STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Overland Park	12000 Lamar Avenue Overland Park, KS 66209

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 1 was treated with dignity and respect when Certified Nurses Aide (CNA) M snapped her fingers at R1 in order to get his attention so he would stop acting out.Findings included:- R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dysphagia (swallowing difficulty), muscle weakness, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), lack of coordination, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).R1's Admission/ Five Day Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R1 required partial to moderate assistance with oral hygiene, upper body dressing, personal hygiene, rolling in bed, sitting to lying, lying to sitting on the side of the bed, sit to stand, and chair to bed/bed to chair transfers, and toilet transfers. R1 required substantial to maximal assistance with toileting hygiene, shower/bathing, lower body dressing, putting on and taking off footwear. R1 felt down, depressed, or hopeless two to six days. R1 had physical behavioral symptoms directed towards others, he rejected care one to three days.R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/21/25 documented he had one episode of pushing and rejecting cares. R1 had cognitive impairment issues and cognitive deficits that could affect his mood, behavior, and ability to understand things. R1 required redirection, encouragement, and ongoing cueing to make safe decisions.R1's Activities of Daily Living (ADL) Care Plan initiated on 12/17/25 directed that he required assistance to dress and for his ADLs.Review of the surveillance footage of R1's room dated 12/21/25 at 11:17 PM revealed four staff members attempting to help R1 get dressed. R1 sat on his bed. There were three staff members, CNA M, CNA N, and a third unidentified staff member in front of him. There was a fourth staff member, Licensed Nurse (LN) G standing behind the group of three staff members in front of R1. CNA M attempted to help R1 get his right arm into his shirt. While doing this CNA M's right arm moved forward quickly, and a snap or pop sound can be heard. After that noise, R1 turned and looked directly at CNA M with a somber look on his face. CNA M continued to attempt to pull his shirt up to his shoulder on his right arm.On 04/14/26 at 12:37 PM, CNA M stated that she snapped her fingers at R1 but did not strike him. CNA M further stated that the snap was to get R1's attention. CNA M explained R1 had been acting out so she snapped her fingers at R1 to get his attention. CNA M revealed that she did not know that there was a camera in R1's room until the next day.On 04/14/26 at 01:15 PM, CNA O stated that in the event that a staff member snapped their fingers at a resident, she would assure the resident that it was not ok to be treated like that and she would report it. CNA O stated that the behavior of snapping at a resident was not ok and she would definitely report it.On 04/14/26 at 01:18 PM, LN H stated that if a staff member snapped at a resident in front of her, LN H would nicely say in front of the resident that was not how staff communicated with residents and have that staff member leave the room. LN H would make sure the resident ok and (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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then report it to management. LN H revealed that she felt a snap was not respectful and it was rude.On 04/14/26 at 02:38 PM, Administrative Nurse D stated that the surveillance video startled her. Administrative Nurse D stated she expected staff to acknowledge that event, address the staff member, and let the on-call staff know. Administrative Nurse D stated that CNA M said the snap was to get R1's attention. Administrative Nurse D further stated that she attempted to explain to CNA M that snapping at a resident could be perceived as derogatory.The facility's Resident Rights policy, reviewed October 2022, documented associates should adhere to and respect resident's rights as applicable to state and federal regulations.The facility's Quality of Life - Dignity policy, last revised March 2026, documented residents should be cared for in a manner that promoted and enhanced their sense of well-being level of satisfaction with life, and feelings of self-worth and self-esteem. The policy documents demeaning practices and standards of care that compromise dignity are prohibited.