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	03/13/2024

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

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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	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** - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented a staff assessment was completed and indicated moderately impaired cognition. The MDS documented R16 required set-up assistance of staff with eating during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented that R16 required set-up assistance from staff with eating. R16's undated Nutritional Status Care Area Assessment (CAA) lacked a documented analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated 12/14/20 documented R16 was dependent on two staff members for assistance with eating. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit beside R16. LN L sat down and continued to assist R16 with lunch. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated staff should always be sitting next to the resident they are assisting at mealtimes. On 03/13/24 at 02:45 PM, Licensed Nurse (LN) K stated staff should never stand next to a resident when they are assisting the resident with dining. LN K stated staff should always sit next to the resident and be at eye level. On 03/13/24 at 04:02 PM, Administrative Nurse D stated she expected staff to be seated next to the resident during mealtimes. Administrative Nurse D stated staff should engage the resident during the meal while they assisted the resident. The facility's undated Resident' Rights policy documented the residents' right to be treated with dignity and respect was the foundation on which all other resident rights and responsibilities are (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based. The facility failed to ensure R16 was treated with dignity during dining. This deficient practice placed R16 at risk for weight loss and impaired dignity.The facility identified a census of 81 residents. The sample included 21 residents with two residents reviewed for dignity. Based on observation, record review, and interviews the facility failed to provide care in a respectful, dignified manner for Resident (R) 286 when staff failed to place R286's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) urine collection bag inside a dignity bag and failed to provide a dignified dining experience for R16 when staff stood beside R16 while assisting with a meal. This placed the residents at risk for impaired dignity and quality of life. Findings included: - On 03/12/24 at 07:32 AM an observation revealed R286's bedroom door was open, and he rested in his bed. R286's catheter urine collection bag hung from the side of his bed and had urine in it. A catheter dignity bag hung beside R286's urine collection bag. R286's catheter bag and urine were visible from the hallway outside of his room. On 03/12/24 at 08:25 AM Certified Nurse Aide (CNA) LL entered R286's room and left without placing R286's catheter bag inside the dignity bag. On 03/12/24 at 08:25 AM CNA MM entered R286's room and left without placing R286's catheter bag inside the dignity bag. On 03/13/24 at 02:13 PM, CNA N stated the catheter bags were hung on the side of the bed, below a resident's bladder, and placed inside a dignity bag. On 03/13/24 at 04:03 PM Administrative Nurse D stated if a resident was in bed, she expected staff to place the resident's catheter bag on the side of their bed, lower than their bladder, and that staff should have placed the catheter bag inside of a dignity bag. No policy related to dignity was provided by the facility. The facility failed to provide care in a respectful, dignified manner for R286 when staff failed to place R286's catheter bag inside a dignity bag. This placed R286 at risk for impaired dignity and quality of life.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 81 residents. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to include Resident (R) 12 in the development and planning of the resident's care plan, which placed R12 at risk of impaired care and autonomy. Findings included: - R12's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of acute and chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide) with hypoxia (inadequate supply of oxygen), obstructive sleep apnea (disorder of sleep characterized by periods without respirations), depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), seasonal allergic rhinitis (allergic reaction that causes sneezing, congestion, itchy nose and watery eyes), morbid obesity(excessive body fat), and Covid- 19 (highly contagious respiratory virus). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R12 required total assistance with bathing and dressing. The Functional Abilities Care Area Assessment (CAA) dated 03/13/23 documented R12 required total assistance with his activities of daily living (ADLs). The Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 03/13/23, documented R12 required total assistance with ADL. R12 required total assistance with toileting. R12 used a Hoyer (full body mechanical lift) lift with assistance from two staff to get in and out of bed, and in and out of the wheelchair. R12's Care Plan revised 12/01/23, documented R12 has a diagnosis of obsessive-compulsive disorder, anxiety disorder, depression disorder, agitation, and periods of isolation. R12's Care Plan documented the last care conference was on 11/29/22. The EMR lacked further documentation of care conferences. On 03/12/24 at 09:23 AM R12 stated he had not had a care conference in a long time, he stated he desired to participate. On 03/13/24 at 04:04 PM, Administrative Nurse D stated she had been doing the care plans, and care plans were updated when there were any changes with the resident. The facility's Care Plan Conference policy, revised 05/21, documented the facility identifies resident needs and establishes obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for each resident. The facility failed to include R12 in the development and planning of the resident's care plan placing the resident at risk for impaired care and autonomy.

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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 81 residents. The sample included 21 residents with two reviewed for reasonable accommodation of needs related to assistive devices. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)80's call light remained within his reach. The facility additionally failed to honor R12's preferences related to his bathing. This deficient practice left both residents vulnerable to impaired care and decreased autonomy. Findings Included: - The Medical Diagnosis section within R80's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), heart disease, anxiety disease, cognitive communication deficit muscle weakness, and gastroesophageal reflux disorder (GERD-backflow of stomach contents to the esophagus). R80's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he required substantial to maximal assistance with bed mobility. The MDS indicated he was at risk for the development of pressure ulcers. The MDS noted the use of pressure-reducing devices for his bed and chair. The MDS indicated he received hospice services (end-of-life comfort care). On 03/11/24 the Care Area Assessments (CAA) were not completed for R80. R80's Care Plan initiated 02/08/24 indicated he was at risk for pain, skin breakdown, pressure injuries, and decreased psychosocial wellbeing. The plan indicated he had a deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) on his coccyx (area of skin over the tailbone). The plan noted instructed staff to assess him for pain related to his pressure ulcer or its treatment. The plan noted for staff to turn and reposition him frequently. The plan indicated he used pressure-reducing devices on his bed and chair. On 03/11/24 at 07:28 AM R80 slept in his bed. His call light was on the floor underneath his bed. On 03/11/24 at 08:21 AM R80 slept in his bed. His call light was on the floor underneath his bed. At 08:50 AM R80 awoke and began yelling out help due to his call light being under his bed. Staff entered the room at 09:01 AM and gave him pain medication due to his pressure injuries. On 03/13/24 at 02:18 PM Certified Nurses Aid (CNA) S stated R80's call light should be placed within reach and staff should be checking its placement during each encounter. On 03/13/24 at 04:01 PM Administrative Nurse D stated staff were expected to ensure each resident's call light always remained within their reach. The facility's Call Light policy revised 01/2017 instructed staff to ensure the call lights were answered within a reasonable timeframe and remained within reach of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R80's call light remained within its reach. This deficient practice placed R80 at risk for preventable accidents and injuries. - R12's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of acute and chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide) with hypoxia (inadequate supply of oxygen), obstructive sleep apnea (a disorder of sleep characterized by periods without respirations), depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), seasonal allergic rhinitis (allergic reaction that causes sneezing, congestion, itchy nose and watery eyes), morbid obesity (excessive body fat), and Covid- 19 (highly contagious respiratory virus). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R12 required total assistance with bathing and dressing. R12's Functional Abilities Care Area Assessment (CAA) dated 03/13/23 documented R12 required total assistance with his activities of daily living (ADLs). The Activity of Daily Living Care Area Assessment (CAA), dated 03/13/23, documented R12 required total assistance for all ADLs. R12's Care Plan revised 12/01/23, documented R12 has a diagnosis of obsessive-compulsive disorder, anxiety disorder, depression disorder, agitation, and periods of isolation. R12's Care Plan lacked documentation related to his bathing schedule and preferences. R12's EMR under the Orders tab revealed the following physician orders: Shower schedule: Tuesday, Thursday, and Saturday from 03:00-11:00 PM, staff to complete the shower sheet after each shower. A review of R12's EMR revealed no bathing opportunities occurred in March. A review of the bathing sheets revealed R12 did not receive his shower on Saturday, 03/09/23 per his preference. On 03/11/24 at 02:11 PM, R12 stated he did not get his shower on 03/09/24. R12 stated he asked the Certified Nursing Aide CNA) on the evening shift on 03/10/24 if he could have a shower, but he still did not get a shower. On 03/12/24 at 09:22 AM R12 stated he still had not had a shower. R12 stated the CNA the previous evening and the CNA suggested R12 could wait until his scheduled day. On 03/12/24 at 09:50 PM, CNA N stated all residents can ask for a shower on any day. She stated the CNA staff tried to provide a shower to all who asked for one. On 03/13/24 at 10:55 PM, Licensed Nurse (LN) H stated all residents can ask for a shower on a day they are not scheduled. LN H stated the resident may have to wait until later in the day, but the aides did try to get all the showers done. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 02:00 PM in an interview, Administrative Nurse D stated that all residents could ask for a shower even if it was not their scheduled shower day. Administrative Nurse D said the CNAs would attempt to fit in unscheduled showers as soon as they were able. Administrative Nurse D stated the facility scheduled residents' showers to ensure all residents received a shower. The facility policy Resident Rights last revised 07/29/2021 documented: The right to be treated with dignity and respect is the foundation on which all other resident rights and responsibilities are based. To make sure surroundings are safe, clean, and comfortable; make it possible for you to keep and use your clothing and personal items to the extent space permits; provide safeguards against any kind of harsh or abusive treatment; avoid using restraints, unless they are necessary for medical reasons; and make it possible for you to share a room with your spouse. The facility failed to honor R12's preferences for bathing. This deficient practice left R12 vulnerable to impaired care and decreased autonomy.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. The facility reported a census of 81. Based on observations, record reviews, and interviews, the facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being and impaired quality of life. Findings Included: - A review of the Facility's Council Minutes from 03/2023 through 03/2024 indicated the council had recurring concerns with missing property and clothing, slow call light response and staff response time, staff cell phone use, lack of healthy snacks, specialized diets, and grievances not being resolved. The 03/2023 Resident Council Minutes documented recurring concerns related to call lights not being answered in the evening and missed showers for residents. The minutes indicated the council requested diabetic cookies be ordered for residents on special diets. The minutes lacked actions taken or outcomes for the repeat concerns. The 05/2023 Resident Council Minutes documented recurring concerns with missing property and slow call light response. The minutes indicated residents were encouraged to complete grievances to speed up the response time for missing items. The minutes lacked actions taken or outcomes for the repeat concerns. The minutes lacked actions taken or outcomes for the repeat concerns. The 06/2023 Resident Council Minutes documented ongoing concerns with call light response times. The minutes documented continued concerns about missing clothing. The minutes lacked actions taken or outcomes for the repeat concerns. The 07/2023 Resident Council Minutes documented ongoing concerns with slow call light response times. The minutes indicated concerns related to staff using phones and earbuds during shift making it difficult to hear call lights and calls for help. The minutes indicated staff re-education for the earbud usage. The 08/2023 Resident Council Minutes documented concerns that certain rooms were not being cleaned. The minutes indicated the usage of personal cellphones was out of control by staff. The council minutes indicated staff were still using earbuds. The council minutes request more low- low-carbohydrate-based foods. The council minutes requested fruits be always made available. The minutes lacked actions taken or outcomes for the repeat concerns. The 09/2023 Resident Council Minutes documented continued concerns with staff being on their cell phones during work. The council minutes noted ongoing concerns with lost laundry. The council minutes noted a resident's clothing was thrown in the trash instead of the laundry basket. The council minutes request the residents need more healthy snacks and fruits. The council minutes noted the facility ran out of snacks. The council reported some residents and staff may have been hoarding snacks. The minutes lacked actions taken or outcomes for the repeat concerns. The 10/2023 Resident Council Minutes noted old business noted continued concerns with staff cell phone usage, missing property, and aids throwing clothing in the trash instead of laundry baskets. The council minutes noted continued slow call light response on the night shift. The minutes indicated (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the need for more healthy snacks was still not resolved. The council minutes indicated continued concerns with a lack of nighttime snacks, healthy snacks, and special diet-based snacks. The 11/2023 Resident Council Minutes indicated continued staff cellphone usage and slow call light response were still not resolved. The council minutes noted concerns about missing laundry. The 01/2024 Resident Council Minutes indicated ongoing concerns related to slow call light response time. The council minutes noted some rooms were not being cleaned on certain days and continued concerns with staff using cell phones while on duty. The 02/2024 Resident Council Minutes indicated continued concerns with long call light responses, staff cellphone usage, and room cleanings. The minutes lacked actions taken or outcomes for the repeat concerns. The 03/2024 Resident Council Minutes indicated continued concerns with long call light responses, staff cellphone usage, and room cleanings. The minutes lacked actions taken or outcomes for the repeat concerns. On 03/12/24 at 02:00 PM, the Resident Council reported frustration with ongoing concerns about missing clothing, diabetic snacks, healthy snack choices, evening snacks, staff cell phones, and long call light wait times in the evening. The council reported concerns with the facility following up with reported concerns and not having the concerns resolved. On 03/13/24 at 09:12 AM Laundry Staff U stated resident's laundry was sent down labeled and washed separately from another resident. She stated the laundry was sent directly back up to the designated room. She stated that lost items may have occurred before being sent down. On 03/13/24 at 12:53 PM Activities staff Z stated she recorded the resident council minutes each month and was responsible for ensuring the concerns were given to the correct department head. She stated if council concerns were not addressed by the facility, she would return to the department head and ask why the identified concern was not resolved. She stated if an issue was outstanding or not resolved in a reasonable amount of the she would report it to the administrator. On 03/13/24 at 01:18 PM, Dietary BB stated that the facility always had snacks available. Dietary AA stated they tried to have a variety of chips, fruit, crackers, and at times made-up special snacks to be passed out to the residents in the evening. Dietary AA stated that in each dining area, there were snacks that were always out for the residents. Dietary AA stated if a resident preferred a snack other than what was on the cart the staff was able to get something else from the kitchen like sugar-free pudding or Jell-O. Dietary AA stated the chef was trying to order more of a variety of items and foods to suit the resident's preferences, but some food items were not always available. The facility did not provide a policy related to Resident Council as requested on 03/13/24. The facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being and impaired quality of life.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 81 residents. The sample included 21 residents with two residents reviewed for personal property. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 81's right to private communications when R81's package was opened. This placed R81 at risk for impaired privacy and decreased autonomy. Findings included: - R81's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lymphedema (swelling caused by the accumulation of lymph), cardiomyopathy (heart disease), congestive heart failure (a condition where the lower left chamber of the heart is not able to fill properly with blood during the diastolic phase, reducing the amount of blood pumped out to the body), and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) R81's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitively intact. A review of R81's MDS dated on 02/06/24 indicated no Care Area Assessments analysis were completed. R81's Care Plan revised on 02/05/24 indicated she was independent and self-directed in her activity choices. She enjoyed being creative in a variety of ways as well as participating in religious activities. A review of January 2024 and February 2024 Grievance Logs revealed no concerns related to R81's opened package and no resolution. On 03/12/24 at 07:20 AM, R81 sat in her room looking at the mail. R81's legs were wrapped with an ace wrap. She stated she would be leaving for breakfast soon. She said she had a package arrive sometime before the current month and went on to say the package had been opened, and the contents removed before the facility brought her the package. R81 stated she called her daughter and talked to Administrative Staff A. R81 stated the facility was still investigating. 03/13/24 at 04:01 PM, Administrative Staff A stated it was never the facility's intent for any resident mail to be opened. Administrate Staff A stated the facility investigated R81's package being opened, and the contents removed, but the facility could not determine what happened. The facility policy Resident Rights, documented the right to be treated with dignity and respect and, to make sure the surroundings were safe, clean, and comfortable. Provide safeguards against any kind of harsh or abusive treatment. The facility failed to ensure R81's right to private communications when R81's package was opened, and the contents were removed prior to R81 receiving the package. This placed R81 at risk for impaired privacy and decreased autonomy.

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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 81 with 21 residents included in the sample. The facility identified seven residents who were discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Skilled Nursing Facility Advance Beneficiary Notification (SNF ABN) form 10055 (the form used to notify Medicare A participants of potential financial liability when a Medicare Part A episode ends) for Resident (R) 12 and R 18. This failure placed the residents at risk for decreased autonomy and impaired decision-making. Findings included: - A review of R12's Electronic Medical Record (EMR) documented the Medicare Part A episode began on 12/13/23 and ended on 01/05/24. R12 remained in the facility for custodial care. The facility was unable to provide evidence that staff issued the SNF ABN 10055. A review of R18's EMR documented the Medicare Part A episode began on 01/02/24 and ended on 01/23/24. R18 remained in the facility for custodial care. The facility was unable to provide evidence that staff issued the SNF ABN 10055. On 03/12/24 at 11:25 PM Administrative Staff A stated that she was unaware she needed to use form 10055 with an estimated cost for continued services. Administrative staff A stated she was the one doing the ABN, but going forward it would be social services. The facility did not provide an Advance Beneficiary Notices policy. The facility failed to ensure the forms provided at the end of skilled services contained the required information for the residents to make informed choices and appeal the non-coverage decisions. This failure placed the residents at risk for decreased autonomy and impaired decision-making.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. The facility identified a census of 81 residents. The sample includes 21 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. The facility additionally failed to maintain the results of all grievances for the required three years. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances and concerns. Findings Included- - A review of the facility's Grievance Logs from March 2023 through March 2024 revealed the facility was missing logs from November 2023 through February 2024. The facility was unable to provide the missing documentation as requested on 03/13/24. On 03/12/24 at 08:00 AM an inspection of the facility revealed no designated grievance drop boxes or system available in the areas accessible to the residents and visitors of the facility. On 03/12/24 at 02:00 PM, the Resident Council members reported they were not aware if the facility provided a way to complete anonymous grievances. The council reported Social Services X was responsible for complaints and grievances. The council reported they had to get grievance forms from the front desk and then give them to staff to turn in to the appropriate person. On 03/13/24 at 12:25 PM, Social Service X stated the grievance forms were kept at the front desk and could be brought to the residents by staff. She stated a drop box was on the back wall of the administrative office, but she was not aware if the residents could turn the forms in themselves or anonymously. On 03/13/24 at 04:01 PM Administrative Staff A stated she was unable to locate the missing grievance logs due to recent changes in staffing. She stated the residents could file grievances using the facility's corporate grievance number but would not have paper records to show for it. The facility's provided Grievance policy revised 06/2021 indicated the facility would ensure each resident's right to file a grievance in writing, verbally, or anonymously. The policy indicated the facility would ensure the grievances were documented and ensure all written decisions included corrective actions and prompt resolution. The policy noted the grievance documentation will be kept for three years beyond the written decision. The facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously within the facility. The facility additionally failed to maintain grievance records. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances.

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	03/13/2024

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented a staff assessment was completed and indicated moderately impaired cognition. The MDS documented R16 required set-up assistance of staff with eating during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented that R16 required set-up assistance from staff with eating. R16's undated Nutritional Status Care Area Assessment (CAA) lacked a documented analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated 12/14/20 documented R16 was dependent on two staff members for assistance with eating. R16 's EMR under the Progress Notes tab documented a Nursing Progress Note dated 11/29/23 at 11:31 PM, recorded as a late entry on 11/30/23 at 01:16 AM, that noted R16 was sent to the hospital. On 12/04/23 at 01:57 PM a Nursing Progress Note documented R16 was readmitted from the hospital. The facility was unable to provide evidence a written notification was sent to the legal representative with information of where R16 was transferred and the reason for the facility-initiated transfer to the hospital. The facility was unable to provide evidence that the Long-Term Care Ombudsman (LTCO) was notified of the transfer to the hospital. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit beside R16. LN L sat down and continued to assist R16 with lunch. On 03/13/24 at 04:35 PM Administrative Nurse D stated that the business office was responsible for doing the bed holds and notification of transfer or discharge. Administrative Nurse D could not state if a written notification of the transfer was sent to R16 or her representative but said the representative was called and notified of the transfer. The facility's Facility Initiated Transfer/Discharge without Consent of Resident/Representative policy last revised in September 2022 documented that before a resident was transferred or discharged , the facility would send a written notice consistent with the discharge rights set forth to the resident and resident representative in a language and manner reasonably as soon as practicable. Included in the written notice would be the following information: the reason for transfer or discharge; the effective date of the transfer or discharge; the resident's right to appeal the transfer notice to the director of the Division of Aging or his/her designated hearing official within 30 days of the (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receipt of the notice; and information on how to obtain an appeal form. The facility failed to provide notification of a facility-initiated transfer to the LTCO for R16. The facility also failed to provide a written notice of transfer as soon as practicable to R16 and their representative. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R16. The facility identified a census of 81 residents. The sample included 21 residents with three residents sampled for discharge. Based on observation, record review, and interview the facility failed to provide notification to the State Long-term Care Ombudsman (LTCO) for Resident (R) 43 and R16's facility-initiated transfers. The facility failed to provide written notice of transfer as soon as practicable to R43 and R16 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R43 and R16. Findings included: - The electronic medical record (EMR) for R43 documented diagnosis of cerebral vascular incident (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), hypertension (elevated blood pressure), hemiplegia and hemiparesis (muscular weakness and paralysis of one side of the body). The Annual Minimum Data Set (MDS) dated 06/29/23 documented R43 had long and short-term memory problems. R43 had severely impaired cognitive skills for decision-making. R43 was dependent on staff for all activities of daily living (ADLs). R43's Cognition Care Area Assessment (CAA) dated 07/06/23 documented he had a history of a CVA with residual hemiparesis/hemiplegia. R43 was not able to speak. Staff had to anticipate his needs. Staff would continue to assist R43 so that his needs were met and help him maintain his current level of functioning without further decline. The Discharge MDS dated 12/05/23 for R43 documented an unplanned discharge to an acute hospital with an anticipated return to the facility. R43's Entry MDS dated 12/11/23 documented a reentry to the facility from an acute hospital. R43's Care Plan last revised on 01/04/24 documented R43 had no plans to be discharged from the facility and planned to stay at the facility. Staff was directed to review quarterly with the resident, his family, and the social services department for R43's potential to be discharged from the facility. R43's EMR documented a Progress Note dated 12/05/23 stating the resident was very lethargic and unable to respond as per his norm. The doctor recommended sending R43 to the hospital due to hypernatremia (high sodium level). R42 was transported to the hospital via ambulance. The nurse notified the resident's spouse of his condition. A Progress Note dated 12/11/23 for R43 documented he returned to the facility from an acute care hospital visit. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide evidence of a written notification of the facility-initiated transfer on 12/05/23. The facility was unable to provide evidence the LTCO was notified of the transfer. On 03/13/24 at 09:19 AM R43 lay in bed. He wore a hand splint on his right hand. On 03/13/24 at 12:35 PM Administrative Staff D stated a written notification of transfer had not been provided to R43 and his representative upon his discharge to the hospital, but going forward the written notification would be provided as indicated. On 03/13/24 at 04:35 PM Administrative Nurse D stated that the business office was responsible for doing the bed holds and notification of transfer or discharge. Administrative Nurse D could not state if written notification of the transfer was sent to R43 or his representative but said the representative was called and notified of the transfer. The facility policy Facility Initiated Transfer/Discharge without Consent of Resident/Representative revised September 2022 documented: Before a resident is transferred or discharged , the facility shall send a written notice consistent with the discharge rights set forth to the resident and resident representative in a language and manner reasonably as soon as practicable. Included in the written notice shall be the following information: the reason for transfer or discharge; the effective date of the transfer or discharge; the resident's right to appeal the transfer notice to the director of the Division of Aging or his/her designated hearing official within 30 days of the receipt of the notice; and information on how to obtain an appeal form. The facility failed to provide notification of a facility-initiated transfer to the LTCO for R43. The facility also failed to provide a written notice of transfer as soon as practicable to R43 and their representative. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R43.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with three residents sampled for discharge. Based on observation, record review, and interview, the facility failed to provide a bed hold with the required information to Resident (R) 43 and R16 and/or to their family representative when they were transferred to the hospital. This deficient practice placed the residents at risk for impaired ability to return to the facility or his same room. Findings included: - The electronic medical record (EMR) for R43 documented diagnosis of cerebral vascular incident (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), hypertension (elevated blood pressure), hemiplegia and hemiparesis (muscular weakness and paralysis of one side of the body). The Annual Minimum Data Set (MDS) dated 06/29/23 documented R43 had long and short-term memory problems. R43 had severely impaired cognitive skills for decision-making. R43 was dependent on staff for all activities of daily living (ADLs). R43's Cognition Care Area Assessment (CAA) dated 07/06/23 documented he had a history of a CVA with residual hemiparesis/hemiplegia. R43 was not able to speak. Staff had to anticipate his needs. Staff would continue to assist R43 so that his needs were met and help him maintain his current level of functioning without further decline. The Discharge MDS dated 12/05/23 for R43 documented an unplanned discharge to an acute hospital with an anticipated return to the facility. R43's Entry MDS dated 12/11/23 documented a reentry to the facility from an acute hospital. R43's Care Plan last revised on 01/04/24 documented R43 had no plans to be discharged from the facility and planned to stay at the facility. Staff was directed to review quarterly with the resident, his family, and the social services department for R43's potential to be discharged from the facility. R43's EMR documented a Progress Note dated 12/05/23 stating the resident was very lethargic and unable to respond as per his norm. The doctor recommended sending R43 to the hospital due to hypernatremia (high sodium level). R42 was transported to the hospital via ambulance. The nurse notified the resident's spouse of his condition. A Progress Note dated 12/11/23 for R43 documented he returned to the facility from an acute care hospital visit. The facility was unable to provide evidence that a bed hold was provided for the facility-initiated transfer on 12/05/23. On 03/13/24 at 09:19 AM R43 lay in bed. He wore a hand splint on his right hand. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 12:35 Administrative Staff A stated a bed hold notification had not been signed by R43's representative upon his discharge to the hospital on [DATE], but his file had a signed bed hold from his admission. On 03/13/24 at 04:35 PM Administrative Nurse D stated that the business office was responsible for doing the bed holds and notification of transfer or discharge. Administrative Nurse D could not state if a bed hold was completed upon R43's discharge on [DATE]. The facility did not provide a policy regarding bed holds. The facility failed to provide a bed hold with the required information to R43 and his family representative when R43 transferred to the hospital. This deficient practice placed R43 at risk for impaired ability to return to the facility or his same room. - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented a staff assessment was completed and indicated moderately impaired cognition. The MDS documented R16 required set-up assistance of staff with eating during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented that R16 required set-up assistance from staff with eating. R16's undated Nutritional Status Care Area Assessment (CAA) lacked a documented analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated 12/14/20 documented R16 was dependent on two staff members for assistance with eating. R16 's EMR under the Progress Notes tab documented a Nursing Progress Note dated 11/29/23 at 11:31 PM, recorded as a late entry on 11/30/23 at 01:16 AM, that noted R16 was sent to the hospital. On 12/04/23 at 01:57 PM a Nursing Progress Note documented R16 was readmitted from the hospital. The facility was unable to provide evidence a bed hold notification was provided to the legal representative when R16 was transferred to the hospital. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit beside R16. LN L sat down and continued to assist R16 with lunch. On 03/13/24 at 12:35 Administrative Staff A stated a bed hold notification had not been signed by R16's representative upon his discharge to the hospital on [DATE], but his file had a signed bed hold from his admission. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 04:35 PM Administrative Nurse D stated that the business office was responsible for doing the bed holds and notification of transfer or discharge. Administrative Nurse D could not state if a bed hold was completed upon R16's discharge on [DATE]. The facility was unable to provide a policy related to bed hold notification. The facility failed to provide a bed hold with the required information to R16 and her family representative when R16 transferred to the hospital. This deficient practice placed R16 at risk for impaired ability to return to the facility or his same room.

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	175182	A. Building B. Wing	03/13/2024

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. The facility identified a census of 81 residents. The sample included 21 residents. Based on record review and interviews, the facility failed to fully complete the comprehensive Minimum Data Set (MDS) assessment Section V, Care Area Assessment Summary (CAA) for Resident (R) 1, R3, R16, R17, R30, R3, R50, R52, R67, R80, R81, and R286 to include an analysis and rationale for care planning decisions. This placed these residents at risk for not accurately reflecting each resident's needs to develop an individualized comprehensive plan of care. Findings included: - R1's Annual MDS with assessment reference date (ARD) of 02/02/24 Section V Care Area Assessment (CAA) was not completed to include an analysis and rationale for care planning decisions. R3's Annual MDS with ARD of 10/10/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R16's Annual MDS with ARD of 12/23/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R17's admission MDS with ARD of 03/02/24 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R30's Significant Change MDS with ARD of 10/20/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R31's Annual MDS with ARD of 01/25/24 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R50's Annual MDS with ARD of 11/13/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R52's admission MDS with ARD of 02/29/24 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R67's Annual MDS with ARD of 10/16/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R80's admission MDS with ARD of 02/29/24 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R81's admission MDS with ARD of 02/20/24 Section V CAA was not completed to include an analysis and rationale for care planning decisions. R286's MDS with ARD of 12/28/23 Section V CAA was not completed to include an analysis and rationale for care planning decisions. On 03/13/24 at 12:35 PM Administrative Nurse D stated that she had completed the MDS and had (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed the assessments for residents. Administrative Nurse D stated at the end of the assessments that had a section V, she was not able to close that section until she had validated it or finalized the section. Administrative Nurse D stated she did not realize that there was a separate page to go in to document the analysis data for information that needed to be added to the care plan. Administrative Nurse D stated after she had signed that page it would take her back to the original page with all the sections on it and at that allowed her to validate everything and finalize the section without completing the worksheets. The Resident Assessment Instrument Manual version 3.0 states, that the CAA process provides a framework for guiding the review of triggered areas and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care. Upon request, the facility did not provide a policy for Minimum Data Set Completion. The facility failed to complete comprehensive MDS Section V, CAA for R1, R3, R16, R17, R30, R31, R50, R52, R67, R80, R81, and R286 which placed these residents at risk for not accurately reflecting each resident's status and needs, to develop an individualized comprehensive plan of care.

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	03/13/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition The facility identified a census of 81 residents. The sample included 21 residents. Based on observation, record review and interviews, the facility failed to complete a comprehensive Significant Change Minimum Data Set (MDS) assessment of Resident (R) 24 after the addition of hospice services to identify needs, in order to develop an individualized comprehensive plan of care. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory, confusion), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes), weakness, and hypertension (HTN-elevated blood pressure) The Annual MDS dated 03/03/23 documented that a Brief Interview of Mental Status (BIMS) should be conducted but was not done. R24's MDS documented she had not received hospice services. R24's EMR recorded a Quarterly MDS done on 07/21/23 that recorded R24 had not received hospice services. R24's Quarterly MDS dated 10/21/23 documented she was receiving hospice services. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/03/24 lacked an analysis. R24's Care Plan revised 12/04/23 documented that R24 was independent with ambulation, and completing activities of daily living (ADLs), but may need staff assistance due to dementia, general weakness, and potential medication side effects. The plan revised on 12/20/23 documented R24 elected to have hospice care. R24's EMR under the Orders tab for R24 dated 08/17/23 documented R24 was to be admitted to hospice services for dementia. A review of R24's clinical record lacked evidence the facility completed a Significant Change MDS to address the resident's recent physical decline and addition of hospice services within the required timeframe. On 03/12/24 at 07:26 AM R24 walked to breakfast with a walker. On 03/13/24 at 10:27 AM R24 sat with a group of residents and participated in an exercise class. On 03/13/24 at 04:02 PM, Administrative Nurse D stated she was currently doing the MDS. Administrative Nurse D stated she would start a significant change in MDS on the eighth day after hospice services were added to the resident's care and completed by day 14 after hospice was added. The RAI Manual documented that a Significant Change MDS must be completed no later than 14 days after a resident was admitted to hospice services. The facility did not provide an MDS policy. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to identify the addition of hospice services for R24 as a significant change and complete a comprehensive Significant Change MDS. This placed the resident at risk for unidentified care needs.

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	175182	A. Building B. Wing	03/13/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents. Based on observation, record review, and interviews, the facility failed to complete an accurate Minimum Data Set (MDS) assessment for Resident (R) 47's status regarding the use of a restraint. This deficient practice placed R47 at risk for inappropriate care planning and care needs. Findings included: - R47's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cognitive communication deficiency, difficulty walking not elsewhere classified, and hypertension (HTN-elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented that the Brief Interview of Mental Status (BIMS) was not completed. The MDS documented R47 was independent with walking during the observation period. The Quarterly MDS dated 10/23/23 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R47 was independent with walking during the observation period. The MDS documented R47 used a trunk restraint less than daily during the observation period. The Quarterly MDS dated 01/15/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R47 was independent with walking during the observation period. The MDS documented R47 used a trunk resident less than daily during the observation period. R47's Falls Care Area Assessment (CAA) dated 05/09/23 documented R47 was independent with ambulation with the use of her rolled walker. R47's Care Plan dated 08/22/23 documented she ambulated independently with a four-wheeled walker. The plan of care lacked direction for a trunk restraint. R47's EMR under the Orders tab lacked evidence of a physician order for a trunk restraint. A review of R47's clinical record lacked evidence of a facility assessment for a trunk restraint. On 03/12/24 at 01:55 PM, R47 sat on the couch with her four-wheeled walker in reach. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated she was not aware of any residents in the facility that had an order for any type of restraint. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated he did not know of any resident that had an order for a restraint. On 03/13/24 at 04:02 PM, Administrative Nurse D stated there were no residents in the facility with a current restraint order. Administrative Nurse D stated she was not aware R47's MDS was marked for use of a trunk restraint. Administrative Nurse D stated that would be an error. The facility's Restraint management policy last reviewed in May 2021 documented this policy was to (continued on next page)

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	03/13/2024

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abide by the resident's right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. A restraint is any method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to their body. It was the policy of the facility to promote a restraint-free environment. Restraints would be used on a limited basis to ensure the immediate physical safety of the resident or other residents and only upon the written order of a physician that specifies the medical signs and symptoms and the circumstances under which the specific restraints are to be used, except in emergencies. Assessment of Restraint: If a restraint use was deemed necessary, the goal would be to use the least restrictive type for the shortest period possible. Restraints would only be used to enable the treatment of medical symptoms or as a therapeutic intervention. Each resident must be assessed on an individual basis. Order obtained from Physician. The facility's Physical Restraint Weekly Form would be completed by the charge nurse or nurse manager upon application of a restraint and reviewed weekly for four weeks and quarterly to ensure assistive devices are consistent with the resident's needs. Quarterly reviews would be completed on the Physical Restraint Quarterly form. Interventions would be care planned. Provide an ongoing assessment for change of condition. Provide appropriate training for the use of assistive devices for caregivers. Properly maintain resident's equipment. The facility failed to accurately document R47's status on the MDS for the use of a trunk restraint that was not ordered. This deficiency placed R47 at risk for inappropriate care planning and care needs.

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	175182	A. Building B. Wing	03/13/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with 21 residents reviewed for baseline care plans. Based on observation, record review, and interviews, the facility failed to identify Resident (R)82's required level of care assistance and her high-risk medication (Seroquel- antipsychotic medication used to treat major mental conditions that cause a break from reality) on her care plan. The facility additionally failed to complete a baseline care plan for R81. This deficient practice placed both residents at risk for preventable falls and injuries due to uncommunicated care needs. Findings included: - R82 admitted to the facility on [DATE]. The Medical Diagnosis section within R82's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), fracture (bone break) of the right femur (large leg bone), insomnia (difficulty sleeping), and history of falls. R82's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she required partial to moderate assistance with transfers, bed mobility, grooming, ambulation, personal hygiene, and bathing. The MDS indicated she had no psychosis (any major mental disorder characterized by a gross impairment in reality perception) or behavioral symptoms. The MDS indicated she was taking antipsychotic medication (medication used to treat major mental conditions that cause a break from reality) on a routine basis. A review of R82's EMR on 03/12/24 indicated no Care Area Assessments were completed. R82's Care Plan initiated 02/21/24 indicated she had a deficit in her activities of daily living (ADL) self-care related to her recent leg fracture and dementia. The plan instructed staff to assist as indicated but did not indicate the level of staff/assistance she required for her ADLs. The plan did not identify or address R82's Seroquel. R82's EMR under Physician Orders indicated an admission order date of 02/22/24 for 25 milligrams (mg) of Seroquel to be given twice daily by mouth for delusion, agitation, and behaviors. On 02/27/24 the dosage was reduced to 25mg once daily and increased back to 25mg twice daily on 03/05/24. On 03/12/24 at 11:04 AM R82 slept in her bed as her representative watched television in her room. R82's representative stated that R82 had improved walking with her walker but required close staff interaction and assistance due to recovery from her recent hip fracture. He stated the Seroquel medication was started at the acute care facility while her hip fracture was being repaired. On 03/13/24 at 02:18 PM, Certified Nurses Aid (CNA) S stated the care plan should include interventions identifying which residents required what level of assistance from staff. She stated that R82 had a history of falls and required contact guard assistance with a gait belt for transfers. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated the baseline care plan should identify (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	high-risk medications and note what monitoring each medication required and the side effects of each medication. On 03/13/24 at 04:01 PM Administrative Nurse D stated the baseline care plans should instruct staff of the level of assistance required for each activity each resident required. She stated high-risk medications she be included within the plan to help identify side effects and needed monitoring. The facility's Care Plan policy revised 05/2021 indicated the care plan will reflect each resident's appropriate care levels and assistance needs. The policy noted the plan should reflect the resident care needs, treatment goals, medication, and risks associated with care. The facility failed to identify R82's required level of care assistance and her Seroquel medication on her baseline care plan. This deficient practice placed both residents at risk for preventable falls and injuries due to uncommunicated care needs.

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	03/13/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, history of traumatic brain injury, hypertension (HTN-elevated blood pressure), chronic pain, myalgia (muscle pain), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented required partial to moderate assistance with personal hygiene during the observation period. The Quarterly MDS dated 01/18/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented required partial to moderate assistance with personal hygiene during the observation period. R30's undated Functional Abilities Care Area Assessment (CAA) lacked an analysis of her care areas triggered by the significant change MDS dated [DATE]. R30's Care Plan dated 02/25/21 documented that nursing staff would assist R30 with bathing two times a week and as needed. The plan of care lacked direction to the nursing staff of R30's preference for facial hair. On 03/12/24 at 11:37 AM R30 sat in her wheelchair at the dining room table as she colored her pictures. R30 had very long chin hairs noted, R30 stated she had forgotten to ask the staff to trim her chin hairs during her last few baths. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated she was not sure what R30's preference was for trimming her facial hair and that would be something that should be on R30's plan of care. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated a resident's personal preferences should be added to the care plan. On 03/13/24 at 04:02 PM, Administrative Nurse D stated if the resident let the facility know the resident's preference concerning facial hair, that information would be added to the care plan. The facility's Care Plan Conference, Interdisciplinary policy last revised in May 2021 documented an Interdisciplinary Care Planning Conference that identified the resident's needs and established obtainable goals. An appropriate plan of action was designed to ensure optimal levels of activity and independence for all residents. The facility failed to ensure R30's comprehensive care plan included her personal preference regarding trimming her facial hair was included on the person-centered care plan. This deficient practice placed R30 at risk of her at risk for impaired care due to uncommunicated care needs.The facility identified a census of 81. The sample included 21 with 21 reviewed for comprehensive care plans. Based on observation, record review, and interview, the facility failed to develop comprehensive care plans for Resident (R)80, R30, and R81. The deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings Included: -R80 admitted to the facility on [DATE]. The Medical Diagnosis section within R80's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), heart disease, anxiety disease, cognitive communication deficit muscle weakness, and gastroesophageal reflux disorder (GERD-backflow of stomach contents to the esophagus). R80's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he required substantial to maximal assistance with bed mobility. The MDS indicated R80 was dependent on staff for dressing, bathing, and toileting. The MDS indicated he was at risk for the development of pressure ulcers. The MDS noted the use of pressure-reducing devices for his bed and chair. The MDS indicated he received hospice services (end-of-life comfort care). On 03/11/24 the Care Area Assessments (CAA) were not completed for R80. R80's Care Plan initiated 02/08/24 indicated he required he was at risk for was at risk for pressure injuries/ulcers, decreased psychosocial wellbeing, and decline in activities related to his medical diagnoses. The plan indicated he required assistance from staff for his activities of daily living (ADLs) but lacked documentation related to his bowel incontinence and Foley Catheter. The plan lacked documentation showing R80 was dependent on staff for dressing, bathing, and toileting. The plan lacked documentation showing R80's low-air-loss mattress and settings. On 03/11/24 at 08:21 AM R80 slept in his bed. His call light was on the floor underneath his bed. R80's bed had a Drive Model #14530 pump attached to his alternating air mattress. The weight setting on his air pump was 150 lbs. At 08:50 AM R80 awoke and began yelling out help due to his call light being under his bed. Staff entered the room at 09:01 AM and gave him pain medication due to his pressure injuries. On 03/13/24 at 08:11 AM R80 was awake in his bed. He stated the mattress setting was changed and he felt more comfortable. An inspection of the indicated the weight settings was 120 lbs. On 03/13/24 at 02:25 PM Licensed Nurse (LN) K stated the care plan should reflect R80's specific treatment goals, care needs, assistance levels, preferences, and risk areas for interventions. On 03/13/24 at 12:23 PM Administrative Nurse D stated she completed the comprehensive assessments on each resident and the information was carried over to help develop the care comprehensive plans. She stated some of the residents ' CAAs may not have been completed due to her misunderstanding of the online assessment system. She stated the comprehensive care plans should reflect each resident's individual goals, treatments, preferences, and needs from the MDS assessments. The facility's Care Plan policy revised 05/2021 indicated the care plan will reflect each resident's appropriate care levels and assistance needs. The policy noted the plan should reflect the resident's care needs, treatment goals, medication, and risks associated with care. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop comprehensive care plans for R80 related to his air mattress settings. The deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. - R81's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of lymphedema (swelling caused by the accumulation of lymph), cardiomyopathy (heart disease), congestive heart failure (a condition where the lower left chamber of the heart is not able to fill properly with blood during the diastolic phase, reducing the amount of blood pumped out to the body), and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) R81's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitively intact. A review of R81's MDS dated [DATE] indicated none of the triggered Care Area Assessments (CAA) were completed. R81's Care Plan revised on 02/05/24 indicated she was independent and self-directed in her activity choices. R81 was very independently active. She enjoyed being creative in a variety of ways as well as participating in religious activities. R81's Care Plan lacked care plan interventions related to R81's insulin (a hormone that lowers the level of glucose in the blood), and the use of her daily leg wraps. R81's EMR recorded a Physician's Order dated 02/06/24 that documented staff should wrap R81's legs (toes to knees) with compression wrap in the morning, before getting out of bed. Wrap legs between 05:30 -06:30 AM but not at 0500 per resident request. Apply compression pump, as needed (PRN) per resident request due to lymphedema. R81's EMR recorded a Physician's Order dated 02/20/224 that documented to give Lantus (long-acting insulin pen) 13 units and hold if blood sugar is less than 100 or if nothing by mouth at bedtime. R81's EMR recorded a Physician's Order dated 02/21/24 that documented to give Novolog U-100 (short-acting insulin) per sliding scale and call the physician if blood sugar is under 70. On 03/13/24 at 08:12 AM R81 left for an out-of-facility physician appointment. On 03/13/24 at 12:23 PM, Administrative Nurse D stated she completed the comprehensive assessments on each resident, and the information was carried over to help develop the care comprehensive plans. She stated some of the residents ' CAAs may not have been completed due to her misunderstanding of the online assessment system. She stated the comprehensive care plans should reflect each resident's individual goals, treatments, preferences, and needs from the MDS assessments. On 03/13/24 at 04:01 PM Administrative Nurse D stated the care plans should instruct staff of the level of assistance required for each activity each resident required. She stated high-risk medications should be included within the plan to help identify side effects and needed monitoring. The facility's Care Plan policy revised 05/2021 indicated the care plan will reflect each resident's appropriate care levels and assistance needs. The policy noted the plan should reflect the (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care needs, treatment goals, medication, and risks associated with care. The facility failed to develop and implement a comprehensive, person-centered care plan for R81 This deficient practice placed R81 at risk for impaired care due to uncommunicated care needs.

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	03/13/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R52's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral infarction (stroke - the 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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and contracture (abnormal permanent fixation of a joint or muscle) of the left hand. The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R52 had impairment on one upper extremity during the observation period. The Quarterly MDS dated 01/06/24 documented a BIMS score of 13 which indicated intact cognition. The MDS documented R52 had impairment on one upper extremity during the observation period. R52's undated Functional Abilities Care Area Assessment (CAA) lacked an analysis of her care area triggered by the admission MDS dated [DATE]. R52's Care Plan dated 12/11/20 documented she required a wheelchair for mobility and was dependent on staff assistance to propel her. The plan of care documented R52 had a left armrest on her wheelchair. The plan of care lacked direction for R52's left-hand splint. R52's EMR under the Orders tab revealed the following physician orders: R52 was to have a left-hand splint 24 hours a day and seven days a week with skin checks, repositioning, and hand washing during every shift dated 10/09/23. On 03/13/24 at 07:29 AM Certified Nurse Aide (CNA) N pushed R52 up to the dining room table in her wheelchair. R52 did not have her left hand splint on as ordered. R52 stated she should always have it on, but some days staff forget to put it on her left hand. On 03/13/24 at 02:13 PM, CNA N stated the care and information about the application of R52's left-hand splint should be on her plan care. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated the information and care for R52's left-hand splint should be included in her plan of care. On 03/13/24 at 04:02 PM, Administrative Nurse D stated the resident's plan of care should have the information for any splints when the splint was to be worn, the reason the splint was worn, and the care of the splint. The facility's Care Plan Conference, Interdisciplinary policy last revised in May 2021 documented an Interdisciplinary Care Planning Conference that identified the resident's needs and established obtainable goals. An appropriate plan of action was designed to ensure optimal levels of activity and independence for all residents. The facility failed to revise R52's comprehensive care plan with the application of her left-hand splint on the person-centered care plan. This deficient practice placed R52 at risk of worsening (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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	contractures and further loss of independence with ADLs. The facility identified a census of 81 residents. The sample included 21 residents with 21 residents reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R)61's plan of care to include her spironolactone medication (diuretic- medication to promote the formation and excretion of urine) and R24's plan of care to include her Eliquis medication (anticoagulant- used to treat and prevent blood clots). The facility additionally failed to revise R52's Care Plan to include her ordered left-hand splint. The deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. Findings Included: - R61 admitted to the facility on [DATE]. The Medical Diagnosis section within R61's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. R61's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 11 indicating mild cognitive impairment. The MDS indicated she required substantial to maximal assistance with dressing, transfers, and bathing. The MDS indicated she took an antidepressant (a class of medications used to treat mood disorders) and diuretic medications. R61's Psychotropic Medication Care Area Assessment (CAA) started on 03/12/24 indicated she took antidepressant medication. The CAA instructed staff to monitor her for behaviors and side effects. R61's Care Plan initiated 07/09/23 indicated she had limits in her cognition that could impact her safety awareness and decision-making abilities. The plan indicated she took Lexapro (an antidepressant) for depression. The plan noted staff will monitor her for changes in her behaviors and side effects related to the antidepressant medications. The plan lacked information related to her spironolactone. R61's EMR under Physician's Order indicated an order started on 07/13/23 for 25 milligrams (mg) of spironolactone by mouth once daily. On 03/11/24 at 08:30 AM R61 was pushed out of her room to the 200 hall dining area. She was positioned at a bedside table in front of the nurse's station. R61 wore shoes and her feet slid on the floor from her room to the dining area. Her wheelchair did not have foot pedals attached. On 03/13/24 at 02:25 PM Licensed Nurse (LN) K stated care plan should identify high-risk medications and note what monitoring each medication required and the side effects of each medication. On 03/13/24 at 04:00 PM Administrative Nurse D stated the care plans should instruct staff of the level of assistance required for each activity each resident required. She stated high-risk medications should be included within the plan to help identify side effects and needed monitoring. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plan policy revised 05/2021 indicated the care plan will reflect each resident's appropriate care levels and assistance needs. The policy noted the plan should reflect the resident's care needs, treatment goals, medication, and risks associated with care. The facility failed to revise R61's Care Plan to include her spironolactone medication. This placed R61 at risk for impaired care due to uncommunicated care needs. - R24's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes), weakness, and hypertension (HTN-elevated blood pressure) The Annual MDS dated 03/03/23 documented that a Brief Interview of Mental Status (BIMS) should be conducted but it was not done. R24 received an anticoagulant (a medication that thins the blood) during the observation period. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/03/24 lacked an analysis. R24's Care Plan dated 12/03/23 documented the resident received medications that have a Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration), increasing her risk for adverse consequences. R24's Care Plan lacked direction for staff to ensure monitoring for anticoagulant side effects. R24's EMR dated 04/12/23 documented a Physician's order which directed to give Eliquis (anticoagulant) tablet 2.5 milligrams (mg) twice daily in the morning and at bedtime. On 03/12/24 at 07:26 AM R24 walked to breakfast with a walker. On 03/13/24 at 10:27 AM R24 sat with a group of residents and participated in an exercise class. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated the care plan should identify high-risk medications and note the monitoring of each medication required and the potential side effects. On 03/13/24 at 04:01 PM Administrative Nurse D stated high-risk medications should be included within the plan to help identify side effects and necessary monitoring. The facility's Care Plan Conference, Interdisciplinary policy last revised in May 2021 documented an Interdisciplinary Care Planning Conference that identified the resident's needs and established obtainable goals. An appropriate plan of action was designed to ensure optimal levels of activity and independence for all residents. The facility failed to revise R24's Care Plan to reflect her use of an anticoagulant. This deficient practice placed R24 at risk for impaired care due to uncommunicated care needs.

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	03/13/2024

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide the necessary assistance with personal hygiene for Resident (R) 30. This deficient practice placed R30 at risk for poor hygiene, decreased self-esteem, and impaired dignity. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, history of traumatic brain injury, hypertension (HTN-elevated blood pressure), chronic pain, myalgia (muscle pain), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented required partial to moderate assistance with personal hygiene during the observation period. The Quarterly MDS dated 01/18/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented required partial to moderate assistance with personal hygiene during the observation period. R30's undated Functional Abilities Care Area Assessment (CAA) lacked an analysis of her care areas triggered by the significant change MDS dated [DATE]. R30's Care Plan dated 02/25/21 documented that nursing staff would assist R30 with bathing two times a week and as needed. The plan of care lacked direction to the nursing staff of R30's preference for facial hair. On 03/12/24 at 11:37 AM R30 sat in her wheelchair at the dining room table as she colored her pictures. R30 had very long chin hairs noted, R30 stated she had forgotten to ask the staff to trim her chin hairs during her last few baths. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated staff should offer to trim facial hair and nails during bathing. CNA N stated she was not sure what R30's preference was for trimming her facial hair and that would be something that should be on R30's plan of care. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated staff should offer assistance with personal hygiene during bathing, dressing, and as needed. LN K stated a resident's personal preferences should be added to the care plan. On 03/13/24 at 04:02 PM, Administrative Nurse D stated if the resident let the facility know their preference concerning facial hair, that information would be added to the care plan. Administrative Nurse D stated the nursing staff should offer assistance during bathing to trim their nails or facial hair. The facility was unable to provide a policy related to personal hygiene. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R30 received assistance with her trimming her facial hair. This deficient practice placed her at risk for poor hygiene, decreased self-esteem, and impaired dignity.R30's Care Plan dated 02/25/21 documented nursing staff would assist R30 with bathing two times a week and as needed. The plan of care lacked direction to nursing staff of R30's preference for facial hair. On 03/12/24 at 11:37 AM R30 sat in her wheelchair at the dining room table as she colored her pictures. R30 had very long chin hairs noted, R30 stated she had forgotten to ask the staff to trim her chin hairs during her last few baths. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated staff should offer to trim facial hair and nails during bathing. CNA N stated she was not sure what R30's preference was for trimming her facial hair and that would be something that should be on R30's plan of care. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated staff should offer assistance with personal hygiene during bathing, dressing and as needed. LN K stated a resident's personal preferences should be added to the care plan. On 03/13/24 at 04:02 PM, Administrative Nurse D stated if the resident would let the facility know what their preference concerning facial hair, then that information would be added to the care plan. Administrative Nurse D stated the nursing staff should offer assistance during bathing to trim their nails or facial hair. The facility was unable to provide a policy related to personal hygiene. The facility failed to ensure R30 received assistance with her trimming her facial hair. This deficient practice placed her at risk for poor hygiene, decreased self-esteem, and impaired dignity.

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	175182	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for quality of care. Based on observation, record review, and interview, the facility failed to provide services to maintain Resident (R) 31's highest practicable level of physical function and promote comfort. The facility further failed to implement the protective sleeve (sleeve used to protect the skin on the arms and legs against damage caused by friction and shearing) to R67's right arm per the order and care plan. This deficient practice placed R31 at risk for increased impairment, pain, and contractures (abnormal fixation of a joint or muscle) and placed R67 at risk for skin injury. Findings included: - R31's Electronic Medical Record (EMR) documented a diagnosis of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia (a progressive mental disorder characterized by failing memory, confusion), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Annual Minimum Data Set (MDS) dated [DATE] noted the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R31 had problems with recall ability and short-term and long-term memory. The MDS further documented R31 had severely impaired cognitive skills for daily decision-making and that R31 never or rarely made decisions. The MDS documented R31 was dependent on staff for all activities of daily living (ADL). The MDS documented R31 was not on a restorative program and was on hospice. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) triggered but lacked an analysis. R31's Care Plan with a problem start date of 08/25/20, documented R31 was dependent on staff for ADL related to the disease progression of her Parkinson's and dementia. An approach with a start date of 04/13/21, directed staff to follow occupational, physical, and speech therapy recommendations and documented an occupational recommendation that directed staff to use the tilt function of R31's wheelchair at appropriate times for postural alignment. A goal with a target date of 09/26/23, documented R31 would not deteriorate in ADLs further as evidenced by maintained proper body alignment in the Broda chair (specialized wheelchair with the ability to tilt and recline) through the next review date. R31's Care Plan with a problem start date of 12/26/23, documented that R31 was on hospice services. An Occupational Therapy OT Discharge Summary with dates of service of 12/18/23 - 12/26/23, documented wedges were added to R31's upper extremities to increase neutral alignment and a fair sitting position. The discharge summary further documented R31 had made consistent progress with skilled interventions and that R31 was discharged from skilled services due to R31's return to hospice services. On 03/11/24 at 09:53 AM R31 sat in her Broda chair in the dining room. R31 leaned to the right side of her Broda chair with her arms held across her chest. Her hands were closed, and her knees were together. R31's neck was bent to the right side and the side of her head rested on her right shoulder. On 03/13/24 at 09:17 AM R31 sat in her Broda chair in the dining room. R31 was placed in front of (continued on next page)

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the TV by staff. R31's neck was bent to the right and the side of her head rested on her right shoulder. R31's arms were across her chest and her hands were closed. On 03/13/24 at 02:02 PM, an observation revealed R31 rested in her bed in her room. R31 laid on her back but leaned to the right. Her neck was bent to the right side, and the side of her head rested on her right shoulder. R31 had a thin pillow that was under her right shoulder. A document posted on the wall above R31's bed directed staff to add a long wedge under R31's right side to promote neutral posture of her hip and pelvis, place a pillow between her knees for increased comfort, and place a small wedge under a pillow on the right side to decrease right lateral leaning of R31's head. R31 had positioning wedges on her bedside table and there were no wedges placed under her pillow, on her right side, and no pillow was placed between her knees. On 03/13/24 at 10:39 AM Administrative Staff B stated R31 went on hospice on 01/31/22 and came off hospice on 11/18/23 then later went back on hospice services on 12/26/23. Administrative Staff B stated R31 received skilled therapy from 12/02/21 through 01/07/22 and again on 12/24/21 through 01/18/22 and R31 was placed on a skilled maintenance plan. Administrative Staff B stated there were no records of R31 being placed on a restorative plan and no record that R31 received any restorative services while on hospice. Administrative Staff B further stated skilled services would have ended while R31 was in hospice and she was unsure if restorative services would have been provided to R31. On 03/13/24 at 10:54 AM Administrative Staff A stated restorative services could have been provided to residents who were on hospice and should not have been stopped services due to a resident being on hospice. On 03/13/24 at 12:41 PM Therapy Consultant HH stated she worked with R31 when R31 came off hospice services. Consultant HH stated that R31 never went on a restorative program after skilled services ended. Consultant HH further stated she worked with R31 on her wheelchair and neck positioning. Consultant HH stated R31 had some right lean to her posture and neck when she was admitted , and R31 was making progress with skilled services. She went on to say R31's alignment and neck position were worse since skilled services ended. Consultant HH stated she was allowed to work with R31 while the resident was on hospice for a short period to train staff on how to properly position R31 and stated staff were supposed to use the wedges to help maintain R31s position and alignment while R31 was in bed. Consultant HH stated she attempted to reach out to the hospice nurse to provide education on how to work with and position R31 however, the hospice nurse did not meet with her. Consultant HH stated that restorative-type services had not been provided to residents on hospice in the facility. On 03/13/24 at 02:53 PM, Licensed Nurse (LN) G stated R31's alignment and positioning had become much worse. LN G stated R31's neck had moved further down, and she did not believe R31 was safe while eating due to the position of the resident's head. On 03/13/24 at 04:00 PM Administrative Staff B stated she spoke to one of the facility's restorative aides, Certified Nurse Aide (CNA) NN, and stated CNA NN reported to her that R31 had never received restorative services including positioning, or since R31 stopped therapy. On 03/13/24 at 04:03 PM Administrative Staff A stated hospice residents should have received restorative services at the facility. Administrative Staff A further stated restorative services were provided in-house and were not part of a therapy program and residents should not have been precluded due to being on hospice services. (continued on next page)

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	03/13/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a Restorative Therapy Program with a revised date of 5/2021, documenting it is the policy of the facility to assist each resident to attain and, or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal regulations. The facility failed to provide services to maintain R31's highest practicable level of physical function and failed to promote comfort. This deficient practice placed R31 at risk for further impairment, pain, and contractures. - R67 ' s Electronic Medical Record (EMR) documented a diagnosis of cerebral infarction (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), and hemiplegia (paralysis of one side of the body). The Annual Minimum Data Set (MDS) dated [DATE], noted the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R67 had problems with recall ability and short-term and long-term memory. The MDS further documented R67 had severely impaired decision-making abilities. The MDS documented R67 used a wheelchair and was dependent on staff for all activities of daily living (ADL) including mobility and transfers. The MDS further documented R67 was at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). R67's Cognitive Loss/Dementia Care Area Assessment (CAA) triggered but lacked an analysis. R67 ' s Care Plan with a problem start date of 09/13/22, documented R67 was at risk for skin breakdown due to reduced mobility and a history of cerebrovascular accident (CVA - stroke) with residual hemiparesis (muscular weakness of one half of the body). An approach with a start date of 09/13/22 documented that R67 had two open wounds to her right elbow, and the nurse practitioner recommended for R67 to wear a protective sleeve on her right arm to help aid in healing and to prevent further skin injury. An Order with a start date of 03/09/23, documented for R67 to wear a right arm sleeve daily when up in her wheelchair. Review of the View 14 Day Administration History dated 02/29/24 through 03/13/24, Licensed Nurse (LN) G documented on 03/11/24 and 03/12/24 for the 07:00 AM to 03:00 PM shift, yes in the on and yes in the off boxes for R67 ' s right arm sleeve order. A review of R67's progress notes for 03/11/24 and 03/12/24 lacked evidence of a refusal from R67 to wear the right arm sleeve. On 03/11/24 at 09:58 AM R67 sat in her wheelchair in the dining room. R67's right arm was strapped to an armrest cushion for her right arm. R67 did not have a right arm sleeve on her right arm. On 03/11/24 at 12:21 PM, R67 sat in her wheelchair in the dining room with her right arm strapped to a right armrest cushion. R67 did not have a right arm sleeve on. On 03/12/24 at 11:00 AM, R67 sat in her wheelchair in front of the TV in the dining room. R67's right armrest cushion was in place; however, R67's right arm was not strapped to the cushion at that time. R67 did not have a sleeve on her right arm. (continued on next page)

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	03/13/2024

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 08:58 AM LN G stated R67's sleeve documentation could be interpreted by staff in different ways. LN G stated when she documented yes in the on box and yes in the off box, that it meant yes, the sleeve was off and yes, she put it on. LN G stated other staff may have documented it differently. On 03/13/24 at 02:53 PM, LN G stated sometimes R67's sleeve would be taken to the laundry and did not always make it back to the resident in time. LN G stated they did not have a backup sleeve for R67 and that it might have been in the laundry. LN G stated that R67 had gotten better, but it was still supposed to be on. On 03/13/24 at 04:03 PM in a joint interview with Administrative Staff A, Administrative Staff B, and Administrative Nurse D, Administrative Staff A was unable to say if staff charted yes in both on and off boxes meant the sleeve was in place or not. Administrative Nurse D stated she believed it changed depending on what time of day it was documented. Administrative Nurse D stated if it was documented during the day shift then a yes in both on and off boxes would have meant it was in place from her understanding. Administrative Nurse D further stated if there was an order for R67 to have a protective sleeve on while up in the wheelchair then she expected staff to have put the sleeve on R67. Administrative Nurse D stated if R67 refused to wear the sleeve, she expected the refusal to have been documented in a progress note. Administrative Staff B stated some education may need to be provided for staff on how to document, when an item such as a protective sleeve, was on or refused. The facility was unable to provide a policy on non-pressure-related skin injury prevention. The facility failed to apply a protective sleeve to R67 per her order and care plan. This deficient practice placed R67 at risk for skin injury.

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	175182	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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** - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, history of traumatic brain injury, hypertension (HTN-elevated blood pressure), chronic pain, myalgia (muscle pain), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R30 was at risk for the development of pressure ulcers during the observation period. The Quarterly MDS dated 01/18/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R30 was at risk for the development of pressure ulcers during the observation period. R30's undated Pressure Ulcer Care Area Assessment (CAA) lacked an analysis of her care area triggered by the significant change MDS dated [DATE]. R30's Care Plan dated 08/21/22 documented R30 would wear her PRAFO (special pressure reducing heel protectors) while in bed. On 03/11/24 at 02:25 PM R30 laid on her bed with her bilateral extremities rested directly on the bed. R30's PRAFO boots lay on the floor next to her wheelchair. R30 stated she should have them on when she was in bed but had forgotten to remind the staff to put them on. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated the pressure reliving boots and other pressure ulcer preventive items were found on the care plan. CNA N stated that R30's pressure-reducing boots should be on her lower extremities when in bed. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated all the nursing staff was responsible for ensuring each resident had their pressure reliving items in place when needed. LN K stated everyone had access to the care plan to review what preventive measures were in place for each resident related to skin management. On 03/13/24 at 04:02 PM, Administrative Nurse D stated she was responsible for ensuring each resident's plan of care included pressure ulcer prevention and the level of assistance provided by staff. The facility's Pressure Ulcer Prevention policy last revised in May 2021 documented to prevent the development of Pressure Ulcers, the facility would implement the use of foot pillows, moon boots, and/or heel protectors. The facility failed to implement pressure-reducing boots for R30, who was at risk of developing of pressure ulcers. This placed R30 at increased risk for development of pressure ulcers. The facility identified a census of 81 residents. The sample included 21 with five reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)80's low air-loss mattress pump was set to a tolerable comfort level and correct for his current weight. The facility (continued on next page)

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	03/13/2024

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additionally failed to utilize pressure-relieving boots for R30. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R80's Electronic Medical Records (EMR) included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), heart disease, anxiety disease, cognitive communication deficit muscle weakness, and gastroesophageal reflux disorder (GERD-backflow of stomach contents to the esophagus). R80's admission Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he required substantial to maximal assistance with bed mobility. The MDS indicated he was at risk for the development of pressure ulcers. The MDS noted the use of pressure-reducing devices for his bed and chair. The MDS indicated he received hospice services (end-of-life comfort care). The MDS indicated he weighed 117 pounds (lbs.) upon admission. On 03/11/24 the Care Area Assessments (CAA) were not completed for R80. R80's Care Plan initiated 02/08/24 indicated he was at risk for skin breakdown, pressure injuries, and decreased psychosocial wellbeing. The plan indicated he had a deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) on his coccyx (area of skin over the tailbone). The plan noted instructed staff to assess him for pain related to his pressure ulcer or its treatment. The plan noted for staff to turn and reposition him frequently. The plan indicated he used pressure-reducing devices on his bed and chair. R80's EMR under Orders indicated he received an alternating air mattress on 03/07/24. The order indicated the mattress should be set for comfort and checked by staff each shift. A Wound Care progress note dated 03/6/24 indicated R80 had a large pressure-induced deep tissue injury spanning from his coccyx to his left and right buttocks identified on 02/14/24. The note indicated an open area on 02/21/24. A review of the low air-loss mattress manufacturer's operation (Drive Model #14530) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual recommended the pump be set based on the resident's weight. The manual indicated the firmness of the mattress could be set within 30 lbs. weight intervals from 80 to 350 lbs. On 03/11/24 at 08:21 AM R80 slept in his bed. His call light was on the floor underneath his bed. R80's bed had a Drive Model #14530 pump attached to his alternating air mattress. The weight setting on his air pump was 150 lbs. At 08:50 AM R80 awoke and began yelling out help due to his call light being under his bed. Staff entered the room at 09:01 AM and gave him pain medication due to his pressure injuries. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/24 at 03:45 PM, an inspection of R80's mattress pump revealed it was still set to 150 lbs. R80 stated his back and bottom hurt due to the bed. He stated he hated air mattresses, and that the bed was too hard. He stated no one had offered to adjust the mattress. At 03:50 PM Licensed Nurse (LN) G stated she was R80's assigned nurse and the bed should be flat but was not sure what setting the air pump was to be set out. She confirmed the weight setting was at 150lbs and that R80 was in pain. She stated she would check to see what the bed settings should be and correct them. On 03/13/24 at 08:11 AM R80 was awake in his bed. He stated the mattress setting was changed and felt more comfortable. An inspection of the indicated the weight settings was 120 lbs. On 03/13/24 at 04:01 PM Administrative Nurse D stated the low air-loss mattresses were to be set based on the resident's comfort levels and staff should be checking the levels each shift. She acknowledged the higher weight setting would cause the mattress to be firmer for smaller residents. A review of the facility's Pressure Ulcer Prevention revised 05/2021 indicated residents at risk or with existing pressure injuries will be provided interventions to reduce the risks of worsening existing pressure-related injuries. The policy noted preventative interventions would include frequent repositioning, skin lotions, elbow protectors, seat cushions, and special mattresses. The policy noted staff will assess and report changes within the resident's skin, abilities, or cognition relative to signs of increased pressure, pain, or infections. The facility failed to ensure R80's low air-loss mattress pump was set to a tolerable comfort level and his correct weight. This deficient practice placed R80 at risk for complications related to skin breakdown and pressure ulcers.

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	03/13/2024

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

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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 81 residents. The sample included 21 residents with five residents reviewed for position, and mobility. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 52's splint was applied as directed, to prevent an avoidable reduction of range of motion (ROM) and/or mobility of her left hand. This deficient practice left R52 at risk for further decline and decreased ROM or mobility. Findings included: - R52's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral infarction (stroke - the 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), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and contracture (abnormal permanent fixation of a joint or muscle) of the left hand. The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R52 had impairment on one upper extremity during the observation period. The Quarterly MDS dated 01/06/24 documented a BIMS score of 13 which indicated intact cognition. The MDS documented R52 had impairment on one upper extremity during the observation period. R52's undated Functional Abilities Care Area Assessment (CAA) lacked an analysis of her care area triggered by the admission MDS dated [DATE]. R52's Care Plan dated 12/11/20 documented she required a wheelchair for mobility and was dependent on staff assistance to propel her. The plan of care documented R52 had a left armrest on her wheelchair. The plan of care lacked direction for R52's left-hand splint. R52's EMR under the Orders tab revealed the following physician orders: R52 was to have a left-hand splint on 24 hours a day and seven days a week with skin checks, repositioning, and hand washing during every shift dated 10/09/23. On 03/13/24 at 07:29 AM Certified Nurse Aide (CNA) N pushed R52 up to the dining room table in her wheelchair. R52 did not have her left hand splint on as ordered. R52 stated she should always have it on, but some days staff forget to put it on her left hand. On 03/13/24 at 02:13 PM, CNA N stated R52 should always wear her left-hand splint. CNA N stated she forgot to apply R52's left-hand splint that morning after getting her up for breakfast. CNA N stated the care and information about the application of R52's left-hand splint should be on her plan of care. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated R52 should always wear her left-hand splint to prevent worsening of her contracture. LN K stated the nurse was responsible for ensuring R52 was wearing her left-hand splint. LN K stated the nurse would check her skin, clean the hand splint, and (continued on next page)

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	03/13/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reapply the left-hand splint after her hand was dry. On 03/13/24 at 04:02 PM, Administrative Nurse D stated the nurse was responsible for ensuring a resident wore their splint as ordered. Administrative Nurse D stated the resident's plan of care should have the information for any splints when the splint was to be worn, the reason the splint was worn, and the care of the splint. The facility's Range of Motion (Active, Active Assistance and Passive) policy last reviewed in May 2021 documented the facility would follow an established plan developed by a therapist or nurse with a corresponding nursing or physician order for the range of motion plan to include joints to be ranged and frequency of treatment. The facility failed to ensure R52's left-hand splint was applied and removed as directed to prevent an avoidable reduction of ROM and/or mobility. This deficient practice left R52 at risk for further decline and decreased ROM.

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	03/13/2024

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, history of traumatic brain injury, hypertension (HTN-elevated blood pressure), chronic pain, myalgia (muscle pain), and major depressive disorder (major mood disorder which causes persistent feelings of sadness). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented required partial to moderate assistance with personal hygiene during the observation period. The Quarterly MDS dated 01/18/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented R30 required partial to moderate assistance with personal hygiene during the observation period. R30's undated Falls Care Area Assessment (CAA) lacked an analysis of her care areas triggered by the significant change MDS dated [DATE]. R30's Care Plan dated 09/18/22 documented she required the assistance of two staff members with the Hoyer (full body mechanical lift) lift for a safe transfer. R30's EMR under the Progress Notes tab revealed a Nursing Note at 02:44 PM dated 03/03/24 documented Certified Nurse Aide (CNA) notified the charge nurse that R30 was bumped on the forehead during a Hoyer lift transfer. A review of the undated facility investigation provided by the facility documented on 03/03/24, two CNAs reported to Licensed Nurse (LN) H that R30 was accidentally bumped in the head with the Hoyer lift bar during a transfer. LN H assessed R30 and found her to be without apparent injury. LN H educated CNA O and CNA P about being more careful and slowing down during transfers with residents who required a mechanical lift. LN H also interviewed R30 regarding the incident during the Hoyer lift transfer. LN H noted that R30 was upset because she stated this was the second time that this had happened. A facility-wide skills fair was conducted on 02/29/24 and 03/01/24, which included hands-on training for mechanical lifts. Ongoing training continued with return demonstration required, to ensure that staff were competent in providing safe transfers with mechanical lifts. A review of the sign-in sheets provided by the facility from the skills fair conducted from 02/29/24 through 03/01/24 lacked signatures from CNA O and CNA P that indicated they had received the Hoyer lift training. On 03/13/24 at 07:51 AM CNA N, CNA M, and Certified Medication Aide (CMA) R assisted R30 with a Hoyer lift transfer from her bed and into her wheelchair. CMA R operated the Hoyer lift controls, CNA M guided R30's Hoyer lift sling from the left side of the wheelchair, and CNA N assisted R30 from behind the wheelchair to prevent R30's head from hitting the Hoyer lift transfer bar. On 03/12/24 at 09:54 AM Administrative Staff A stated the staff responsible for providing staff education did not track hours and the facility did not have the staff education from the previous 12 months. Administrative Staff A stated the facility took steps to improve the education process and tracking at the facility and that a new educator was hired. Administrative Staff A further stated (continued on next page)

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	03/13/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	education was tracked under the new system since February 2024 and that the facility had a skills fair for the staff that counted as six hours of education, and included dementia, abuse, neglect, exploitation, and lift training. On 03/13/24 at 02:13 PM Certified Nurse Aide (CNA) N stated she received lift training during the facility's skills fair that was held from 02/29/24 through 03/01/24. 03/13/24 at 02:25 LN K stated he received Hoyer lift training approximately six months ago through the facility. On 03/13/24 at 04:03 PM Administrative Staff A stated lift training was offered during the skills fair that was held from 02/29/24 through 03/01/24. Administrative Staff A stated LN KK had received lift training during the skills fair before the incident. Administrative Staff A stated CNA O had received lift training after the second incident that involved a lift transfer. The facility did not provide a policy for safe resident transfers. The facility failed to ensure an environment free from preventable accidents when staff hit R30 in the head with the Hoyer lift bar during a transfer. This placed R30 at risk for preventable injuries. - The electronic medical record (EMR) for R17 documented diagnoses of hypertension (elevated blood pressure), and chronic kidney disease (CKD-a condition in which the kidneys are damaged and cannot filter blood as well as they should). R17's admission Minimum Data Set (MDS) dated 02/14/24 documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. R17 had impairment on one side of her lower extremities. R17 used a wheelchair for mobility. R17 required substantial assistance to total dependence on staff for activities of daily living (ADLs). R17 had a history of a fall with a fracture before admission. R17 was taking an antidepressant (a class of medications used to treat mood disorders), and an opioid (a class of medication used to reduce pain and could be addictive). R17 triggered the Care Area Assessment (CAA) but lacked analysis documentation. R17's Care Plan initiated on 02/20/24 directed staff to monitor for pain and edema (swelling). Staff was directed to administer medications and monitor and record effectiveness. Staff was directed to provide assistance with ADLs as indicated. Staff was to use a Hoyer lift (total body mechanical lift) with assistance from two persons for transfers. An Event Report for R17 documented an event that occurred on 03/07/24 at approximately 08:00 AM. R17 was struck in the head by the Hoyer lift bar during a transfer from her bed to her wheelchair. Licensed Nurse (LN) KK and Certified Nurse Aide (CNA) O were transferring R17 when her wheelchair wheel slipped making her hit the Hoyer lift on the front right side of her forehead. R17 was upset that she was intentionally hit. LN KK assessed the resident and found no visible injuries. R17 was reassured that the incident was an accident and not an intentional act. LN KK assessed R17's vital signs and neurological checks were initiated. R17's physician, nurse management, and emergency contact were notified. Administrative Staff A's undated summary of the event from 03/07/24 documented LN KK reported that (continued on next page)

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	03/13/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17 was accidentally bumped in the head with the Hoyer lift bar during a transfer. Administrative Staff A documented the two employees (LN KK and CNA O) did not have the resident facing the lift. R17 was instead seated perpendicular to the base of the lift. This caused the chair legs to become elevated once the lift was in place. As the staff were raising the lift with the resident's sling attached, the legs of the chair shifted and fell to the ground. The few inches of shift caused the resident to move suddenly. LN KK and CNA O could not tell if the resident fell into the lift with her head or if the lift swung into her head. Administrative Staff A educated both staff that any use of a modified lift was against facility policy and should not be used. Both LN KK and CNA O expressed concern that some residents have decreased flexibility that they feel may call for such modifications to the proper lift procedure. Administrative Staff A advised LN KK and CNA O that if they felt any resident was unsafe being transferred per policy to notify the assistant director of nursing (ADON) or herself immediately so the resident could be evaluated during policy-approved transfers. Administrative Staff A made it clear that no resident under any circumstances should have modifications to how they were positioned in the lift. Both LN KK and CNA O verbalized understanding. The facility was unable to provide evidence that CNA O had received an education, training, or competency assessment for transfers with a mechanical lift. A review of a Lift Inservice dated 02/2024 revealed LN KK received training on the use of lifts. A facility CNA Competency checklist for full body transfer with mechanical lift dated and signed 03/08/24 by CNA O and Administrative Nurse E. On 03/13/24 at 12:01 PM R17 sat in her wheelchair watching TV, the resident voiced no concerns. On 03/13/24 at 02:13 PM, CNA N stated they did not work the day of 03/07/24 when the incident happened but did know that two staff should always be present when transferring a resident using the Hoyer lift. CNA N stated the facility had provided transfer training and education about a month ago. On 03/13/24 at 12:35 PM Administrative Nurse D stated two staff were expected to use proper mechanical lift skills when transferring a resident using the Hoyer lift. CNA O had been re-educated and had to show competency for lift use after the incident on 03/07/24. On 03/13/24 at 04:28 PM Administrative Staff A stated that she had CNA O given reeducation and competency check for mechanical lift use by Administrative Nurse E on 03/08/24. Administrative Staff A stated CNA O was absent from the facility skills fair held in February 2024. Administrative Staff A stated the use of the Hoyer lift, required two qualified staff for all transfers. The facility did not provide a policy for safe resident transfers. The facility failed to ensure an environment free from preventable accidents when staff hit R17 in the head with the Hoyer lift bar during a transfer. This placed R17 at risk for preventable injuries. The facility had a census of 81 residents. The sample included 21 residents with three residents reviewed for accident/fall prevention. Based on observation, record review, and interview the facility failed to ensure an environment free from accident hazards when staff failed to secure chemicals in a safe, locked area, and out of reach of the thirteen cognitively impaired, independently mobile residents. The facility additionally failed to utilize safe assistive techniques related to Resident (continued on next page)

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(R)61's wheelchair foot pedals and safe mechanical lift transfer techniques for R17 and R30. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - On 03/11/24 at 07:14 AM a walkthrough of the facility was completed. An inspection of an unlocked janitor closet on the 200 hallway revealed unsecured Diversify cleaning products including heavy-duty floor cleaners, bowl and bath cleaners, and general-purpose cleaners. The closet also contained two cans of Ajax powdered drain cleaner. All products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. An inspection of the facility's first and second-floor spa rooms revealed unlocked cabinets containing chemical sanitizing wipes and chemical sanitizing spray bottles. All products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 03/13/24 at 02:18 PM, Certified Nurses Aid (CNA) S stated cleaning products should be locked out of reach of the residents. She stated the cabinets and closets should always be locked. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K said staff should never leave the cleaning products out where the residents could access them. On 03/13/24 at 04:00 PM Administrative Nurse D stated staff were expected to ensure the areas containing hazardous chemicals remained locked and not accessible to the residents. The facility's provided Chemical Storage policy effective 06/2022 indicated all hazardous chemicals will be stored in a secured area, properly labeled, and out of reach from the residents. The facility failed to secure chemicals in a safe, locked area, and out of reach of the thirteen cognitively impaired, independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries. - The Medical Diagnosis section within R61's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. R61's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 11 indicating mild cognitive impairment. The MDS indicated she required substantial to maximal assistance with dressing, transfers, and bathing. The MDS indicated she used a wheelchair and could ambulate herself under staff supervision. The MDS indicated she had a history of falls. R61's Falls Care Area Assessment (CAA) started on 03/12/24 indicated she was at risk for falls related to her dementia diagnosis. The CAA indicated she had a decline in functional status with problems of gait, impaired balance, and difficulty maintaining seated balance. R61's Care Plan initiated 07/09/23 indicated she had limits in her cognition that could impact her safety awareness and decision-making abilities. The plan encouraged staff to emphasize safe choices. The plan instructed staff to ensure she maintained a good position in her wheelchair. The plan (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated she required assistance with transfers, dressing, bed mobility, grooming, and bathing. On 03/11/24 at 08:30 AM Staff pushed R61 out of her room to the 200 hall dining area. She was positioned at a bedside table in front of the nurse's station. R61 wore shoes and her feet slid on the floor from her room to the dining area. Her wheelchair did not have foot pedals attached. On 03/12/24 at 07:45 AM R61 was wheeled to the dining area with her shoes sliding on the floor multiple times as she was pushed. Her wheelchair did not have foot pedals attached. On 03/13/24 at 02:18 PM, Certified Nurses Aid (CNA) S stated residents that who wheeled themselves around the facility would not have the pedals on their wheelchairs, but staff should never allow a resident's feet to drag on the ground while being pushed. She stated the residents could get hurt or fall. On 03/13/24 at 02:25 PM Licensed Nurse (LN) K stated the resident's feet should be propped up on foot pedals if they cannot hold their feet up during transport. On 03/13/24 at 04:00 PM Administrative Nurse D stated staff were expected to ensure foot pedals were used on residents that cannot hold their feet up. She stated the resident's feet should never touch the ground while in motion. The facility's provided Fall Risk/Prevention policy reviewed 04/2021 indicated staff will ensure safe practices and appropriate usage of transfer equipment including mechanical lifts, walkers, wheelchairs, and techniques to prevent accidents and falls. The facility failed to ensure an environment free from accident hazards when staff failed to use foot pedals when they propelled R61 in her wheelchair. This deficient practice placed R61 at risk for preventable accidents and injuries.

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	03/13/2024

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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 81 residents. The sample included 21 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to provide adequate respiratory care and services for Resident (R)12 when staff failed to ensure orders to clarify settings and failed to ensure sanitary storage for R12's respiratory equipment. This placed R12 at an increased risk for respiratory infection and complications. Findings included: - R12's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of acute and chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide) with hypoxia (inadequate supply of oxygen), obstructive sleep apnea (disorder of sleep characterized by periods without respirations), depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness), seasonal allergic rhinitis (allergic reaction that causes sneezing, congestion, itchy nose and watery eyes), morbid obesity (excessive body fat), and Covid- 19 (highly contagious respiratory virus). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R12 bilevel positive airway pressure (BiPAP-medical device that helps with breathing) during the observation period. R12's Functional Abilities Care Area Assessment (CAA) dated 03/13/23 documented R12 required total assistance with his activities of daily living (ADLs). R12's EMR under the Orders tab dated 12/12/23, revealed the following physician orders: BiPAP when at rest or sleeping and bedtime, document if resident refused, The EMR lacked direction regarding R12's BiPAP settings. R12's EMR also lacked evidence of staff disinfecting the BiPAP routinely. On 03/12/24 at 03:48 PM, R12 sat in his electric wheelchair watching a basketball game on the television. R12's BiPAP mask was laid on top of the machine and not stored in a container or bag. On 03/13/24 at 08:33 AM, R12 lay in bed with the head of his bed elevated. R12 ate breakfast consisting of eggs and sausage. R12's BiPAP mask laid on top of the machine. The mask was not stored in a sanitary container. R12 stated he did not wear the mask on 03/12/24 because he forgot to turn his light on to have the staff apply the mask. On 03/12/24 at 10:50 AM Certified Nursing Assistant (CNA) S stated she did not know who was responsible for the cleaning or storage of R12's BiPAP. CNA S stated it used to be cleaned by one of the night nurses, but that nurse was no longer employed there. On 03/13/24 at 07:30 AM Licensed Nurse (LN) I stated there was not an order or anywhere for the nursing staff to sign or indicate when to clean or how to store R12's BiPAP mask. LN, I stated on the night shift staff cleaned the mask with special wipes before putting the mask on R12. (continued on next page)

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	03/13/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 04:04 PM Administrative Nurse D stated there should be direction for staff to how to provide care using the BiPAP including how to clean and store the equipment. The facility failed to provide adequate respiratory care and services for R12 when staff failed to ensure orders to clarify the settings and failed to ensure sanitary storage for R12's respiratory equipment. This placed R12 at an increased risk for respiratory infection and complications.

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. The facility had a census of 81 residents. The sample included 21 residents of which two residents were reviewed for pain. Based on observation, record review, and interview the facility failed to recognize, evaluate, manage, and treat the underlying cause of pain for Resident (R) 286. This deficient practice resulted in unmanaged pain which also placed the resident at risk for impaired mobility and diminished quality of life. Findings included: - R286's Electronic Medical Record (EMR) documented that R286 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (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) affecting the left non-dominant side. The Significant Change in Status Minimum Data Set (MDS), dated 01/18/24, documented R286 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented no presence of pain on the pain assessment interview. The MDS documented R286 used a wheelchair and had a functional limitation in range of motion and impairment of the upper and lower extremities on one side. The MDS further documented R286 was dependent on staff for toileting, bathing, dressing, personal hygiene, and mobility. R286's Activities of Daily Living Care Area Assessment (CAA) triggered but lacked an analysis. R286's Care Plan with a problem start date of 02/23/23, documented R286 required assistance with mobility and activities for daily living (ADL) due to a history of stroke, hemiplegia, reduced mobility, and general weakness. R286's Care Plan lacked direction to staff regarding pain and lacked indication related to R286's tolerable or acceptable level of pain. A review of R286's Medication Administration Record (MAR) from 03/01/24 - 03/12/24 revealed R286 reported pain rated at three out of 10 (on a zero to ten scale with zero representing no pain and 10 the worst pain imaginable) on the 07:15 - 11:15 AM shift on 03/02/24, 03/03/24, 03/09/24 and 03/10/24. Staff documented R286 reported pain, on the 7:15 - 11:00 PM shift rated a four out of 10 on 03/01/24, a three out of 10 on 03/02/24 and 03/03/24, a two out of 10 on 03/08/24, and three out of 10 on 03/09/24 and 03/10/23. A review of R286's MAR from 03/01/24 - 03/12/24 revealed an order for tramadol (medication used to treat pain) of 50 milligrams (mg) every four hours as needed. R286's MAR lacked evidence tramadol was administered, offered, or refused during the review period. A review of R286's Progress Notes from 02/27/24 - 03/12/24 lacked evidence R286 was offered, received, or refused any treatment or intervention for any reported pain on the following documented dates: 03/01/24, 03/02/24, 03/03/24, 03/08/24, 03/09/24, and 03/10/24. On 03/11/24 at 07:46 AM R286 lay in his bed awake. R286 stated he had pain in his left hand and stated that his hand hurt all the time. R286 reported he had not received anything to help with his (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain and he could not get any relief. R286 further stated he had told staff about the pain in his hand; however, he had not received anything to help relieve it. On 03/13/24 at 07:16 AM R286 lay in his room in bed, with his door open and Certified Nurse Aide (CNA) Q was also in the room. R286 informed CNA Q about his left hand pain and asked for something to help relieve the pain. CNA Q stated he would let R286's nurse know and would get back to him. Approximately five minutes later, CNA Q returned and informed R286 that the nurse had been notified of his left hand pain and that his nurse would be with him shortly. A continuous observation from 07:16 AM to 08:44 AM revealed no staff returned to R286's room to address his left hand pain. At 08:58 AM R286 made an occasional mild groan from his room and reported his pain was an eight out of 10 in his left hand. R286 stated his pain would sometimes get as high as a 10 out of 10. R286 stated he had received nothing to help with his pain. R286 stated that he considered any pain higher than a one out of 10 as too much for him to tolerate. On 03/13/24 at 08:58 AM Licensed Nurse (LN) G stated she believed R286 had pain in his left hand due to the brace he wore at night to help prevent contractures (abnormal permanent fixation of a joint or muscle). LN G stated she would talk with therapy and ask about adjusting the schedule as to when the brace was on or off, and that she would massage his hand at times when pain was reported. LN G reviewed R286's MAR and verified he had not received any tramadol from 03/01/24 - 03/12/24 and upon further inspection, LN G stated R286 did not have another option such as acetaminophen available for as-needed pain relief. LN G stated R286 may have declined the PRN tramadol; but further stated if he had, staff should have entered a progress note that documented the offer and refusal. LN G stated she would go visit with R286 and address his pain. On 03/13/24 at 04:03 PM Administrative Staff B stated she had worked with R286 during the night shift and that she had not heard any complaints of pain from R286 and was not aware he had pain in his hand. Administrative Staff B stated if R286 complained of pain, she expected staff to assess him and decide on how best to address his pain. Administrative Staff B further stated she expected staff to document what interventions were tried, offered, and/or refused. Administrative Staff B stated if R286 refused the use of pain medications, she expected staff to try something else to address his pain. On 03/13/24 at 05:41 PM Administrative Staff B stated LN G met with R286 to address his hand pain. Administrative Nurse B stated R286 had refused the PRN tramadol and stated he wanted to stay away from taking pain medications. Administrative Nurse B further stated that if R286 refused the medication she expected staff to provide an alternative intervention to address his pain. No policy was provided related to pain by the facility. The facility failed to recognize, evaluate, manage, and treat the underlying cause of pain for R286. This deficient practice resulted in unmanaged pain. This also placed the resident at risk for impaired mobility and diminished quality of life.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility had a census of 81 residents. The sample included 21 residents and two medication carts. Based on observation, record review, and interview the facility failed to provide a consistent reconciliation of controlled drugs at the end of each work shift on one cart. This placed the 16 residents with controlled substances on the cart at risk for misappropriation of medications. Findings included: - On 03/13/24 at 10:16 AM, observation on the lower-level Hall B medication cart Controlled Drug Record flow sheet lacked evidence the staff completed the narcotic reconciliation for night shifts on 02/01/24, 02/09/24, 02/10/24, ,02/11/24, 02/23/24, 02/29/24, 03/01/24, 03/03/24,03/09/24 and 03/10/24 02/23/24, 02/29/24, 03/01/24 and 03/03/24 for evening shift; 03/01/24 and 03/03/24 for day shift (sixteen times out of a possible 126 work shifts). On 03/13/24 at 10:25 AM, Licensed Nurse (LN) H stated nurses were expected to count the narcotics with another nurse each shift. LN H stated the nurse coming on duty and the nurse going off duty should ensure the narcotic count is correct. LN H stated all nurses and medication aides have been educated on narcotic counting. On 03/13/24 at 04:04 AM, Administrative Nurse D stated she expected the nurse coming on duty and the nurse leaving duty to count each card and ensure the narcotic count was correct. Administrative Nurse D said the two nurses together determined the count was correct. The Medication and Controlled Substance policy revised 02/2023 stated controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled medication should be reported to a supervisor and the pharmacy immediately. The facility failed to provide a consistent reconciliation of controlled drugs at the end of daily work shifts, placing the 16 residents with controlled substances on the cart at risk for misappropriation of medications by staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented per staff assessment, R16 had moderately impaired cognition. The MDS documented R16 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine) medication, and antidepressant (class of medications used to treat mood disorders) during the observation period. The MDS documented that the medication received did not have a documented indication. The MDS also lacked documentation a drug regimen review was completed during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented R16 had received insulin, diuretic medication, and antidepressant medication during the observation period. The MDS documented the medication received did not have an indication. The MDS lacked documentation a drug regimen review was completed during the observation period. R16's undated Psychotropic Drug Use Care Area Assessment (CAA) lacked an analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated 12/14/20 documented the pharmacist would review her medication monthly and as needed, along with providing a recommendation when indicated. R16's EMR under the Orders tab revealed the following physician insulin orders: Levemir flex pen (long-acting insulin pen), 100 units/ml (3ml), administer 12 units twice a day for diabetes mellitus. Call the physician if blood sugar was less than (<) 70 milligram (mg)/deciliter (dl) dated 12/20/23. Humalog U-100 insulin (short-acting insulin) solution; 100 units/milliliters (ml), administer three units before each meal for diabetes mellitus. Hold if blood sugar was < 80mg/dl dated 01/30/24. R16's EMR under the Reports tab review of her Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/04/23 through 03/11/24 (99 days) revealed R16's blood sugar was < 70 mg/dl on the following dates 12/14/23 and 02/05/24, the clinical record lacked evidence the physician was notified of blood sugar below ordered parameters. R16's EMR under the Orders tab revealed the following physician medication orders: Amitriptyline (antidepressant) tablet 10 mg give two tablets by mouth at bedtime dated 12/04/23. The order lacked an indication for administration. Aspirin (non-steroidal anti-inflammatory drug) tablet delayed release 81 mg give one tablet by mouth daily dated 2/04/23. The order lacked an indication for administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Famotidine tablet (decreasing the amount of acid your stomach makes) 20 mg give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. Lexapro (escitalopram oxalate) tablet five mg give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. Lasix (furosemide) (diuretic) tablet 20 mg give one tablet by mouth daily dated 12/08/23. The order lacked an indication for administration. Losartan tablet (antihypertensive) 25 mg give one tablet by mouth daily dated 03/08/24. The order lacked an indication for administration. Metoprolol succinate (antihypertensive) tablet 50mg extended release 24 hours, give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. Raloxifene tablet (used to build bone density) 60 mg give one tablet daily dated 12/04/23. The order lacked an indication for administration. A review of R16's EMR under the Documents tab, for the Monthly Medication Review (MMRs) from December 2023 through February 2024 lacked evidence the CP identified and reported the blood sugars outside the physician-ordered parameters and as well the lack of indications for medication administration. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit down beside R16. LN L sat down and continued to assist R16 with lunch. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit down beside R16. LN L sat down and continued to assist R16 with lunch. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated he did take care of the MMRs from the pharmacy. LN K stated he thought the medication without indication for administration would be something the CP would note as an irregularity. On 03/13/24 at 04:18 PM Administrative Nurse D stated that all the MMRs from the pharmacy are emailed to medical records. Administrative Nurse D stated medical records sent the MMRs out to the attending physicians for review and signatures. Administrative Nurse D stated medical records would make the changes if possible to the residents' orders and then the signed copy was scanned into the resident's EMR. Administrative Nurse D stated medical records would notify the charge nurse of any changes or new orders. The facility's Pharmacist Consultant Duties and Responsibilities policy last revised in May 2021 documented the CP monitored medications administration to verify that the resident had received medications according to the prescriber's orders and facility policy. The CP reviewed each resident's chart to identify and address any irregularities of medications without indications, untreated indications, improper medication selection, potentially inappropriate medications in the elderly, gradual (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose reductions, psychotropic medications, and regulatory issues. The facility failed to ensure the CP identified and reported the irregularities related to physician notification of blood sugars outside the physician-ordered parameters and lack of an indication for use for R16's physician-prescribed medications. This placed R16 at risk of unnecessary medication administration and possible adverse reactions. The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 1 and R16's medications lacked an indication for use. The deficient practice placed the residents at risk of unnecessary medication administration and adverse side effects. Findings included: - The electronic medical record (EMR) for R1 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), 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 Annual Minimum Data Set (MDS) dated 01/20/24 documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The Psychotropic Drug Use Care Area Assessment (CAA) was triggered but lacked any documentation of analysis. R1's Care Plan last revised on 12/04/23 directed staff that the pharmacy would review medications monthly and as needed with recommendations shared with R1's physician. Staff was to monitor R1 for any adverse medication reactions and notify his physician. The plan directed staff to administer medications as ordered and to watch for side effects. Staff was directed that the pharmacy would review medications monthly and as needed to provide recommendations for gradual dose reduction (GDR) as indicated. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 09/13/22 for medroxyprogesterone (a hormone used to treat sexually driven behavior problems) 2.5 milligram (mg) tablet to be taken daily but lacked a diagnosis or indication for use. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 02/25/22 for Nuedexta (a central nervous system medication used to treat mental/mood disorders) to take one capsule by mouth twice daily. The order lacked a diagnosis or indication for use. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 01/27/22 for rosuvastatin (a medication used to reduce cholesterol) 10 mg at bedtime. The order lacked an indication for use or diagnosis. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 01/27/22 for tamsulosin (a medication used to treat an enlarged prostate). (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the CP's monthly medication regimen review from March 2023 to the present revealed no recommendation or report of R1's medications not having a diagnosis or indication for use. On 03/12/24 at 10:07 AM R1 participated with other residents in the morning group exercises. On 03/13/24 at 07:47 AM Licensed Nurse (LN) J stated that any medication ordered for a resident should have a diagnosis on the order. LN G could not state the reason why some of R1's medications did not have the diagnosis listed. On 03/13/24 at 04:18 PM Administrative Nurse D stated that all medications should have a diagnosis included on the Medication Administration Record as a medication should not be given without a diagnosis. On 03/14/24 Consultant GG was not able to be reached for an interview. The facility policy Pharmacist Consultant Duties and Responsibilities revised in May 2021 documented the CP monitored medication administration to verify that the resident had received medications in accordance with the prescriber's orders and facility policy. The CP reviewed each resident's chart to identify and address any irregularities of medications without indications, untreated indications, improper medication selection, potentially inappropriate medications in the elderly, gradual dose reductions, psychotropic medications, and regulatory issues. The facility failed to ensure the CP identified and reported the lack of an indication for use or diagnosis for R1's physician-prescribed medications. This placed R1 at risk of unnecessary medication administration and possible adverse reactions.

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	175182	A. Building B. Wing	03/13/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (a progressive mental disorder characterized by failing memory, and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented per staff assessment, R16 had moderately impaired cognition. The MDS documented R16 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine) medication, and antidepressant (class of medications used to treat mood disorders) during the observation period. The MDS documented that the medication received did not have a documented indication. The MDS also lacked documentation a drug regimen review was completed during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented R16 had received insulin, diuretic medication, and antidepressant medication during the observation period. The MDS documented the medication received did not have an indication. The MDS lacked documentation a drug regimen review was completed during the observation period. R16's undated Psychotropic Drug Use Care Area Assessment (CAA) lacked an analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated 12/14/20 documented the pharmacist would review her medication monthly and as needed, along with providing a recommendation when indicated. R16's EMR under the Orders tab revealed the following physician insulin orders: Levemir flex pen (long-acting insulin pen), 100 units/ml (3ml), administer 12 units twice a day for diabetes mellitus. Call the physician if blood sugar was less than (<) 70 milligram (mg)/deciliter (dl) dated 12/20/23. Humalog U-100 insulin (short-acting insulin) solution; 100 units/milliliters (ml), administer three units before each meal for diabetes mellitus. Hold if blood sugar was < 80mg/dl dated 01/30/24. R16's EMR under the Reports tab review of her Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/04/23 through 03/11/24 (99 days) revealed R16's blood sugar was < 70 mg/dl on the following dates 12/14/23 and 02/05/24, the clinical record lacked evidence the physician was notified of blood sugar below ordered parameters. R16's EMR under the Orders tab revealed the following physician medication orders: Amitriptyline (antidepressant) tablet 10 mg give two tablets by mouth at bedtime dated 12/04/23. The order lacked an indication for administration. Aspirin (non-steroidal anti-inflammatory drug) tablet delayed release 81 mg give one tablet by mouth daily dated 2/04/23. The order lacked an indication for administration. Famotidine tablet (decreasing the amount of acid your stomach makes) 20 mg give one tablet by mouth (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily dated 12/04/23. The order lacked an indication for administration. Lexapro (escitalopram oxalate) tablet five mg give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. Lasix (furosemide) (diuretic) tablet 20 mg give one tablet by mouth daily dated 12/08/23. The order lacked an indication for administration. Losartan tablet (antihypertensive) 25 mg give one tablet by mouth daily dated 03/08/24. The order lacked an indication for administration. Metoprolol succinate (antihypertensive) tablet 50mg extended release 24 hours, give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. Raloxifene tablet (used to build bone density) 60 mg give one tablet daily dated 12/04/23. The order lacked an indication for administration. A review of R16's EMR under the Documents tab, for the Monthly Medication Review (MMRs) from December 2023 through February 2024 lacked evidence the CP identified and reported the blood sugars outside the physician-ordered parameters and as well the lack of indications for medication administration. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit down beside R16. LN L sat down and continued to assist R16 with lunch. On 03/11/24 at 12:51 PM, R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit down beside R16. LN L sat down and continued to assist R16 with lunch. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated the physician should be notified if R16's blood sugar was outside the physician-ordered parameters. LN K stated that would be documented in the R16's EMR under the progress note. LN K stated all medication administered to each resident should have an indication for administration. LN K stated he would clarify the order. On 03/13/24 at 04:18 PM Administrative Nurse D stated that all medications should have a diagnosis included on the Medication Administration Record as a medication should not be given without a diagnosis. Administrative Nurse D stated the physician should be notified of blood sugars as ordered by the physician and the notification would be documented under the progress note in the resident's EMR. The facility was unable to provide a policy related to physician orders. The facility failed to ensure the physician was notified of blood sugars outside the physician-ordered parameters and failed to ensure an indication for use for R16's physician-prescribed medications. This placed R16 at risk of unnecessary medication administration and possible adverse reactions. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to identify Resident (R) 1 and R16's medications lacked an indication for use. The deficient practice placed the residents at risk of unnecessary medication administration and adverse side effects. Findings included: - The electronic medical record (EMR) for R1 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), 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 Annual Minimum Data Set (MDS) dated 01/20/24 documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The Psychotropic Drug Use Care Area Assessment (CAA) was triggered but lacked any documentation of analysis. R1's Care Plan last revised on 12/04/23 directed staff that the pharmacy would review medications monthly and as needed with recommendations shared with R1's physician. Staff was to monitor R1 for any adverse medication reactions and notify his physician. The plan directed staff to administer medications as ordered and to watch for side effects. Staff was directed that the pharmacy would review medications monthly and as needed to provide recommendations for gradual dose reduction (GDR) as indicated. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 09/13/22 for medroxyprogesterone (a hormone used to treat sexually driven behavior problems) 2.5 milligram (mg) tablet to be taken daily but lacked a diagnosis or indication for use. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 02/25/22 for Nuedexta (a central nervous system medication used to treat mental/mood disorders) to take one capsule by mouth twice daily. The order lacked a diagnosis or indication for use. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 01/27/22 for rosuvastatin (a medication used to reduce cholesterol) 10 mg at bedtime. The order lacked an indication for use or diagnosis. R1's Medications Administration History from 03/01/24 to 03/13/24 documented an order dated 01/27/22 for tamsulosin (a medication used to treat an enlarged prostate). On 03/12/24 at 10:07 AM R1 participated with other residents in the morning group exercises. On 03/13/24 at 07:47 AM Licensed Nurse (LN) J stated that any medication ordered for a resident should have a diagnosis on the order. LN G could not state the reason why some of R1's medications did not have the diagnosis listed. (continued on next page)

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	03/13/2024

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 04:18 PM Administrative Nurse D stated that all medications should have a diagnosis included on the Medication Administration Record as a medication should not be given without a diagnosis. The facility did not provide a policy for unnecessary medications. The facility failed to ensure R1's physician-prescribed medications had an indication for use. This placed R1 at risk of unnecessary medication administration and possible adverse side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure Resident (R) 16's psychotropic (alters mood or thought) medications had an indication for use. The deficient practice placed the residents at risk of unnecessary medication administration and adverse side effects. Findings included: - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of senile degeneration of the brain, dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and hypertension (HTN-elevated blood pressure). R16's Annual Minimum Data Set (MDS) dated [DATE] documented per staff assessment, R16 had moderately impaired cognition. The MDS documented R16 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine) medication and antidepressant (class of medications used to treat mood disorders) during the observation period. The MDS documented the medication received did not have a documented indication. The MDS also lacked documentation a drug regimen review was completed during the observation period. R16 Quarterly MDS dated 01/19/24 documented she had moderately impaired cognition. The MDS documented R16 had received insulin, diuretic medication, and antidepressant medication during the observation period. The MDS documented the medication received did not have an indication. The MDS lacked documentation a drug regimen review was completed during the observation period. R16's undated Psychotropic Drug Use Care Area Assessment (CAA) lacked an analysis of her care area triggered by the annual MDS dated [DATE]. R16's Care Plan dated09/18/22 documented staff would encourage her to take her prescribed medication as ordered by the provider. The plan of care documented the nursing staff would notify [NAME] provider if R16 refused her medications. R16's EMR under the Orders tab revealed the following physician orders: Amitriptyline (antidepressant) tablet 10 mg give two tablets by mouth at bedtime dated 12/04/23. The order lacked an indication for administration. Lexapro (escitalopram oxalate) tablet five mg give one tablet by mouth daily dated 12/04/23. The order lacked an indication for administration. On 03/11/24 at 12:51 PM R16 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Licensed Nurse (LN) L stood on R16's left side and assisted her with a few bites of food before another staff member motioned to LN L to sit down beside R16. LN L sat down and continued to assist R16 with lunch. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated all medication administered to each resident should have an indication for administration. LN K stated he would clarify the order. On 03/13/24 at 04:18 PM Administrative Nurse D stated that all medications should have a diagnosis included on the Medication Administration Record as a medication should not be given without a diagnosis. The facility was unable to provide a policy related to physician orders. The facility failed to ensure the lack of an indication for use for R16's physician prescribed medications. This placed R16 at risk of unnecessary medication administration and possible adverse reactions.

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	175182	A. Building B. Wing	03/13/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. The facility identified a census of 81 residents. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to provide and serve food substitutions that accommodated Resident (R) 3's preferences. This placed the resident at risk for impaired autonomy and decreased quality of life. Findings included: - R3's ordered diet dated 10/07/22 was a regular diet. R3's Care Plan last revised on 12/24/23 directed staff to allow the resident to make her own choices at meals. At this time R3 declined to make any adjustments to her diet. An 08/03/23 physician's Progress Note for R3 documented resident verbalized frustrations that the facility offered no diabetic diet, and that the meals were high in carbohydrates. The physician recommended and encouraged R3 to follow a no-concentrated sweets diet. A review of resident council minutes from May 2023 revealed the request for diabetic cookies. A review of resident council minutes from 2023 revealed in August 2023, residents made the complaint that low-carbohydrate foods had been requested. A review of the September 2023 resident council minutes revealed resident complaints that some residents and staff hoarded the snacks after dinner. A review of the November 2023 resident council minutes revealed a voiced complaint from residents that vegan (a person who does not eat any food derived from animals) shakes were not offered, more sides needed to be added to the alternate menu, and corndogs needed to be added back to the menu. Review of the January 2024 resident council minutes, residents voiced complaints that there were not enough diabetic (a person with diabetes) options. Residents requested more alternative sides/options with meals. Observation on 03/12/24 at 10:20 AM of available prepackaged syrup options revealed only regular syrup options in a basket on the counter outside of the kitchen. Observation on 03/12/24 at 03:15 PM of the snack cart items revealed bags of chips, packaged cheese and crackers, pudding, cookies, jello, and fresh fruit. Dietary BB stated sugar sugar-free pudding and jello were available for residents if requested. Observation on 03/12/24 at 10:20 AM of available prepackaged syrup options revealed only regular syrup options in a basket on the counter outside of the kitchen. During an interview on 03/11/24 at 02:36 PM R3 voiced that a low carbohydrate (food consisting of or containing a lot of sugar and starches) diet was not provided. R3 stated desserts and snacks provided were either high in sugar content or by the time staff offered R3 a snack in the evening, there was no low-sugar items were not available. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/24 at 10:13 AM R3 stated she wished that the facility offered sugar-free syrup at breakfast time to accommodate diabetic residents. ON 03/12/24 at 02:00 PM with members of the facility resident council, R3 stated that the facility did not offer enough choices for residents who were diabetics. R3 stated much of the food served was high in sugar content, and desserts and snacks with low sugar were rarely offered if ever. On 03/12/24 at 11:43 AM Dietary CC stated the facility followed a four-week menu plan and also offered an alternative menu. Consultant CC stated that the menu offered a well-balanced diet that was suitable for all residents and the facility would try to accommodate any resident's personal preferences if those choices were available. Consultant CC stated the facility did have some sugar-free and low-sugar snacks available for residents who would request them. ON 03/12/24 at 02:00 PM with members of the facility resident council, R3 stated that the facility did not offer enough choices for residents who were diabetics. R3 stated much of the food served was high in sugar content, and desserts and snacks with low sugar were rarely offered if ever. On 03/13/24 at 01:15 PM, Dietary BB stated the facility did not offer specific special diets like low carb or low sugar. Dietary BB stated the menu for each meal provided well-balanced choices and a resident was always able to order an alternative to the main meal being served. The facility policy Enhancing the Dining Experience dated 2014 documented meals would be nourishing and satisfying and would be served in a pleasing, attractive manner. The enhanced dining experience was designed to provide residents with as many choices as possible. All residents would be on the most liberal diet possible, consistent with the American Diabetes Association (ADA) position paper on Liberalizing Diets in Long Term Care, and to achieve maximum foot intake and nutritional status. Resident who remained on restricted therapeutic diets would have their meal selections guided by the menu spreadsheet. Residents on restricted diets who selected foods outside of the ordered modified diet would be referred to the Registered Dietician for follow-up. The resident retained the right to decline therapeutic meal options planned and offered, therefore, alternate selections would be provided based on the resident's request. It was ideal to offer as many choices as possible at mealtime to increase meal consumption and meal satisfaction. The facility failed to provide and serve food substitutions that accommodated R3's preferences. This placed the resident at risk for impaired autonomy and decreased quality of life.

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	175182	A. Building B. Wing	03/13/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 81 residents. The facility had one main kitchen and three dining areas. Based on observation, record review, and interview, the facility failed to ensure food was appropriately labeled and dated during storage. The facility failed to ensure tableware was stored appropriately before meal service. The facility failed to ensure dining staff handled plates in a sanitary manner. This placed the residents at risk for foodborne illness. Findings included: - On 03/11/24 at 07:15 AM the initial tour of the main kitchen revealed the walk-in freezer had an open bag of tater tots that was not labeled or dated and was not in a sealed bag. There was an opened bag that contained four or five breaded chicken breasts that were not labeled or dated. There was an opened bag of donuts that was not labeled or dated in a sealed bag. There was an opened bag of mixed vegetables that was not in a sealed bag and lacked an open date. On 03/11/24 at 07:20 AM the walk-in refrigerator had two opened bags of whipped cream that had no open date on them. Observation of the temperature log for the dishwasher on 03/11/24 lacked evidence staff assessed the temperature on 03/06/24. Observation on 03/12/24 at 11:25 AM of the food temperature logs for March 2024 lacked evidence food temperatures for meals were assessed from 03/03/24 to 03/11/24. Observation on 03/12/24 at 11:45 AM revealed Dietary DD, Dietary EE, and Dietary FF prepared for the service of the lunch meal. The clean meal plates and bowls were face up on the serving table. The dietary staff donned clean gloves without performing hand hygiene first, and wore hairnets, as they stood near the steam table. Dietary FF began to scoop up food items onto a clean plate from the steam table. Dietary EE grabbed the plate from Dietary FF and walked out of the kitchen to serve to a resident out in the dining room. On 03/12/24 at 01:30 PM, Dietary BB all food should be in sealed containers/bags with the item and date opened on the bag. The temperature logs for food and the dishwashers should be obtained daily and at each meal. The Food Storage (Dry/Refrigerated/Frozen) policy dated 2014 documented that all foods would be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. The Storing Utensils, Tableware, and Equipment policy dated 2014 documented that cleaned and sanitized utensils and equipment would be stored at least six inches off the floor in a clean, dry location in a way that keeps them from contamination by splash, dust or other means. Cleaned and sanitized equipment and utensils should be handled in a way that protects them from contamination. Spoons, knives, and forks should be touched only by their handles. Cups, glasses, bowls, plates, and similar items should be handled so as not to touch any surface that may come into contact with food or a resident's mouth. Glass and cups should be stored inverted. (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility lacked a policy regarding food service during mealtimes. The facility failed to ensure dietary staff appropriately stored, dated, and labeled food items after the original storage bag had been opened. The facility failed to ensure food temperatures and dishwasher temperature logs were assessed and monitored. This placed residents at risk of food-borne illnesses and cross-contamination.

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	175182	A. Building B. Wing	03/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility identified a census of 81 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to the disinfecting of shared equipment and the sanitary storage of respiratory equipment. The facility failed to ensure the appropriate chemicals were used to clean a clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements) isolation room and failed to post the correct type of isolation precautions for Resident (R) 236, who had a C-diff infection. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings included: - Observation on 03/11/24 at 07:26 AM revealed an enhanced barrier isolation sign was posted on Resident (R) 236's door with isolation bins that contained clean personal protective equipment (PPE-gowns, face shields and/or eyeglasses/goggles, and gloves) in the hallway outside the door. Upon further investigation, staff verified that R236 was on isolation precautions for C-diff. On 03/11/24 at 07:46 AM R286's bilevel positive airway pressure (BiPAP-medical device which helps with breathing) mask was laid on the floor next to his bed and his mask used for breathing treatments laid on top of a nightstand table next to his bed. R286's BiPap and breathing treatment masks were not stored inside a bag. On 03/11/24 at 08:58 AM R9's oxygen tubing was coiled and rested on the seat of her wheelchair next to the bed. The coiled oxygen tubing lacked a plastic bag or container for storage when not in use. On 03/12/24 at 03:48 PM, R12's BiPAP mask was laid directly on the top of the BiPAP machine unbagged. On 03/13/24 at 07:51 AM Certified Nurse Aide (CNA) M pushed the Hoyer (total body mechanical lift) from R30's room following a Hoyer transfer to the shower room, CNA M then walked to the dining room area. CNA M did not sanitize the lift before ensuring the lift was disinfected. On 03/13/24 at 08:33 AM, R12's BiPAP mask remained unbagged on the top of his BiPAP machine. On 03/13/24 at 12:04 PM Housekeeping Staff V used the Oxivir Tb Diversify disinfectant to clean R236's room who had a diagnosis of C-diff. The Disinfectant Products Overview sheet provided by the facility revealed the disinfectant used was not approved to kill the C-diff virus. On 03/13/24 at 02:13 PM, Certified Nurse Aide (CNA) N stated the mechanical lifts should be disinfected between each resident. CNA N stated respiratory equipment should be stored in a plastic bag when not in use. CNA N stated staff would know what PPE was to be worn and precautions to be taken before entering an isolation room by the sign posted on that resident's door. On 03/13/24 at 02:25 PM, Licensed Nurse (LN) K stated shared equipment should be disinfected and cleaned between each use. LN K stated respiratory equipment should be stored in a plastic bag when not in use, not on the cushion of the wheelchair. LN G stated the nurse would post the isolation sign on a resident's door when a resident was placed in isolation. LN G stated a resident with C-diff (continued on next page)

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	175182	A. Building B. Wing	03/13/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be placed in contact isolation not enhanced barrier isolation. On 03/13/24 at 04:025 PM, Administrative Nurse D stated respiratory equipment should be stored in a plastic bag when not in use. Administrative Nurse D stated shared equipment should be disinfected between each use. Administrative Nurse D stated a R236 should be on contact isolation, she was not aware that R236's room had an enhanced barrier isolation post on his door. The facility's Isolation Precautions policy dated 03/2020 documented: Contact Precautions: are used for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items. Contact Precautions, for example, when a draining wound cannot be contained, when a resident exhibits noncompliant behavior with stool or other body fluids, or when a resident has very poor personal hygiene, etc. The above includes epidemiologically important organisms or other highly transmissible infections such as Clostridium difficile. Wash hands immediately with soap and water or alcohol-based hand rub unless the isolated organism was C-diff than soap and water are recommended. The facility failed to ensure proper infection control standards were followed related to the disinfecting of shared equipment and the sanitary storage of respiratory equipment. The facility failed to ensure the appropriate chemicals were used to clean a C-diff isolation room and failed to post the correct type of isolation precautions for R236 who had a C-diff infection. This deficient practice placed the residents at risk for complications related to infectious diseases.

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	175182	A. Building B. Wing	03/13/2024

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility identified a census of 81 residents. Based on record review and interviews, the facility failed to designate a staff member with the required qualification and certification as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program. This deficient practice placed all residents at risk for lack of identification, tracking/trending, and treatment of infections. Findings included: - During the entrance conference Administrative Staff, A reported the facility did not have a certified Infection Preventionist and Administrative Nurse E was in the process of becoming certified. On 03/13/24 Administrative Nurse E was not available for the interview. On 03/13/24 at 04:02 PM Administrative Nurse D stated she was not certified as an Infection Preventionist, but had been tracking the immunizations, and doing the antibiotic stewardship. The facility was unable to provide an Infection Preventionist policy. The facility failed to ensure a staff member had the required qualification and certification as an Infection Preventionist to be responsible for the facility's Infection Prevention and Control Program. This deficient practice placed all residents at risk for lack of identification, tracking/trending, and treatment of infections.

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	175182	A. Building B. Wing	03/13/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 81 residents. The sample included 21 residents with five residents reviewed for immunizations. Based on record review and interview the facility failed to ensure that Resident (R) 16 and R82 were offered and educated regarding the Prevnar 20 (PCV20) pneumococcal (type of bacterial infection) vaccination or assessed by the physician to determine if contraindicated as recommended by the Centers for Disease Control and Prevention (CDC). This deficient practice placed these residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease. Findings included: - R16's immunization record in the EMR documented she had received a pneumococcal vaccination on 09/11/14 and 04/13/19. The facility lacked evidence the resident was assessed for appropriateness, offered, and educated regarding the PCV20. R61's immunization record in the EMR lacked documentation of any pneumococcal vaccinations being received or offered since admission on [DATE]. R82's immunization records in the EMR lacked records or documentation that she had been offered or had received the PCV20 vaccination. On 03/13/24 at 10:53 AM Administrative Nurse D stated she kept a file with her infection control information of what immunizations a resident had received. Administrative Nurse D stated the pneumococcal vaccine and PCV20 were offered at admission and every five years after. Administrative Nurse D stated the PCV20 was offered on admission and tracked in the Preventative Health tab. The Vaccination of Residents, Pneumococcal policy last revised 02/2024 documented that upon admission, residents would be assessed for the need for the pneumococcal vaccination. The CDC's Advisory Committee on Immunization Practices (ACIP) recommended a single dose of PCV20 for adults aged 65 years or older who had not previously received the pneumococcal conjugate vaccine (three pneumococcal vaccines PCV13, PCV15, and PCV20 are different vaccines recommended for different people based on age and medical status) or whose vaccination history was unknown. For adults aged 19 to 64 years with certain underlying medical conditions or risk factors who had not previously received the pneumococcal conjugate vaccine or whose vaccination history was unknown, ACIP recommended a single dose of PCV20. The facility failed to offer R16 and R82 the PCV20 vaccination as recommended by the CDC. This placed the facility residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease.

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	175182	A. Building B. Wing	03/13/2024

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. The facility reported a census of 81 residents. The sample included 21 residents. Five Certified Nurse Aides (CNA) were sampled for prevention of abuse, neglect, and exploitation training. Based on record review, and interviews the facility failed to provide evidence of the required prevention of abuse, neglect, and exploitation training for the two of the five CNAs that were sampled. Findings included: - Employee record review of CNA PP revealed the facility failed to provide evidence that CNA PP received the required abuse, neglect, and exploitation training. Employee record review of CNA QQ revealed the facility failed to provide evidence that CNA QQ received the required abuse, neglect, and exploitation training. On 03/13/24 at approximately 01:00 PM facility staff had placed two white binders on a table for survey staff to review. The binders contained various education topics from 2023 with accompanied staff sign-in sheets. The binders were separated with blank tabs and the majority of topics lacked a duration or tracked time period for the education provided. The binders lacked any clear way that demonstrated education hours and topics were tracked. On 03/12/24 at 09:54 AM Administrative Staff A stated she could not show the required 12 hours of yearly in-service education. Administrative Staff A further stated the staff responsible for providing staff education didn't track hours and the facility did not have the staff education from the previous 12 months. Administrative Staff A stated the facility took steps to improve the education process and tracking at the facility and that a new educator was hired. Administrative Staff A further stated education was tracked under the new system since February 2024 and that the facility had a skills fair for the staff that counted as six hours of education, and included dementia, abuse, neglect, and exploitation training. Administrative Staff A stated new staff would have to complete an eight-hour orientation. On 03/12/24 at 10:03 AM Administrative Staff B stated administrative staff searched through all the records and that the facility had all the education except for the year 2023. Administrative Staff B stated the previous educator may have left with the education records for 2023. Administrative Staff B stated CNA PP only worked at the facility one day a week, and that CNA PP had done his education at another facility. Administrative Staff B stated the facility had a plan in place to provide education for CNA PP despite him working only one day a week. Administrative Staff B further stated CNA QQ had completed the education from the skills fair; however, CNA QQ had not returned the book, and it had not been graded. Administrative Staff B stated the education hours would not have been recorded until the education was graded. On 03/13/24 at 10:56 AM Administrative Staff A stated the Inservice Records for NA/CNAs was the form used to track staff education in their new system. Administrative Staff A stated the information documented on the forms was all the facility had for education and that any staff who did not have the skills fair documented on their Inservice Records for NA's/CNA's form must not have made it to the training. (continued on next page)

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	03/13/2024

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility provided Certified Nursing Assistants/Medication Aids (CNAs/CMAs) with a reviewed date of 06/21, documented all direct care staff are required to attend twelve hours of continuing education annually including but not limited to dementia and prevention of abuse, neglect and exploitation of residents and immediately reporting. The facility failed to provide evidence of the required prevention of abuse, neglect, and exploitation training for two of the five CNAs that were sampled.

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	03/13/2024

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility had a census of 81 residents. The sample included 21 residents and five Certified Nurse Aides (CNAs) reviewed for required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education and two of the five CNA staff had the required in-service education for dementia (a progressive mental disorder characterized by failing memory, confusion) care. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's in-service records revealed the following: CNA LL, hired on 12/09/16, had eight hours of in-service in the past 12 months. CNA OO hired 09/29/09, had six hours of in-service in the past 12 months. CNA PP, hired on 10/26/21, had zero hours of in-service in the past 12 months, and CNA PP's records lacked evidence of the required education on the topic of dementia in the past 12 months. CNA QQ, hired on 01/03/18, had zero hours of in-service in the past 12 months, and CNA QQ's records lacked evidence of the required education on the topic of dementia in the past 12 months. CNA RR, hired on 02/14/18, had six hours of in-service in the past 12 months. On 03/13/24 at approximately 01:00 PM facility staff had placed two white binders on a table for survey staff to review. The binders contained various education topics from 2023 with accompanied staff sign-in sheets. The binders were separated with blank tabs and the majority of topics lacked a duration or tracked time period for the education provided. The binders lacked any clear way that demonstrated education hours and topics were tracked. On 03/12/24 at 09:54 AM Administrative Staff A stated she could not show the required 12 hours of yearly in-service education. Administrative Staff A further stated the staff responsible for providing staff education didn't track hours and the facility did not have the staff education from the previous 12 months. Administrative Staff A stated the facility took steps to improve the education process and tracking at the facility and that a new educator was hired. Administrative Staff A further stated education was tracked under the new system since February 2024 and that the facility had a skills fair for the staff that counted as six hours of education and new staff would have to complete an eight-hour orientation. On 03/12/24 at 10:03 AM Administrative Staff B stated administrative staff searched through all the records and that the facility had all the education except for the year 2023. Administrative Staff B stated the previous educator may have left with the education records for 2023. Administrative Staff B stated CNA PP only worked at the facility one day a week, and that CNA PP had done his education at another facility. Administrative Staff B stated the facility had a plan in place to provide education for CNA PP despite him working only one day a week. Administrative Staff B further stated CNA QQ had completed the education from the skills fair; however, CNA QQ had not returned the book, and it had not been graded. Administrative Staff B stated the education hours would not have been (continued on next page)

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	03/13/2024

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Delmar Gardens of Overland Park	12100 W 109th Street Overland Park, KS 66210

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recorded until the education was graded. On 03/13/24 at 10:56 AM Administrative Staff A stated the Inservice Records for NAs/CNAs was the form used to track staff education in their new system. Administrative Staff A stated the information documented on the forms was all the facility had for education and that any staff who did not have the skills fair documented on their Inservice Records for NA's/CNA's form must not have made it to the training. The facility provided Certified Nursing Assistants/Medication Aids (CNAs/CMAs) documented all direct care staff are required to attend twelve hours of continuing education annually including but not limited to dementia and prevention of abuse, neglect and exploitation of residents and immediately reporting. The facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education and two of the five CNA staff had the required in-service education for care. This placed the residents at risk for inadequate care.