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	01/22/2026

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 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. The facility had a census of 77 residents. The sample included 18 residents, with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure a blanket warming equipment and pressurized supplemental oxygen tanks in a safe, locked area and out of reach of the eight cognitively impaired, independently mobile residents. Findings Included:- On 01/19/26 at 07:04 AM, a walkthrough of the facility revealed an unsecured storage closet next to the nurse's station on the 400 hallway. An inspection of the unsecured closet revealed 25 (full size) and six (small) fully pressurized cylindrical oxygen containers in the oxygen racks. An inspection of the unsecured closet also revealed an Enthermics EC2060 blanket warming unit. The unit was warm to touch and set to 200 degrees Fahrenheit. On 01/19/26 at 07:10 AM, Licensed Nurse (LN) G verified the room was unsecured and stated staff were expected to ensure the door was fully closed before exiting the room. She stated the room was to always remain locked. On 01/22/26 at 11:20 AM, Administrative Nurse D stated the storage closet and oxygen areas were to remain locked. She stated the residents were not allowed to access those areas. A review of the Enthermics EC2060 blanket warming unit operator's manual revealed the risk of exposure to burns and chemicals. A review of the facility's Oxygen policy, revised 08/2023, indicated oxygen cylinders would be stored in a locked, well-ventilated room separated from electrical appliances. A review of the facility's Environment policy, revised 08/2023, indicated the facility would provide a safe, functional, sanitary, and comfortable environment for the residents.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 77 residents. The sample included 18 residents, with six residents reviewed for unnecessary medication. Based on record review and interviews, the facility failed to ensure Resident (R) 70's as-needed Lorazepam, antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date, or a physician's rationale for extended use.Findings included:- R70's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (elevated blood pressure), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), aphagia (loss of the ability to swallow), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and encounter for palliative care.The Significant Change Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R70 needed substantial to maximal assistance for eating and oral care and was dependent on staff for toileting and bathing. The MDS documented R70 had an impairment of both sides of her upper and lower body. The MDS documented R70 received an antidepressant (a class of medications used to treat mood disorders) medication during the observation period.R70's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/05/25 documented R70 was admitted to the facility for skilled rehabilitation and nursing care with the goal of returning to her home. The CAA documented R70 had continued overall decline in self-care and transitioned to long-term care with hospice services. The CAA documented R70 needed substantial to total assistance of one to two staff for daily activities (ADL). The CAA documented that R70 had depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and took depression medication.R70's Care Plan documented:10/20/25- R70 had a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and depression.10/20/25- R70 would remain free of drug-related complications.10/20/25- Nursing staff were to administer medication as ordered and monitor for side effects and effectiveness.10/20/25- Nursing staff were to discuss with the physician and family of the ongoing need for the use of the medication.R70's EMR under Orders documented the following physician's order:Lorazepam oral tablet 0.5 milligrams (mg), give one tablet by mouth every four hours as needed for anxiety or hallucination (sensing things while awake that appear to be real, but the mind created), start date 12/12/25.R70's EMR lacked a 14-day stop date for Lorazepam or a physician's rationale for extended use.On 01/22/26 at 10:24 AM, R70 sat in her wheelchair at an activity with peers. R70s head was down, and eyes were shut.On 01/22/26 at 08:21 AM, License Nurse (LN) H stated the physician handled all the 14-day stops on antianxiety medication. LN H stated upon admission, orders were placed in the charts, the night nurse completed a chart check, and the next day, the facility's quality management performed a chart check. LN H stated she was unsure who double-checked hospice orders and monitored the orders for accuracy. On 01/22/26 at 10:58 AM, Administrative Nurse D stated the facility's policy was to follow regulation for as-needed psychotropic medication. She stated that psychotropic medications should have a 14-day stop date or a physician's rationale for extended use. She stated the interdisciplinary team met daily and reviewed new orders and new admissions.The facility's Psychotropic Drug Management Policy, revised 10/2025, documented non-drug interventions should be implemented to the extent possible to assist the resident attain a satisfactory quality of life. The policy documented to provide a therapeutic environment and use only those medications with a therapeutic benefit to the individual resident. Unnecessary drugs should be avoided. An unnecessary drug was any drug when used in excessive dose including duplicate drug therapy, for excessive duration without adequate monitoring, without adequate indication for its reduction or discontinuation.

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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. The facility identified a census of 77 residents. The sample included 18 residents, with one resident reviewed for hospice services. Based on interviews, observation, and record review, the facility failed to provide a description of the medication, services, and equipment provided to Resident (R) 51 by hospice.Findings included:- R51's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Lewy body dementia (a type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Significant Change Minimum Data Set (MDS) dated 09/10/25 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition, and no staff interview was completed. The MDS documented R51 received hospice services during the observation period. R51's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 09/16/25 documented she was admitted on to hospice services on 09/03/25.R51's Care Plan documented the following: 09/03/25- Staff would provide assistance at meals as needed, assistance with transfers as needed, provide incontinence care as needed, and assist R51 with turning and positioning as needed.09/04/25- Staff would assist R51 with dressing and grooming as needed.09/04/25- Staff would coordinate care with the hospice nurse and aides.09/04/25- Staff would notify hospice nurse of changes in condition as needed, give medication(s) as ordered, monitor for relief and document results, notify the physician and hospice if relief was not obtained, and monitor R51 for pain and/or discomfort.The care plan lacked direction for the staff regarding the medications, equipment, and services provided by hospice.R51?s EMR under the Orders tab revealed the following physician orders:Admit to hospice with a diagnosis of Alzheimer's disease, early onset, dated 09/03/25.On 01/21/26 at 08:20 AM, R51 was asleep on a chair in the common area. She was seated with her legs over the arm of the chair.On 01/22/26 at 08:37 AM, Certified Medication Aide (CMA) R stated what equipment, supplies, and services provided by hospice should be on the care plan.On 01/22/26 at 08:44 AM, Licensed Nurse (LN) I stated the frequency of hospice staff visits, the equipment, and supplies provided by hospice should be listed on the care plan.On 01/22/26 at 10:56 AM, Administrative Nurse D stated the services, equipment, and medications provided by hospice should be placed on the residents' care plan. Administrative Nurse D stated the unit manager was responsible for ensuring the resident's care plan was updated when a resident was admitted on to hospice services.The facility's Hospice Care policy, revised 12/2025, documented hospice care may be provided when ordered by the health care provider and agreed to by the resident and or representative. The selected hospice would have a current contract with the community which followed federal requirements. The purpose of this policy was to provide hospice care for residents who elected hospice services who have known terminal illnesses or end-stage conditions.