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	01/28/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 97 residents, with one kitchen and dining room. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to food and equipment storage.Findings included:- On 01/26/25 at 09:05 AM, a walkthrough of the facility's kitchen was completed:An inspection of the steam table serving area revealed clean plates stored upward on the plate rack without a sanitary cover or barrier. An inspection of the dishwashing area revealed that clean plates were stored upward on the plate rack without a sanitary cover or barrier.An inspection of the walk-in freezer's air condenser unit revealed that it had leaked large amounts of fluid onto stored bags of servable ice and boxes of ice cream sandwiches stored below the leak.An inspection of the walk-in refrigerator revealed a 40-ounce package of Swiss cheese opened and undated on the top right rack of the unit. The cheese package was open and exposed.On 01/28/26 at 12:25 PM, Dietary Staff BB stated staff were expected to inspect the kitchen and storage areas each shift to ensure safe handling of the food. She stated staff were expected to store food and equipment with safe serving practices. She stated the leak was awaiting a part and was scheduled to be fixed on 01/29/26. She removed the boxes within the vicinity of the leak and stated staff would ensure the area remained clear until the leak was fixed.The facility's Storage Guidelines policy (undated) indicated the facility would ensure all food and supplies were stored appropriately to ensure quality and maximizes safety of the food.

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

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

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F 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 97 residents. The sample included 21 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician order for daily weights to monitor for fluid overload for Resident (R) 9.Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of heart failure, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).The Significant Change Minimum Data Set (MDS) dated 11/15/25 documented a Brief Interview for Mental Status (BIMS) score was not assessed and no information was documented during the observation period.R9's Dehydration Care Area Assessment (CAA) dated 01/04/26 documented staff would provide R9 with fluids and beverages to maintain his hydration. R9's Care Plan documented the following:07/02/25- Staff would encourage R9 to participation to the maximin independence.The plan of care lacked direction for monitoring weights and heart failure.R9?s EMR under the Orders tab documented daily weights prior to breakfast. Notify the physician of a weight change of three pounds or greater in one day, dated 12/29/25.Review of R9's Medication Administration Record (MAR), Treatment Administration Record (TAR), and EMR from 12/30/25 to 01/26/26 (28 days) lacked evidence staff measured and recorded R9's weight on the following 12 dates: 12/30/25 weight was missed, 01/03/26 lacked documentation, 01/07/26 R9 was unavailable, 01/08/26 he had refused, 01/12/26 documented did not get the weight, 01/13/26 R9 was at an appointment, 01/14/26 Certified Nurse Aide (CNA) did not get the weight, 01/16/26 lacked documentation, 01/17/26 R9 refused, 01/18/26 R9 refused, 01/23/26 lacked documentation, and 01/24/26 R9 refused.The clinical record lacked documentation of physician's notification that the daily weight was not obtained.On 01/26/26 at 10:20 AM, R9 was asleep in the wheelchair in his room. R9 had a white dressing on his right forearm and wrist, and another white dressing on the top of his right hand. R9 stated he could not remember what had happened to his right arm.On 01/28/26 at 12:06 PM, CNA M stated the nurse would let the staff know who was to be a daily weight when needed. CNA M stated the staff would obtain the weight, or if the resident refused, the nurse would be notified.On 01/28/26 at 12:14 PM, Licensed Nurse (LN) G stated the nurse would notify the CNAs of which residents needed a weight that day. LN G stated if the resident refused, that would be documented in their EMR. LN G stated the physician should be notified and that would also be documented in the residents EMR under the progress note tab. LN G stated it was the nurse's responsibility to ensure the daily weight was charted or the physician was notified of their refusal.On 01/28/26 at 12:57 PM, Administrative Nurse D stated the nurse would notify the CNAs of the residents who needed a weight that day. Administrative Nurse D stated it was the nurse's responsibility to ensure the weight was obtained, or if the resident refused, the physician should be notified. Administrative Nurse D stated that it should be documented in the residents' EMR under the progress notes, which would be the best place for the documentation.The facility's Following Physician Orders policy, dated 06/29/21, documented it was the policy of the community to ensure that all Licensed Professional Nurses (RN/LPN/LVN) and other Healthcare Professionals followed Physician Orders in accordance with State and Federal regulations and their respective practice acts.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 97 residents. The sample included 21 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 4's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask was stored in a sanitary manner.Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), empyema (collection of pus in the pleural cavity related to bacterial pneumonia), open wound to left lower leg, and nicotine dependence.The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R4 was independent with eating and was dependent on staff assistance with toileting. The MDS documented R4 received oxygen therapy during the observation period.R4's Care Plan documented the following:05/21/25- R4 required oxygen therapy related to COPD, pneumothorax (abnormal collection of air between the lung and the chest wall), and respiratory distress. 05/21/25- Nursing staff would monitor oxygen saturation every shift and as needed.R4's plan of care lacked direction for the storage of R4's nebulizer mask.R4?s EMR under the Orders tab revealed the following physician orders:Ipratropium-albuterol solution for nebulization: 0.5 milligrams (mg)-3 mg/3 milliliters (ml), give 3 ml inhalation (medication inhaled to open airways) for respiratory four times a day, dated 05/20/25.Change nebulizer tubing weekly and as needed on Fridays, dated 05/21/25.Albuterol inhalation solution for nebulization: 2.5/3.0 ml 2.5mg per give 2.5mg inhalation for shortness of breath four times a day as needed, dated 06/03/25.On 01/27/26 at 10:24 AM, R4 sat in his electric wheelchair in the commons area watching TV. R4 was wearing oxygen. R4's nebulizer laid on his bedside table. R4's nebulizer mask was not stored in a sanitary manner.On 01/27/26 at 02:22 PM, R4 sat in the commons room close to the TV. R4's nebulizer mask laid dangling over the bedside table. R4's nebulizer mask was not stored in a sanitary manner.On 01/27/26 at 12:05 PM, Certified Nurse's Aide (CNA) M stated respiratory equipment not in use should be put in a bag to keep the equipment clean. CNA M stated it was the nurse who gave the breathing treatment who put the mask into a bag.On 01/27/26 at 12:14 PM, Licensed Nurse (LN) G stated all respiratory equipment should be placed in a bag. She stated it was all the staff's responsibility to ensure the respiratory equipment was kept sanitary.On 01/27/26 at 12:58 PM, Administrative Nurse D stated all respiratory equipment should be placed in a mesh bag. Administrator D stated it was all the staff members' responsibility to ensure the respiratory equipment was not in use. She stated all staff should put the not-in-use equipment in the mesh bag.The facility's Nebulizing Cleaning policy, revised 05/2021, documented pulmonary equipment, including nebulizers, would be cleaned between uses and stored to prevent contamination and prevent the growth of microorganisms.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. The facility identified a census of 97 residents. The sample included 21 residents, with one resident reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 6's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization.Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of PTSD and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The admission Minimum Data Set (MDS) dated 12/24/25 documented the Brief Interview for Mental Status (BIMS) score was not assed or no information. The MDS documented R6 had the active diagnosis of PTSD. R6's Behavioral Symptoms Care Area Assessment (CAA) dated 01/09/26 documented she was not very interested in activities.R6's Care Plan documented the following:12/18/25- Staff would anticipate her needs.The plan of care lacked direction for her PTSD.R6?s EMR under the Assessment tab lacked a trauma informed care assessment and the facility was unable to provide one upon request on 01/28/26 at 12:57 PM. On 01/28/26 at 07:15 AM, R6 sat in her wheelchair next to her bed. R6 propelled herself in the wheelchair down the hallway to the dining room. On 01/28/26 at 12:14 PM, Licensed Nurse (LN) G stated the social worker was responsible for completing the trauma-informed assessment.On 01/28/26 at 12:57 PM, Administrative Nurse D stated the MDS coordinator or the social service was responsible for completing the trauma-informed assessment. Administrative Nurse D stated she did not know if R6 had a trauma-informed assessment completed and would check for the assessment.The facility's Trauma Informed Care and Behavioral Health Management policy, revised 09/2019, documented it was the philosophy of the facility to treat all residents with love, care, and understanding. The Facility believes all behaviors have meaning and are often a way of communicating a need. To assist in the early identification of residents' past traumatic events/behaviors and to develop and implement interventions to manage or de-escalate those behaviors. The facility provided Behavioral Health Services to residents who required such services in accordance with state and federal law. Within seventy-two (72) hours of admission, a review of the admission medical record would be completed by the social worker, and the residents would be asked, If they have experienced any trauma in their life that continues to upset them today.