STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175182	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Overland Park	12100 W 109th Street Overland Park, KS 66210

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 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. Based on observation, record review, and interview, the facility failed to ensure routine catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care was performed per professional standards of practice for Resident (R)1. Findings included:- R1's Electronic Medical Record (EMR) documented diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate, which can lead to interference with urine flow, urinary frequency, and urinary tract infections).The admission / Medicare Minimum Data Set (MDS), dated 06/04/2026, for R1 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 required substantial to maximal assistance for upper body dressing, bed mobility, and transfers. The MDS documented R1 was dependent on staff for toileting hygiene, lower body dressing, and personal hygiene. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/04/2026, documented R1 had BPH and a Foley catheter. The CAA documented R1 had a decline in functional ability with Activities of Daily Living (ADL), toileting, catheter, incontinence care, and transfers.R1's 05/29/2026 Care Plan documented R1 had an indwelling catheter. The 05/29/2026 Care Plan included the following interventions for R1:05/29/2026 - directed staff to monitor for signs and symptoms of a urinary tract infection (UTI-an infection in any part of the urinary system)05/29/2026 - directed staff to provide catheter care every shift and as needed.R1's 05/29/2026 Care Plan documented R1 was at risk for contracting a multi-drug-resistant organism due to right wrist infection, Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics) and Foley catheter. A physician's order, with a start date of 05/29/2026, directed staff to perform catheter care per shift. The order frequency recorded care to be done every day, on day shift, evening shift, and night shift.Review of the Point of Care History, from 05/28/2026 through 06/30/2026, under the Indwelling Catheter Care section, revealed the following:No catheter cares documented, for any shift, on the following (11) days 05/29/2026, 05/30/2026, 05/31/2026, 06/01/2026, 06/03/2026, 06/04/2026, 06/05/2026, 06/08/2026, 06/10/2026, 06/11/2026, and 06/14/2026.Cather care documented as done one time a day on the following (6) days 06/02/2026, 06/06/2026, 06/07/2026, 06/09/2026, 06/12/2026, and 06/13/2026.Catheter care documented as done two times a day on the following (2) days 06/15/2026 and 06/16/2026.There were zero days during the look back period where catheter care was documented as being done on all three shifts as ordered. A Nursing note dated 06/17/2026 at 10:37 AM, documented staff noted dark red urine draining via Foley to gravity drain bag. The note recorded there was approximately 750 milliliters (mL) observed in the catheter bag. The note further recorded the nurse practitioner (NP) was contacted and made aware or red colored urine, that R1 denied pain, and was uncertain of other discomfort. The note recorded new orders were received to send R1 to the emergency department (ED) for evaluation.A Nursing note dated 06/17/2026 at 12:54 PM, documented a call was placed to Emergency Medical Services (EMS) per orders. The note recorded EMS arrived, report was provided, and resident was transported to the ED for evaluation.R1's EMR lacked evidence of any progress notes related to R1 receiving catheter care between 05/28/2026 through 06/17/2026 when R1 was sent to the ED.On 06/30/2026 at 04:18 PM, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	175182	A. Building B. Wing	06/30/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Nurse (LN) G stated when the nurses do patient care they were the ones that cleaned the catheter site, made sure the catheter had good flow, and had no blood or sediment. LN G stated catheter care was supposed to have been done on every shift. LN G stated if catheter care was not done regularly, it would put the resident at risk for infection. She stated a resident could become septic (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) from UTIs. She further stated sometimes the site around the catheter could become irritated or infected, and it was important for catheter care to have been completed on time, every day.On 06/30/2026 at 04:35 PM, Administrative Nurse D stated the nurses were the ones that did the cleaning of the catheter during catheter cares. She stated the Certified Nursing assistants (CNA) may have been documenting the catheter care as being done as they changed the resident's briefs more often and the order popped up under the CNA charting for them to document against. She stated the nurses had to check for signs of infection and perform the actual catheter care. Administrative Nurse D stated a lot of the times the nurses would put in a progress note, but if they cleaned the catheter, and there were no issues they may note have. Administrative Nurse D stated if the CNAs note anything, they report it to the nurse and to her. She stated the only way to know if the catheter care was done was through the CNA documentation on the Point of Care History under the Indwelling Catheter Care section in the EMR. She stated staff did notice the blood in R1's urine that day and had him transferred out via non-emergency transport to the hospital. She stated they ordered a UA, but he was sent out prior to it being collected. Administrative Nurse D stated R1 was on an antibiotic for his wrist infection the whole time he was in the facility. She stated she was surprised he would have a UTI. Administrative Nurse D stated the facility had not received an update on R1 after he was sent to the hospital. She stated she was not sure what had caused the blood in his urine.On 06/30/2026 at 05:06 PM, Consultant GG stated she worked as a nurse at the hospital. She reported she received report from the ED nurse that cared for R1 in the ED. She stated she also reviewed R1's medical records during his current hospital visit. Consultant GG stated R1 had a lot of blood in his urine when he arrived. Consultant GG stated R1 was diagnosed with a UTI at the hospital and was currently being treated for it.The facility's Catheter Care policy, with a revised date of 03/2021, documented purpose: to keep indwelling catheter free of discharge and or crusting which can cause infection. Catheter care should be given every shift and as needed.