDRs done and the physician's risk versus benefit done on residents. Administrative Nurse D stated the physician works hard to ensure the correct indication for medication. The facility's Unnecessary Medication policy last revised on 04/22/25 documented the facility would ensure only medications required to treat the resident's assessed condition were being used, reducing the need for, and maximizing the effectiveness of medications was an important consideration for all residents. As a part of medication management, it was important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility would assess the resident's underlying condition, current, symptoms, and expressions, and preferences and goals for treatment. This would assist the facility in determining if there were any indications for initiating, withdrawing, or withholding medications as well as the use of non-pharmacological approaches. The resident's medical record should show documentation of adequate indicators for a medication's use and the diagnosed condition for which a medication was described. When there were multiple prescribers, the continuation of a medication needed to be evaluated to determine if the medication was still warranted in the context of the resident's other medications and comorbidities.

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	175158	A. Building B. Wing	05/15/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. The facility identified a census of 148 residents. The sample included 29 residents, with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 93, and R248's physician-ordered parameters were obtained and monitored prior to administration of their beta-blocker (medications that help lower blood pressure and heart rate) antihypertensive (a class of medication used to treat high blood pressure) medications. The facility failed to ensure R93's diclofenac gel (topical medication used to treat pain and inflammation) order included the required dosage amount. These deficient practices placed R93 and R248 at risk of unnecessary medication administration and related complications. Findings included: - R93's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by a gross impairment perception), insomnia (inability to sleep), hypertension (HTN - elevated blood pressure), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) R93's admission Minimum Data Set (MDS) dated 04/24/25 documented she had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R93 displayed symptoms of delirium (sudden severe confusion, disorientation, and restlessness) that included inattention and disorganized thinking. R93's MDS documented she displayed both physical and verbal behaviors directed toward others. R93's MDS documented she utilized a Broda chair (specialized wheelchair with the ability to tilt and recline). R93's MDS documented she required set-up assistance for eating and substantial to being dependent on staff for her activities of daily living (ADL) and functional abilities. R93's MDS documented she was frequently incontinent of bladder and always incontinent of bowel. The MDS documented R93 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), and an antidepressant (a class of medications used to treat mood disorders) medication on a regular basis. R93's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/01/25 documented she used psychotropic medications. The facility administered the medications per physician orders and observed the resident for adverse effects. R93's Care Plan revised on 04/22/25 directed staff to avoid taking the blood pressure reading after physical activity or emotional distress. The plan of care directed staff to give antihypertensive medications as ordered and observe for side effects such as orthostatic hypotension (blood pressure dropping with change of position), increased heart rate, and effectiveness. The plan of care directed staff to administer pain medication as ordered. R93's Orders tab of the EMR documented a physician's order dated 04/18/25 for metoprolol (a beta blocker medication) extended-release tablet 100 milligrams (mg) to give one tablet by mouth in the morning for HTN, hold medication if the systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) was below 110 or the pulse was below 60. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R93's Orders tab of the EMR documented a physician's order dated 04/18/25 for diclofenac sodium external gel one percent (%) to apple topically to both knees twice daily for knee pain. This order lacked a dosage amount to apply. Upon review of R93's Medication Administration Record (MAR) from April 2025 revealed R93's blood pressure and pulse had not been obtained and recorded prior to administration of her metoprolol. The MAR lacked blood pressure and pulse readings on 30 of 30 opportunities prior to the administration of metoprolol. Upon review of R93's Medication Administration Record (MAR) from May 2025 revealed R93's blood pressure and pulse had not been obtained and recorded prior to administration of her metoprolol. The MAR lacked blood pressure and pulse readings on 14 of 14 opportunities prior to the administration of metoprolol. On 05/13/25 at 08:17 AM, R93 laid in her bed resting. R93's bed was in the low position and the call light was within reach. On 05/15/25 at 02:08 PM, Licensed Nurse (LN) H stated that blood pressure and pulse should be taken prior to the administration of blood pressure medications. LN H stated the medication should be held according to the parameters and the physician notified when the reading had been out of parameters and held. LN H stated that R93's diclofenac should have a dosage amount to apply. On 05/15/25 at 02:45 PM, Administrative Nurse D stated that R93's blood pressure and pulse should be monitored and recorded prior to the administration of her metoprolol due to the physician-ordered parameters for the medication. Administrative Nurse D further stated that R93's diclofenac should have a dosage amount to be applied. The facility's policy Area of Focus: Physician Orders documented a physician, physician assistant, or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident. The facility was obligated to follow and carry out the order of the prescriber in accordance with all applicable state and federal guidelines. The facility's Unnecessary Medication policy revised on 04/22/25 documented the facility would ensure proper monitoring and accurate documentation of a medication to evaluate the ongoing benefits as well as risks of various medications.

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	175158	A. Building B. Wing	05/15/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), retention of urine (a condition in which you are unable to empty all the urine from your bladder), and chronic kidney disease (the kidneys are damaged and can't filter blood properly, leading to a buildup of waste and fluid in the body). R11's admission Minimum Data Set (MDS) dated 02/26/25 documented R11 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R11 displayed signs and symptoms of delirium (sudden severe confusion, disorientation, and restlessness) including inattention and disorganized thinking. The MDS documented R11 was dependent on staff for all activities of daily living (ADL). The MDS documented R11 required the use of an indwelling catheter. The MDS documented R11 was on hospice care. R11's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/27/25 documented she had a history and diagnosis of dementia with ongoing cognitive impairments that require 24-hour a day care. R11 needed staff assistance to total dependence on staff with ADL cares. R11's Care Plan revised on 02/21/25 directed staff that R11 had terminal illness and was on hospice services. The plan of care directed staff to keep the environment quiet and calm. The plan of care directed staff to keep linens clean, dry, and wrinkle-free. The plan of care directed staff to keep the lighting low and familiar objects nearby. The plan of care directed staff to give medication as ordered. The plan of care directed staff to observe R11 closely for signs of pain, administer pain medications as ordered, and notify the physician immediately if there was breakthrough pain. The plan of care directed staff to reposition R11 for comfort as needed. The plan of care directed staff to work cooperatively with the hospice team to provide the resident's spiritual, emotional, intellectual, physical, and social needs. The plan of care lacked staff direction on the hospice providers' contact information; the services, medications, and equipment provided by hospice; and how often hospice staff would make visits. On 05/15/25 at 07:45 AM, R11 laid in bed with her call light in reach. R11 had no complaints of pain currently and only asked for a drink. R11 utilized her call light to have staff come to assist her. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated the hospice team had a binder at the nurse's station. She stated all nurses could read the binder. LN J stated the plan of care with equipment and supplies were in the binder and staff could look at the hospice binder if the staff members needed to know anything about R31. LN J stated she did not believe the information was in the faculty care plan. LN J stated she thought the care plans should match. On 05/15/25 at 02:42 PM, Administrative Nurse D stated anything the resident received should be in the facility's plan of care. Administrative Nurse D stated she did believe the care plans should match. (continued on next page)

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	175158	A. Building B. Wing	05/15/2025

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hospice policy reviewed on 11/19/24 documented the facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the long-term care facility to attain and maintain the residents highest practicable physical, mental, and psychosocial well-being. The facility identified a census of 147 residents. The sample included 31 residents, with two residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 31 and R11. This placed the resident at risk for inappropriate end-of-life care. Findings Included: - R31's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment in reality perception), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), delusional disorders (a mental illness characterized by persistent false beliefs, known as delusions, that persist for at least one month), major depressive disorder (major mood disorder that causes persistent feelings of sadness), history of falling, hypertension(high blood pressure), contracture (abnormal permanent fixation of a joint or muscle) of the left hand, lack of coordination, dementia (a progressive mental disorder characterized by failing memory and confusion), 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 Modification of Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R31 was dependent on staff for toileting, bathing, dressing, and eating. The MDS documented R31 did not receive hospice services during the observation period. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/21/25 documented R31 had a long history and diagnosis of dementia. The CAA documented R31 had ongoing cognitive and physical impairments that continue to require 24-hour day care. The CAA documented R31 had end-stage dementia disease that rendered her unable to make her needs known in any manner. The staff were responsible for all her care. R31's Care Plan dated 01/16/25 documented R31 had a terminal prognosis and was receiving hospice care. R31's plan of care documented R31's comfort would be maintained. The plan of care for R31 documented staff would honor advance directives and provide comfort with dignity, medication as ordered, repositioning for comfort as needed, and treatment as ordered. The plan of care for R31 documented nursing staff would work cooperatively with the hospice team to provide the resident's spiritual, emotional, intellectual, physical, and social needs. (continued on next page)

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	05/15/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Care Plan lacked direction to staff for collaboration of care and services with the hospice provider which included the services, frequency of visits, medications, and equipment provided by hospice. A review of R31's hospice binder documented R31 was admitted to hospice on 01/15/25. On 05/15/25 at 09:25 AM, Licensed Nurse (LN) J stated the hospice team had a binder at the nurse's station. She stated all nurses could read the binder. LN J stated the plan of care with equipment and supplies were in the binder and staff could look at the hospice binder if the staff members needed to know anything about R31. LN J stated she did not believe the information was in the facility care plan. LN J stated she thought the care plans should match. On 05/15/25 at 02:42 PM, Administrative Nurse D stated anything the resident received should be in the facility's plan of care. Administrative Nurse D stated she did believe the care plans should match. The facility's Hospice policy reviewed on 11/19/24 documented the facility provided hospice care under a written agreement and must ensure that each resident's written plan of care included both the most recent hospice plan of care and a description of the services furnished by the long-term care facility to attain and maintain the residents highest practicable physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 147 residents. The sample included 31 residents, with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to obtain consent or declinations for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 37 R93, R90, R248, and R143 This placed the residents at increased risk for complications related to pneumonia. Findings included: - Review of R37's clinical record revealed PPSV23 was administered on. 04/17/20. R37's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication. A review of R93's clinical record revealed a declination was signed for the PPSV23. R93's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R90's clinical record revealed the PPSV23 was administered on 01/12/23. R90's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R248's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. A review of R143's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration. On 05/15/25 at 10:30 AM, Licensed Nurse (LN) I stated when a resident was due for an immunization it would be listed on the Treatment Administration Record (TAR). LN I stated the infection preventionist (IP) would track the resident's immunizations. LN I stated the Infection Preventionist (IP) would order the vaccines as needed. On 05/15/25 at 11:24 AM, Licensed Nurse (LN) H stated the charge nurses tracked the residents' immunizations. LN H stated the charge nurse would ask the resident at the time of admission for the past immunizations they had received, but sometimes they are unable to ask the questions. LN H stated if the resident was due for an immunization the charge nurse would order the vaccines and administer the vaccine when delivered from the pharmacy. On 05/15/25 at 02:42 PM, Administrative Nurse D stated she was unsure if the PCV20 had been offered. Administrative Nurse D stated the IP would follow up on all vaccines. The facility's Pneumococcal Vaccine policy dated 04/08/25 documented the facility must follow their state rules and regulations regarding physician-approved policies and procedures that incorporate physician orders for the administration of pneumococcal vaccines into physicians' standing orders.