STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 65 residents. The sample included 16 residents, with one reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure a dignified care environment for Residents (R) 31. This deficient practice placed R31 at risk for impaired dignity and unmet care needs. Findings included: - The Medical Diagnosis section within R31's Electronic Medical Record (EMR) included diagnoses 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), major depressive disorder (major mood disorder), muscle weakness, overactive bladder, and need for assistance with personal cares. R31's Significant Change Minimum Data Set (MDS) completed 04/06/25 indicated a Brief Interview for Mental Status (BIMS) of zero, indicating severe cognitive impairment. The MDS noted he exhibited wandering and rejection of care behaviors one to three days a week. The MDS indicated he was dependent on staff assistance for dressing, personal hygiene, bed mobility, toileting, and bathing. The MDS indicated he had one-sided lower extremity impairment and used a wheelchair for mobility. R31's Functional Abilities Care Area Assessment (CAA) completed 04/15/25 indicated he required assistance with self-cares and mobility. The CAA noted R31 exhibited poor judgment and safety awareness. The CAA noted he was at risk for falls, skin breakdown, pressure ulcers, weight loss, and a cognitive decline. The CAA noted he had poor memory recall. R31's Behavioral CAA completed 04/15/25 indicated he had behaviors related to refusing cares offered by staff. The CAA noted the behaviors had the potential to place himself at risk due to his poor safety awareness. The CAA noted his right to decline care needs. The CAA noted a care plan was implemented to minimize the risks associated with his potential behaviors. R31's Care Plan initiated 04/16/25 indicated he was at risk for cognitive loss, communication deficits, declined activities of daily living (ADL), bowel and bladder incontinence, and falls related to his cognitive impairment and medical diagnoses. The plan indicated he had behavioral challenges related to refusal of his ADLs, restorative care, medications, and meals. The plan encouraged staff to speak to him calmly, provide redirections, and ensure his environment was safe during agitation. The plan noted he enjoyed shopping trips, music, and special events. The plan lacked interventions related to his preferences or behaviors related to undressing. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's EMR under ID Notes revealed a Nursing Note completed 06/01/25. The note revealed R31 was found standing in his restroom with no clothes on next to the toilet. The note revealed staff toileted him and assisted with his cares. R31's EMR under ID Notes revealed a Nursing Note completed 05/27/25. The note revealed R31 removed his clothing for the entire night and refused to allow staff to provide cares for him. R31's EMR under ID Notes revealed a Nursing Note completed 06/01/25. The note revealed R31 was found naked in his bed with no sheets or blanket covering him. The note revealed R31 refused to allow staff to dress him or provide cares. On 06/02/25 at 07:03 AM, R31 slept in his bed. R31 was wearing no clothing and was exposed as he slept in his bed. R31's bed was viewable from the hallway. The exterior windows in R31's room were viewable from the outside area. On 06/02/25 at 07:34 AM, R31 was still asleep on his bed. R31 was still naked with nothing covering his body and visible from the hallway. On 06/02/25 at 07:38 AM, Certified Nurse's Aide (CNA) O entered R31's room to provide care. She stated that R31 sometimes preferred to sleep without clothing. She stated staff would still supervise and attempt to cover him up to prevent other residents from seeing him. On 06/04/25 at 11:32 AM, Licensed Nurse (LN) J stated R31 would often take his clothing off at night and refuse to wear them. She stated as long as he remained in his room it was his choice to do so. She stated he often was difficult to redirect or convince to redress or allow care to be given. On 06/05/25 at 12:45 PM, Administrative Nurse D stated residents had the right to choose to wear what they wanted, and staff were expected to make attempts to have the residents dressed. She stated the care plan should indicate a resident's choice or preferences to undress and be naked in their room. She stated staff should attempt to prevent other residents from seeing into the room or ensuring the resident was covered up. The facility's Dignity policy revised 11/2024 stated the facility was to ensure an environment that maintained and enhanced each resident's dignity and respect in full recognition of each resident's individuality.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 65 residents. The sample included 16 residents, with three residents reviewed for Beneficiary Notification. Based on record review and interview the facility failed to ensure a Center for Medicare/Medicaid Services (CMS) form 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) and the CMS form-10123 Notice of Medicare Non-Coverage (NOMNC) form was provided to Resident (R) 165. This placed R165 at risk of uninformed treatment decisions and unexpected costs. Findings included: - Review of R165 ' s Electronic Medical Record (EMR) noted an Interdisciplinary Team (IDT) Progress Note dated 02/03/25 at 04:41 PM documented staff met with R165's daughter and contacted the physician. Staff spoke to R165 regarding the last day covered and discharge to long-term care (LTC) on 02/07/25. Staff discussed with the NOMNC and the right to appeal. Staff discussed a room for the resident in the neighborhood of preference and would coordinate a transition date. The SNF Beneficiary Notification Review form (CMS-20052) completed by social services, documented R165 ' s Medicare Part A episode would end on 02/06/25. R165 remained in the facility for long-term care (LTC). Upon request from Social Services staff, R165 ' s SNF ABN form 10055 and NOMNC form 10123 was not provided. On 06/03/54 at 10:52 AM, Social Services X stated there had been a changeover in staff recently and it had been discovered that the ABN and NOMNC forms had not been issued to residents as they should have been. Social Services X stated she had recently taken over the responsibility of providing the ABN and NOMNC and residents would now receive the forms as required. The facility policy Medicare Denial Notices revised on 01/24/25 documented this facility will inform each resident before, or at the time of admission, and periodically during the resident ' s stay of services available in the facility and charges for those services including any charges for services not covered under Medicare by the facility ' s per diem rate. The facility would provide each resident with a written description of legal rights which included a description of the manner of protecting personal funds. This facility would provide written notification to residents with the necessary information to decide whether to appeal a decision to terminate Medicare care and services at least three days prior to the planned change in payor status or discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 65 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 50 and R1, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. This deficient practice placed R50 and R1 at risk for ineffective treatment, unnecessary medication use, and unwarranted side effects.Findings included:- R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), tachycardia (rapid heartbeat greater than 100 beats per minute), hypotension, hemiplegia (paralysis of one side of the body), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure)The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R50 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic medication during the observation period.The Quarterly MDS dated [DATE] documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R50 had received antipsychotic medication and antidepressant medication during the observation period.R50's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/03/25 documented he was at risk for adverse side effects of psychotropic medications.R50's Care Plan, dated 04/16/24, documented staff provided medication and treatments per the physician's orders. The plan of care documented the staff would monitor for side effects of his medications and notify the physician.R50's EMR under the Orders tab revealed the following physician orders:Olanzapine (antipsychotic) five mg, give one tablet by mouth daily for psychosis (any major mental disorder characterized by a gross impairment in reality perception), dated 03/13/25.Review of the Monthly Medication Review (MMR) reviewed from May 2024 to April 2025 revealed the CP had identified and reported the irregularities related to the non-approved indication for the use of antipsychotic medication Olanzapine for R50 who had a diagnosis of dementia and Alzheimer's disease. The facility was unable to provide physician documentation for risk versus benefits upon request.On 06/04/25 at 08:46 AM, R50 sat upright on the side of his bed as he watched TV in his room.On 06/04/25 at 11:20 AM, Licensed Nurse (LN) I stated he was unsure what the appropriate indications should be for antipsychotic medications. LN I stated the facility documented R50's behaviors.On 06/04/25 at 01:13 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated psychosis was not an appropriate indication for Olanzapine. Administrative Nurse D stated she was unsure if the physician had documented a risk vs benefit for R50's Olanzapine.The facility's Psychotropic Medication Use policy revised on 02/07/22 documented the resident's need for the psychotropic medication would be monitored, as well as when the resident received optimal benefits from the medication and when the medication dose can be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of as-needed (PRN) orders for psychotropic drugs to manage behaviors.- The Diagnosis tab of R1's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), Alzheimer's disease (progressive (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental deterioration characterized by confusion and memory failure), muscle weakness, encounter for palliative care (a specialized form of care that focuses on improving the quality of life for people living with serious illnesses when the resident was nearing the end of life or not), dependence on wheelchair, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The Quarterly Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R1 was rarely or never understood. The MDS documented R1 had behaviors that fluctuated in severity. The MDS documented R1 was dependent on staff for toileting and bathing. The MDS documented R1 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) during the observation period.R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/17/24 documented R1 triggered for this CAA due to the use of antipsychotic medication. The CAA documented the factors that place residents at risk for a problem including the potential for side effects from psychoactive medication. The CAA documented R1 had no recent falls that were attributed to the use of the medication. The CAA documented R1 had not demonstrated any apparent side effects or adverse consequences from the current medication regimen that contains Black Box Warning (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration).R1's Care Plan dated 04/30/24 documented the facility would work with the physician for a reduction in dosing when target behaviors are absent and or easily altered for specified periods, but no less than quarterly. R1's plan of care documented the facility would consider pharmacological interventions using medications other than antipsychotics, such as pain medication, by observing for lessening behavior and collaborating with the interdisciplinary team. The plan of care for R1 documented nursing was to administer a medication regimen as prescribed by the physician and notify the physician and psychiatrist for increased sedation, an increase in behavioral symptoms, unresponsiveness to environmental interventions, or an increase in side effects. R1's plan of care documented the facility would attempt gradual dose reduction (GDR) for antipsychotic medications per physician orders as recommended by the pharmacy consultant. R1's plan of care documented a GDR was being attempted, and staff will provide physical activities for R1 to participate in and help control the number of stimuli in her immediate environment.R1's EMR under Orders documented the following physician's order:Quetiapine fumarate (antipsychotic) 25 milligrams (mg) oral tablet, give 0.5 tablet by mouth every evening for severe dementia with agitation, dated 07/24/24.A review of R1's EMR revealed no physician-documented rationale for the continued use of quetiapine fumarate for dementia-related behaviors. The facility when asked was unable to provide a risk vs benefit for R1's continued use of Quetiapine.On 06/04/25 at 09:32 AM, R1 sat at the dining room table, visiting with peers.On 06/04/25 at 11:20 AM, Licensed Nurse (LN) I stated he was unsure what the appropriate indications should be for antipsychotic medications. LN I stated the facility documented R1's behaviors.On 06/04/25 at 01:13 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated dementia was not an appropriate indication for quetiapine. Administrative Nurse D stated she was unsure if the physician had documented a risk vs benefit for R1's quetiapine.The facility's Psychotropic Medication Use policy revised on 02/07/22 documented the resident's need for the psychotropic medication would be monitored, as well as when the resident received optimal benefits from the medication and when the medication dose can be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of as-needed (PRN) orders for psychotropic drugs to manage behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. The facility identified a census of 64 residents. The sample included 16 residents, with three reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to provide Resident (R) 19 with consistent assistance and supervision during mealtime. This deficient practice placed R19 at risk for potential risk related to impaired nutrition and weight loss. Findings included: - The Medical Diagnosis section within R19's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), anxiety (cognitive or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and speech/language deficits. R19's Quarterly Minimum Data Set (MDS) completed 04/02/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS indicated she required substantial to maximal assistance from staff to eat her meals. The MDS indicated she was at risk for skin breakdown and pressure ulcers but had no wounds. The MDS indicated she had pressure-reducing devices for her bed and wheelchair. The MDS noted she had a repositioning program and nutritional interventions to prevent pressure ulcers. The MDS noted she weighed 122 pounds (lbs.). R19's Functional Ability Care Area Assessment (CAA) completed 01/09/25 indicated she required assistance from staff for her Activities of Daily Living (ADL) related to her medical diagnoses. The CAA noted she had confusion due to a decline in her cognition. The CAA noted she required maximum assistance from one to two staff for bed mobility. The CAA noted she was not always able to express her needs. R19's Nutrition CAA completed 01/09/25 indicated she was at risk for malnutrition and weight loss due to her medical diagnosis. The CAA indicated that the facility was to provide her with a diet as prescribed and implemented interventions to reduce the risk. R19's Care Plan initiated on 01/22/25 indicated she was at risk for impaired decision-making, ADL deficits, falls, and weight loss related to her cognitive impairments and medical diagnoses. The plan noted she required extensive assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and wheelchair mobility. The plan noted that R19 required assistance from one staff while eating her meals. The plan instructed staff to encourage her to have meals in the dining room so R19 had supervision and cues to eat food during meals. The plan instructed staff to provide feeding assistance by mimicking actions to help her with self-feeding during meals. The plan indicated she was not to be left in her room alone while eating. The plan indicated she had a pressure-reducing low air-loss mattress on her bed. R19's EMR under Physician's Orders revealed an order (dated 02/10/22) instructing staff to administer one carton of Ensure (supplemental nutrition to prevent weight loss) by mouth 30 minutes after each meal for protein-calorie malnutrition. R19's EMR under Assessments revealed a Nutrition Risk Assessment completed 05/29/25. The assessment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that R19 required supervision during meals. The assessment noted she required partial to maximal assistance during mealtimes with feeding. The assessment revealed she was provided Ensure supplementation three times daily. On 06/02/25 at 09:30 AM, R19 rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back with the shoulders and neck propped upward to her bedside table. R19's breakfast meal was uncovered and untouched. R19's Ensure supplement was left with her breakfast meal. On 06/02/25 at 09:56 AM, R19 remained asleep in the same position but her Ensure supplement bottle was empty and rested downward in her lap. R19's push-button call light rested on the bed underneath her bed next to the wall. R19's breakfast meal remained untouched. R19's low air-loss mattress control panel was set to 200 lbs. On 06/03/25 at 09:20 AM, R19 rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back with the shoulders and neck propped upward to her bedside table. R19's food was untouched and uncovered. R19's Ensure supplement was served with her meal. On 06/03/25 at 09:32 AM, R19 lay in her bed and ate her breakfast meal in her room. Staff were not present as she consumed her breakfast meal. R19's call light was under her bed near the back wall. On 06/04/25 at 09:37 AM, R19's breakfast was served to her in her room. R19's Ensure supplement was given to her with her breakfast. Staff stayed in the room as R19 ate her meal and consumed her Ensure during her meal. On 06/04/25 at 11:25 AM, Licensed Nurse (LN) J stated that R19 only used the call light attached to her wall. She stated R19 had communication deficits and staff were expected to either move her out to the common area or ensure her call light was in reach while she was in her room. She stated staff were expected to monitor her during meals and provide encouragement. She stated that R19 often was confused and needed cueing. She stated staff were never to allow her to eat alone in her room. On 06/04/25 at 12:24 PM, Certified Nurses Aide (CNA) N stated staff were expected to follow the care plan. She stated if a resident chose to eat in their room and required assistance staff were to stay with them during the meal and aid them. On 06/04/25 at 01:13 PM, Administrative Nurse D stated staff were expected to supervise and provide assistance for residents based on their care planned needs. She stated resident with cognitive impairment should not be left alone in their rooms to eat during mealtimes. She stated staff were expected to encourage them to eat in the dining area or sit with them during mealtimes in their rooms. The facility's Activities of Daily Living policy revised 12/2021 stated the facility was to provide each resident with assistance to complete their daily activities and maintain their abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. The facility identified a census of 65 residents. The sample included 12 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for daily weights to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid) for Resident (R) 50. This deficient practice placed R50 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R17's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), retention of urine, kidney disease, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid, restlessness, and cerebral ischemia (a condition characterized by insufficient blood flow to the brain, leading to lack of oxygen and essential nutrients). The Annual Minimum Data Set (MDS) dated 08/28/24 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R17 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. The Quarterly MDS dated 02/26/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R17 had received diuretic medication during the observation period. R17's Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 02/26/25 documented R17 was noted to be frequently incontinent of bladder and needed extensive assistance with toileting needs including peri care. The CAA documented R17 was continent of bowel, and this increases the risk for skin breakdown and urinary tract infection (UTI). The CAA documented nursing staff would continue to assist R17, as needed, for him to have his needs met and continue his current level of functioning. R17's Care Plan dated 03/15/24 documented R17 was at risk for weight loss related to pain, diabetes, edema, medications, and a mechanically altered diet texture. R17's plan of care documented R17 wished to lose weight by one to two pounds a week. R17's plan of care documented R17 would be served a low carbohydrate diet of his choice with sugar-free beverages. R17's plan of care documented he would be encouraged to eat in the dining room. The plan of care documented R17 would be provided a carbohydrate-controlled diet, as ordered by the physician, and staff would weigh R17 daily as ordered by the physician. R17's EMR under the Orders tab revealed the following physician orders: Daily weight before breakfast, notify the physician with a weight gain of more than two pounds in one day or five pounds in one week, dated 07/15/24. Furosemide (diuretic) 40 milligrams (mg) tablet give one tablet by mouth daily for edema, dated 09/21/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's EMR under the Vitals tab, the Medication Administration Record (MAR), and Treatment Administration Record (TAR) from 03/01/25 to 05/08/25 (69 days) lacked evidence staff measured and recorded R17's weight on following nine dates: 03/04/25, 03/07/25, 03/08/25, 03/12/25, 03/14/25, 03/16/25, 04/04/25, 05/03/25, and 05/08/25. The TAR documented R17 had refused on 05/16/25. The clinical record lacked documentation of physician notification of daily weight was not obtained. On 06/04/25 at 08:38 AM, R17 sat in his wheelchair in his room. R17 sat at the bedside table and ate his breakfast. On 06/04/25 at 12:52 PM, Certified Nurse Aide (CNA) N stated all the staff assisted with obtaining the resident's daily weight if ordered. CNA N stated the nurse would notify the staff who was to be weighed daily. CNA N stated she would notify the nurse of the resident's weight. On 06/04/25 at 01:00 PM, Licensed Nurse (LN) H stated the nurse was responsible for ensuring a resident's daily weight was obtained and recorded. LN H stated the nurse would review the weight and notify the physician if needed and documented the notification and the physician's response in the resident's EMR. On 06/04/25 at 01:13 PM, Administrative Nurse D stated she expected the physician's orders to be followed. Administrative Nurse D stated the physician should be notified if a physician order was not followed, and that notification would be documented in the resident's interdisciplinary notes. The facility's Physician Orders for Medication and Treatments policy dated 10/20/23 documented all medications would be administered as ordered by a healthcare professional authorized by the state to order medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. The facility identified a census of 64 residents. The sample included 16 residents, with three reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because 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) 19's pressure-reducing interventions were implemented correctly when R19's low air-loss mattress pumps were not set within her current weight range. This deficient practice placed R19 at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Medical Diagnosis section within R19's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), anxiety (cognitive or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and speech/language deficits. R19's Quarterly Minimum Data Set (MDS) completed 04/02/25 noted a Brief Interview for Mental Status (BIMS) of zero, indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS indicated she required substantial to maximal assistance from staff to eat her meals. The MDS indicated she was at risk for skin breakdown and pressure ulcers but had no wounds. The MDS indicated she had pressure-reducing devices for her bed and wheelchair. The MDS noted she had a repositioning program and nutritional interventions to prevent pressure ulcers. The MDS noted she weighed 122 pounds (lbs.). R19's Functional Ability Care Area Assessment (CAA)) completed 01/09/25 indicated she required assistance from staff for her Activities of Daily Living (ADL)related to her medical diagnoses. The CAA noted she had confusion due to a decline in her cognition. The CAA noted she required maximum assistance from one to two staff for bed mobility. The CAA noted she was not always able to express her needs. R19's Pressure Ulcer CAA completed 01/09/25 indicated she was at risk for skin breakdown and pressure ulcers. The CAA noted she had no current skin breakdown but had pressure-relieving devices in place. The CAA noted care plan interventions were implemented to minimize the risks related to skin breakdown. R19's Care Plan initiated on 01/22/25 indicated she was at risk for impaired decision-making, ADL deficits falls, and weight loss related to her cognitive impairments and medical diagnoses. The plan noted she required extensive assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and wheelchair mobility. The plan noted that R19 required assistance from one staff member while eating her meals. The plan instructed staff to encourage her to have meals in the dining room so she had supervision and cues to eat food during meals. The plan instructed staff to provide feeding assistance by mimicking actions to help her with self-feeding during meals. The plan indicated she was not to be left in her room alone while eating. The plan indicated she had a pressure-reducing low air-loss mattress (specialized air mattress used to reduce pressure on the body) on her bed. The plan lacked guidance or instructions related to her low air-loss mattress settings. R19's EMR under Assessments revealed a Nutrition Risk Assessment completed 05/29/25. The assessment indicated that R19 required supervision during meals. The assessment noted she required partial 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
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maximal assistance during mealtimes with feeding. The assessment revealed she was provided Ensure supplementation three times daily. The Assessment revealed she had a Braden score (assessment used to predict pressure ulcer development) of 14 indicating she was at risk for developing pressure ulcers. A review of the manual of low air-loss mattress manufacturers' operation (Meridian Medical) indicated that 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 and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. On 06/02/25 at 09:56 AM, R19 remained asleep in the same position but her Ensure supplement bottle was empty and rested downward in her lap. R19's push-button call light rested on the bed underneath her bed next to the wall. R19's breakfast meal remained untouched. R19's low air-loss mattress control panel was set to 200 lbs. The mattress pump had fixed weight settings of 80lbs, 110lbs, 140lbs, 170lbs, 200lbs, 230lbs, 290lbs, 320lbs, and 350lbs. On 06/02/25 at 02:01 PM, R19 slept in her bed. R19's low air-loss mattress was set to 200 lbs. On 06/03/25 at 08:22 AM, R19 rested in her bed. R19's low air-loss mattress was set to 200 lbs. On 06/04/25 at 11:25 AM, Licensed Nurse (LN) J stated that R19's mattress was set by her current weight. She stated she noticed the bed setting was too high and just changed it to her current weight. She stated staff were expected to check the bed settings each shift. On 06/04/25 at 01:13 PM, Administrative Nurse D stated the staff were to check the low air-loss mattresses were set to the resident's current weight or within the weight range. She stated staff were expected to check the bed's settings each shift. The facility's Wound Management policy revised 09/2024 indicated the facility will assess each resident's risk related to pressure ulcers and implement preventative interventions. The policy indicated the effectiveness of the implemented intervention will be evaluated and reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 65 residents. The sample included 16 residents, with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure pressurized supplemental oxygen tanks in a safe, locked area, and out of reach of the 11 cognitively impaired independently mobile residents. The facility additionally failed to provide Resident (R) 19 with consistent supervision during her meals and ensure her call light remained within reach. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings included: - On 06/05/25 at 07:10 AM, an inspection of an unlocked supply closet in the dining area of the 700 hall revealed 13 fully pressurized supplemental oxygen cylinders stored in floor racks. An inspection of a storage closet next to the supply closet revealed unsecured cleaning chemicals. The containers contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 06/05/25 at 07:16 AM, Licensed Nurse (LN) K stated the rooms should be always locked and secured the doors. She stated sometimes staff forget to pull them fully closed. On 06/04/25 at 12:44 PM, Administrative Nurse D stated all utility closets containing chemicals or oxygen were expected to be locked and not accessible to the residents. The facility's Oxygen Storage policy revised 10/2024 indicated oxygen cylinders were to be stored in a manner that ensured proper ventilation, and safety, and secured away from potential combustible elements. The facility's Control of Hazardous Chemicals policy revised 10/2023 indicated the facility was to ensure an environment free from potentially hazardous materials, chemicals, and equipment. - The Medical Diagnosis section within R19's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), anxiety (cognitive or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and speech/language deficits. R19's Quarterly Minimum Data Set (MDS) completed 04/02/25 noted a Brief Interview for Mental Status (BIMS) of zero, indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS indicated she required substantial to maximal assistance from staff to eat her meals. The MDS indicated she was at risk for skin breakdown and pressure ulcers but had no wounds. The MDS indicated she had pressure-reducing devices for her bed and wheelchair. The MDS noted she had a repositioning program and nutritional interventions to prevent pressure ulcers. The MDS noted she weighed 122 pounds (lbs.). R19's Functional Ability Care Area Assessment (CAA) completed 01/09/25 indicated she required assistance from staff for her Activities of Daily Living (ADL) related to her medical diagnoses. The CAA noted she had confusion due to a decline in her cognition. The CAA noted she required maximum assistance from one to two staff for bed mobility. The CAA noted she was not always able to express her needs. The CAA noted she was at risk for falls related to her limited mobility and declining ADLs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's Care Plan initiated on 01/22/25 indicated she was at risk for impaired decision-making, ADL deficits falls, and weight loss related to her cognitive impairments and medical diagnoses. The plan noted she required extensive assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and wheelchair mobility. The plan noted that R19 required assistance from one staff while eating her meals. The plan instructed staff to encourage her to have meals in the dining room so she had supervision and cues to eat food during meals. The plan instructed staff to provide feeding assistance by mimicking actions to help her with self-feeding during meals. The plan indicated she was not to be left in her room alone while eating. The plan indicated she had a pressure-reducing low air-loss mattress on her bed. The plan instructed staff to keep her call light within reach while in her bed or chair. R19's EMR under Physician's Orders revealed an order (dated 02/10/22) that instructed staff to administer one carton of Ensure (supplemental nutrition to prevent weight loss) by mouth 30 minutes after each meal for protein-calorie malnutrition. R19's EMR under Assessments revealed a Nutrition Risk Assessment completed 05/29/25. The assessment indicated that R19 required supervision during meals. The assessment noted she required partial to maximal assistance during mealtimes with feeding. The assessment revealed she was provided Ensure supplementation three times daily. On 06/02/25 at 09:30 AM, R19's rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back with the shoulders and neck propped upward to her bedside table. R19's breakfast meal was uncovered and untouched. R19's Ensure supplement was left with her breakfast meal. On 06/02/25 at 09:56 AM, R19 remained asleep in the same position but her Ensure supplement bottle was empty and rested downward in her lap. R19's push-button call light rested on the bed underneath her bed next to the wall. R19's breakfast meal remained untouched. R19's low air-loss mattress control panel was set to 200 lbs. On 06/03/25 at 09:20 AM, R19's rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back with the shoulders and neck propped upward to her bedside table. R19's food was untouched and uncovered. R19's Ensure supplement was served with her meal. On 06/03/25 at 09:32 AM, R19 lay in her bed and ate her breakfast meal in her room. Staff were not present as she consumed her breakfast meal. R19 call light was under her bed near the back wall. On 06/04/25 at 09:37 AM, R19's breakfast was served to her in her room. R19'sEnsure supplement was given to her with her breakfast. Staff stayed in the room as she ate her meal and consumed her Ensure during her meal. On 06/04/25 at 11:25 AM, Licensed Nurse (LN) J stated R19 only used the call light attached to her wall. She stated R19 had communication deficits and staff were expected to either move her out to the common area or ensure her call light was in reach while she was in her room. She stated staff were expected to monitor her during meals and provide encouragement. She stated R19 often was confused and needed cueing. She stated staff were never to allow her to eat alone in her room. On 06/04/25 at 12:24 PM, Certified Nurses Aide (CNA) N stated staff were expected to follow the care plan. She stated if resident chose to eat in their room and required assistance, staff were to stay with them during the meal and aid them. She stated call lights were to remain within the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's reach while in bed. On 06/04/25 at 01:13 PM, Administrative Nurse D stated staff were expected to supervise and provide assistance to residents based on their care planned needs. She stated resident with cognitive impairment should not be left alone in their rooms to eat during mealtimes. She stated staff were expected to encourage them to eat in the dining area or sit with them during mealtimes in their rooms. She stated call lights were to remain within the resident's reach while in bed. The facility's Fall Management Policy policy revised 02/2025 indicated the facility was to assess each resident to identify potential accident risks and hazards. The policy indicated implementing interventions would be in place.to minimize the risks. The facility's Call Light Policy policy revised 11/2023 indicated the resident were to have access to a call system for communication. The policy indicated staff were expected to ensure the call light remained within reach of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** The facility identified a census of 65 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to address the Consultant Pharmacist (CP) recommendations for Resident (R) 50's Midodrine (hypotension (low blood pressure) medication). The facility also failed to ensure the physician had documented the rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of a non-approved indication use of an antipsychotic (class of medications used to treat a mental disorder characterized by a gross impairment in reality testing) medication for R50 and R1 with a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion). This deficient practice placed R50 and R1 at risk for unnecessary psychotropic medication and related complications.Findings included:- R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia, tachycardia (rapid heartbeat greater than 100 beats per minute), hypotension, hemiplegia (paralysis of one side of the body), and Alzheimer's disease.The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R50 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic medication during the observation period.The Quarterly MDS dated [DATE] documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R50 had received antipsychotic medication and antidepressant medication during the observation period.R50's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/03/25 documented he was at risk for adverse side effects of psychotropic medications.R50's Care Plan, dated 04/16/24, documented staff provided medication and treatments per the physician's orders. The plan of care documented the staff would monitor for side effects of his medications and notify the physician.R50's EMR under the Orders tab revealed the following physician orders:Midodrine five milligrams (mg) tablet give one tablet by mouth, three times a day for hypotension as needed. Administer for systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 130 millimeters (mm) of mercury (Hg) or diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) < 60 mmHg, not to exceed three times a day as needed ordered on 02/11/25 and discontinued on 05/06/25.Review of EMR under the Vitals tab revealed from 03/01/25 to 05/06/25 (67 days) documented blood pressure was within the physician-ordered parameters for administration of Midodrine on the following dates (50 opportunities): 03/01/25, 03/02/25, 03/05/25, 03/07/25, 03/09/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, 03/17/25, 03/18/25, 03/19/25, 03/20/25, 03/21/25, 03/24/25, 03/25/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, 04/01/25, 04/02/25, 04/03/25, 04/04/25, 04/05/25, 04/08/25, 04/09/25, 04/10/25, 04/13/25, 04/14/25, 04/15/25, 04/16/25, 04/17/25, 04/18/25, 04/19/25, 04/20/25, 04/21/25, 04/22/25, 04/23/25, 04/24/25, 04/25/25, 04/28/25, 04/29/25, 04/30/25, 05/01/25, 05/02/25, 05/03/25, 05/04/25, 05/05/25, and 05/06/25. The clinical record lacked documentation the physician was notified.Review of R50's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 03/01/25 to 05/06/25 revealed Midodrine was administered on 03/30/25.Review of the Monthly Medication Review (MMR) from May 2024 to April 2025 revealed the CP had identified and reported the irregularities related to the lack of administration of R50's as needed Midodrine as ordered. The CP had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported R50's blood pressure had been within the physician-ordered parameter to be administered on the following dates: 06/17/24, 07/19/24, 01/28/25, 09/01/24, 02/26/25, and 04/20/25.R50's EMR under the Orders tab revealed the following physician orders:Olanzapine five mg, give one tablet by mouth daily for psychosis (any major mental disorder characterized by a gross impairment in reality perception), dated 03/13/25.Review of the Monthly Medication Review (MMR) reviewed from May 2024 to April 2025 revealed the CP had identified and reported the irregularities related to the non-approved indication for the use of antipsychotic medication Olanzapine for R50 who had a diagnosis of dementia and Alzheimer's disease. The facility was unable to provide physician documentation for risk versus benefits upon request.On 06/04/25 at 08:46 AM, R50 sat upright on the side of his bed as he watched TV in his room.On 06/04/25 at 11:20 AM, Licensed Nurse (LN) I stated he was unsure what an appropriate indication for an antipsychotic medication was. LN I stated he did know there needed to be an indication from the physician for the use of the medication. LN H stated the nurse, or the certified nurse aide (CMA) would obtain the blood pressure and the pulse before administering any medication that required vital signs. LN H stated the nurse was responsible to ensure the medication was given as ordered by the physician. LN H stated the CMA would notify the nurse if a resident's vital signs were outside the normal or physician-ordered parameters. LN H stated the physician should be notified if that was ordered and the notification would be documented in the interdisciplinary (ID) notes, along with the physician's response.On 06/04/25 at 01:13 PM, Administrative Nurse D stated she was unsure what all the indications for the use of an antipsychotic medication were. Administrative Nurse D stated she did realize dementia and psychosis were not appropriate indications for antipsychotic medications. Administrative Nurse D stated she was unsure if the facility had been working with the pharmacist and physician on correct indications for antipsychotic drug use. , Administrative Nurse D stated she expected the physician's orders to be followed. Administrative Nurse D stated the physician should be notified if a physician order was not followed, and that notification would be documented in the resident's ID notes.The facility's Consultant Pharmacist policy last revised 03/24/24 documented the consultant pharmacist agreed to render the required service in accordance with local, state, and federal laws, regulations, guidelines, facility policies and procedures, community standards of practice, and professional standards of practice. Reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards and documenting the review and findings in the elder's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing.- The Diagnosis tab of R1's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, encounter for palliative care (a specialized form of care that focuses on improving the quality of life for people living with serious illnesses when the resident was nearing the end of life or not), dependence on wheelchair, and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The Quarterly Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R1 was rarely or never understood. The MDS documented R1 had behaviors that fluctuated in severity. The MDS documented R1 was dependent on staff for toileting and bathing. The MDS documented R1 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) during the observation period.R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/17/24 documented R1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	triggered for this CAA due to the use of antipsychotic medication. The CAA documented the factors that place residents at risk for a problem including the potential for side effects from psychoactive medication. The CAA documented R1 had no recent falls that were attributed to the use of the medication. The CAA documented R1 had not demonstrated any apparent side effects or adverse consequences from the current medication regimen that contains Black Box Warning (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration).R1's Care Plan dated 04/30/24 documented the facility would work with the physician for a reduction in dosing when target behaviors are absent and or easily altered for specified periods, but no less than quarterly. R1's plan of care documented the facility would consider pharmacological interventions using medications other than antipsychotics, such as pain medication, by observing for lessening behavior and collaborating with the interdisciplinary team. The plan of care for R1 documented nursing was to administer a medication regimen as prescribed by the physician and notify the physician and psychiatrist for increased sedation, an increase in behavioral symptoms, unresponsiveness to environmental interventions, or an increase in side effects. R1's plan of care documented the facility would attempt gradual dose reduction (GDR) for antipsychotic medications per physician orders as recommended by the pharmacy consultant. R1's plan of care documented a GDR was being attempted, and staff will provide physical activities for R1 to participate in and help control the number of stimuli in her immediate environment.R1's EMR under Orders documented the following physician's order:Quetiapine fumarate (antipsychotic) 25 milligrams (mg) oral tablet give 0.5 tablet by mouth every evening for severe dementia with agitation, dated 07/24/24.A review of the CP's Monthly Medication Reviews (MMR) from 04/2024 to 04/2025 revealed the Pharmacist did identify R1's quetiapine and made recommendations for the inappropriate indication of use related to R1's quetiapine medication. Upon request, the facility was unable to provide a risk vs benefit for the use of quetiapine for dementia with agitation.On 06/04/25 at 09:32 AM, R1 sat at the dining room table, visiting with peers.On 06/04/25 at 11:20 AM, Licensed Nurse (LN) I stated he was unsure what an appropriate indication for an antipsychotic medication was. LN I stated he did know there needed to be an indication from the physician for the use of the medication.On 06/04/25 at 01:13 PM, Administrative Nurse D stated she was unsure what all the indications for the use of an antipsychotic medication were. Administrative Nurse D stated she did realize dementia (a progressive mental disorder characterized by failing memory and confusion) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality) were not appropriate indications for antipsychotic medications. Administrative Nurse D stated she was unsure if the facility had been working with the pharmacist and physician on correct indications for antipsychotic drug use.The facility's Consultant Pharmacist policy last revised on 03/24/24 documented the consultant pharmacist agreed to render the required service by local, state, and federal laws, regulations, and guidelines, facility policies and procedures, community standards of practice, and professional standards of practice. Reviewing the medication regimen (drug regimen review) of each elder in the health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards and documenting the review and findings in the elder's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. The facility identified a census of 65 residents. The sample included 16 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician's order for Resident (R) 50's hypotension (low blood pressure) medication) was administered. This deficient practice placed R50 at risk for unnecessary medications and adverse side effects. Findings included: - R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), tachycardia (rapid heartbeat greater than 100 beats per minute), hypotension, hemiplegia (paralysis of one side of the body), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) The Annual Minimum Data Set (MDS) dated 12/25/24 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R50 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Quarterly MDS dated 03/12/25 documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R50 had received antipsychotic medication and antidepressant medication during the observation period. R50's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/03/25 documented he was at risk for adverse side effects of psychotropic medications. R50's Care Plan, dated 04/16/24, documented staff provided medication and treatments per the physician's orders. The plan of care documented the staff would monitor for side effects of his medications and notify the physician. R50's EMR under the Orders tab revealed the following physician orders: Midodrine (hypotensive) five milligrams (mg) tablet, give one tablet by mouth three times a day for hypotension as needed. Administer for systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 130 millimeters (mm) of mercury (Hg) or diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) < 60 mmHg, not to exceed three times a day as needed, ordered on 02/11/25 and discontinued on 05/06/25. Review of EMR under Vitals tab revealed from 03/01/25 to 05/06/25 (67 days) documented blood pressure was within the physician-ordered parameters for administration of Midodrine on the following dates (50 opportunities): 03/01/25, 03/02/25, 03/05/25, 03/07/25, 03/09/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, 03/17/25, 03/18/25, 03/19/25, 03/20/25, 03/21/25, 03/24/25, 03/25/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, 04/01/25, 04/02/25, 04/03/25, 04/04/25, 04/05/25, 04/08/25, 04/09/25, 04/10/25, 04/13/25, 04/14/25, 04/15/25, 04/16/25, 04/17/25, 04/18/25, 04/19/25, 04/20/25, 04/21/25, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/22/25, 04/23/25, 04/24/25, 04/25/25, 04/28/25, 04/29/25, 04/30/25, 05/01/25, 05/02/25, 05/03/25, 05/04/25, 05/05/25, and 05/06/25. The clinical record lacked documentation the physician was notified. Review of R50's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 03/01/25 to 05/06/25 revealed Midodrine was administered on 03/30/25. On 06/04/25 at 08:46 AM, R50 sat upright on the side of his bed as he watched TV in his room. On 06/04/25 at 01:00 PM, Licensed Nurse (LN) H stated the nurse or the certified nurse aide (CMA) would obtain the blood pressure and the pulse before administering any medication that required vital signs. LN H stated the nurse was responsible to ensure the medication was given as ordered by the physician. LN H stated the CMA would notify the nurse if a resident's vital signs were outside the normal or physician-ordered parameters. LN H stated the physician should be notified if that was ordered and the notification would be documented in the interdisciplinary (ID) notes, along with the physician's response. On 06/04/25 at 01:13 PM, Administrative Nurse D stated she expected the physician's orders to be followed. Administrative Nurse D stated the physician should be notified if a physician order was not followed, and that notification would be documented in the resident's interdisciplinary notes. The facility's Physician Orders for Medication and Treatments policy dated 10/20/23 documented all medications would be administered as ordered by a healthcare professional authorized by the state to order medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. The facility identified a census of 65 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 50 was free from a significant medication error by not following the physician-ordered parameter for the administration of Midodrine (hypotensive medication used to treat low blood pressure). This deficient practice placed R50 at risk for increased complications, untreated complications, and falls with possible injuries. Findings included: - R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), tachycardia (rapid heartbeat greater than 100 beats per minute), hypotension (low blood pressure), hemiplegia (paralysis of one side of the body), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) The Annual Minimum Data Set (MDS) dated 12/25/24 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R50 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Quarterly MDS dated 03/12/25 documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R50 had received antipsychotic medication and antidepressant medication during the observation period. R50's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/03/25 documented he was at risk for adverse side effects of psychotropic medications. R50's Care Plan, dated 04/16/24, documented staff provided medication and treatments per the physician's orders. The plan of care documented the staff would monitor for side effects of his medications and notify the physician. R50's EMR under the Orders tab revealed the following physician orders: Midodrine (hypotensive medication) five milligrams (mg) tablet, give one tablet by mouth three times a day for hypotension as needed. Administer for systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 130 millimeters (mm) of mercury (Hg) or diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) < 60 mmHg, not to exceed three times a day as needed, ordered on 02/11/25 and discontinued on 05/06/25. Review of EMR under the Vitals tab revealed from 03/01/25 to 05/06/25 (67 days) documented blood pressure was within the physician-ordered parameters for administration of Midodrine on the following dates (50 opportunities): 03/01/25, 03/02/25, 03/05/25, 03/07/25, 03/09/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, 03/17/25, 03/18/25, 03/19/25, 03/20/25, 03/21/25, 03/24/25, 03/25/25, 03/26/25, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/27/25, 03/28/25, 03/29/25, 04/01/25, 04/02/25, 04/03/25, 04/04/25, 04/05/25, 04/08/25, 04/09/25, 04/10/25, 04/13/25, 04/14/25, 04/15/25, 04/16/25, 04/17/25, 04/18/25, 04/19/25, 04/20/25, 04/21/25, 04/22/25, 04/23/25, 04/24/25, 04/25/25, 04/28/25, 04/29/25, 04/30/25, 05/01/25, 05/02/25, 05/03/25, 05/04/25, 05/05/25, and 05/06/25. The clinical record lacked documentation the physician was notified. Review of R50's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 03/01/25 to 05/06/25 revealed Midodrine was administered on 03/30/25. On 06/04/25 at 08:46 AM, R50 sat upright on the side of his bed as he watched TV in his room. On 06/04/25 at 01:00 PM, Licensed Nurse (LN) H stated the nurse or the certified nurse aide (CMA) would obtain the blood pressure and the pulse before administering any medication that required vital signs. LN H stated the nurse was responsible to ensure the medication was given as ordered by the physician. LN H stated the CMA would notify the nurse if a resident's vital signs were outside the normal or physician-ordered parameters. LN H stated the physician should be notified if that was ordered and the notification would be documented in the interdisciplinary (ID) notes, along with the physician's response. On 06/04/25 at 01:13 PM, Administrative Nurse D stated she expected the physician's orders to be followed. Administrative Nurse D stated the physician should be notified if a physician order was not followed, and that notification would be documented in the resident's interdisciplinary notes. The facility's Physician Orders for Medication and Treatments policy dated 10/20/23 documented all medications would be administered as ordered by a healthcare professional authorized by the state to order medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility identified a census of 65 residents. The sample included 16 residents, with four medication rooms and six medication carts. Based on observation, record review, and interviews, the facility failed to appropriately store medications and biologicals when staff failed to ensure the medication carts were locked when the cart was not within the nurses' view. This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - On 06/02/25 at 10:38 AM, on hall 600 the treatment cart containing residents' treatment supplies and as-needed (PRN) creams. Licensed nurse (LN) G stated the treatment cart should be locked and secured when staff walk away. The medication cart was out of LN G's view. On 06/04/25 at 01:01 PM, Administrative Nurse D stated the expectation of the facility was the medication carts should be locked if the cart was out of the nurse's view. The facility's Medication Labeling and Storage policy revised on 12/20/23 documented medications were labeled and stored in accordance with facility requirements and State and Federal laws. All drug containers would be labeled, and drug labels must be clear, consistent, legible, and in compliance with State and Federal requirements. There would be a standard method for appropriately and safely labeling medications dispensed to all residents. Only the provider pharmacy could modify or change prescription labels. All drugs and biologicals would be stored securely and appropriately following manufacturer recommendations and State and Federal Regulations as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. The facility identified a census of 64 residents. The sample included 16 residents, with three reviewed for specialized diets. Based on observation, record review, and interviews, the facility failed to follow Resident (R) 19's physician's order to provide Ensure supplementation 30 minutes after her meals. This deficient practice placed R19 at risk for potential risk related to impaired nutrition and weight loss. Findings Included: The Medical Diagnosis section within R19's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia (difficulty sleeping), anxiety (cognitive or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and speech/language deficits. R19's Quarterly Minimum Data Set (MDS) completed 04/02/25 noted a Brief Interview for Mental Status (BIMS) of zero, indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for bathing, transfers, bed mobility, personal hygiene, and dressing. The MDS indicated she required substantial to maximal assistance from staff to eat her meals. The MDS indicated she was at risk for skin breakdown and pressure ulcers but had no wounds. The MDS indicated she had pressure-reducing devices for her bed and wheelchair. The MDS noted she had a repositioning program and nutritional interventions to prevent pressure ulcers. The MDS noted she weighed 122 pounds (lbs). R19's Functional Ability Care Area Assessment (CAA) completed 01/09/25 indicated she required assistance from staff for her Activities of Daily Living (ADL)related to her medical diagnoses. The CAA noted she had confusion due to a decline in her cognition. The CAA noted she required maximum assistance from one to two staff for bed mobility. The CAA noted she was not always able to express her needs. R19's Nutrition CAA completed 01/09/25 indicated she was at risk for malnutrition and weight loss due to her medical diagnosis. The CAA indicated that the facility was to provide her with a diet as prescribed and implemented interventions to reduce the risk. R19's Care Plan initiated on 01/22/25 indicated she was at risk for impaired decision-making, ADL deficits, falls, and weight loss related to her cognitive impairments and medical diagnoses. The plan noted she required extensive assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and wheelchair mobility. The plan noted that R19 required assistance from one staff while eating her meals. The plan instructed staff to encourage her to have meals in the dining room so she had supervision and cues to eat food during meals. The plan instructed staff to provide feeding assistance by mimicking actions to help her with self-feeding during meals. The plan indicated she was not to be left in her room alone while eating. The plan indicated she had a pressure-reducing low air-loss mattress on her bed. R19's EMR under Physician's Orders revealed an order (dated 02/10/22) that instructed staff to administer one carton of Ensure (supplemental nutrition to prevent weight loss) by mouth 30 minutes after each meal for protein-calorie malnutrition. R19's EMR under Assessments revealed a Nutrition Risk Assessment completed 05/29/25. The assessment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that R19 required supervision during meals. The assessment noted she required partial to maximal assistance during mealtimes with feeding. The assessment revealed she was provided Ensure supplementation three times daily. On 06/02/25 at 09:30 AM, R19 rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back (supine position) with the shoulders and neck propped upward to her bedside table. R19's breakfast meal was uncovered and untouched. R19's Ensure supplement was left with her breakfast meal. On 06/02/25 at 09:56 AM, R19 remained asleep in the same position but her Ensure supplement bottle was empty and rested downward in her lap. R19's push-button call light rested on the bed underneath her bed next to the wall. R19's breakfast meal remained untouched. R19's low air-loss mattress control panel was set to 200 lbs. On 06/03/25 at 09:20 AM, R19 rested in her bed. R19's bedside table was positioned over her chest. R19 lay flat on her back with the shoulders and neck propped upward to her bedside table. R19's food was untouched and uncovered. R19's Ensure supplement was served with her meal. On 06/03/25 at 09:32 AM, R19 lay in her bed and ate her breakfast meal in her room. Staff were not present as she consumed her breakfast meal. R19's call light was under her bed near the back wall. On 06/04/25 at 09:37 AM, R19's breakfast was served to her in her room. R19's Ensure supplement was given to her with her breakfast. Staff stayed in the room as she ate her meal and consumed her Ensure during her meal. On 06/04/25 at 11:25 AM, Licensed Nurse (LN) J stated supplements were provided with the meals based on the resident's dietary orders. She stated staff were expected to follow the diet and specific needs of the residents. She stated if ordered to wait 30 minutes after each meal, staff were expected to wait the full thirty minutes before offering the ensure. On 06/04/25 at 12:50 PM, Dietary Staff CC stated staff were to hold the Ensure supplement until 30 minutes after R19's meal to ensure she consumed her meal before being given a supplement. He stated the facility wanted to focus on meal consumption before supplements were offered. On 06/04/25 at 01:13 PM, Administrative Nurse D stated staff were expected to follow the dietary orders based on the specific timeframe outlined by the order. She stated staff were expected to wait 30 minutes after R19's meals to offer the Ensure supplement. The facility's Special Diets policy (undated) indicated the facility would provide dietary supplementation to residents at risk for weight loss and malnutrition. The policy indicated the facility would follow the guidance of the medical and dietician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 64 residents. The facility had one main kitchen, three kitchenettes, and dining areas. Based on observation and interview the facility failed to ensure that opened packages of frozen foods were stored in a sealed bag with a label and an open date. The facility failed to ensure staff wore a hairnet when in the kitchen food preparation and serving areas. The facility failed to ensure staff delivered plates of food in a sanitary manner. The facility failed to ensure staff performed hand hygiene after serving residents their plates and or drinks. This placed residents at risk of food-borne illnesses. Findings included: - During the initial tour of the main kitchen area on 06/02/25 at 07:08 AM, the following was noted: Dietary Staff CC was noted not to be wearing a hairnet to cover his hair and was not wearing a beard net to cover his facial hair and beard. In the food prep freezer were three opened brown bags of frozen potato products. The bags had not been placed into a sealed bag and the items had no label or open date present. On 06/02/25 at 12:17 PM, on the 700-hall dining/serving area the unidentified dietary server had a hairnet on and had gloves on during the serving of the food. The unidentified dietary server drained the liquid off a bowl of fruit and then continued to place food items on plates of food for the residents. The unidentified dietary server had not changed her gloves during the meal service. On 06/02/25 at 12:23 PM, an unidentified Certified Nurse Aide (CNA) assisted with serving prepared plates of food to the residents. During the serving of resident plates, the unidentified CNA served two plates to a resident with her thumb on top of the lip of the plate. During the service of four residents, the unidentified CNA failed to perform hand hygiene at any point during the serving of the plated food. On 06/03/25 at 08:56 AM, on the 100-hall kitchenette area, the unidentified dietary server wore gloves while serving food but did not have her long ponytailed hair in a hairnet. On 06/03/24 at 10:58 AM, Dietary Services BB stated all staff either in the kitchen or in the unit kitchenettes should be wearing a hairnet whenever in the food prep or serving areas. Dietary BB also stated that any opened bags of food should be placed in a sealed bag with a label and an open date. Dietary BB stated she would talk to staff to reeducate them on appropriate food serving and hand hygiene techniques. The Food Storage- Food Safety & Infection Control policy dated 09/07/22, documented all opened food items returned to storage must be labeled and dated with the opened date or the prepared and a use-by date. All food items must be properly wrapped or placed in a container. The date the item was opened must be written below the date received. All identified food items that are open and not labeled with a use-by date are immediately discarded. The facility lacked a policy for serving meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 65 residents. The facility identified eleven residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to perform hand hygiene before performing glucose checks, and before performing intravenous (IV - administered directly into the bloodstream via a vein) administration. The facility further failed to sanitize the Hoyer (total body mechanical lift) lift between residents. This defiant practice placed residents at risk of infections. Included findings: - On 06/02/25 at 11:44 AM, Licensed Nurse (LN) G performed a blood glucose checks for Resident (R)163. LN G cleaned the glucometer (an instrument used to calculate blood glucose), with alcohol wipes, LN G wiped R163's finger with the same alcohol wipe and then wiped the hub of the insulin pen. LN G did not perform hand hygiene before preparing the glucometer. On 06/02/25 at 12:18 PM, LN G gathered supplies from the nurse cart. LN G knocked on the door of R58's room. LN G did not perform hand hygiene before going into R58's room. LN G placed the IV supplies for R58 on her bed. LN G opened the alcohol wipe and removed the cap from the IV port hub. LN G cleaned the hub with an alcohol wipe and primed the IV medication. LN G did not perform hand hygiene before attaching the IV medication to the hub. On 06/04/25 at 11:22 AM, Certified Nurse's Aide (CNA) M used the Hoyer lift in R1's room. When CNA M was finished with the Hoyer lift, CNA M pushed the Hoyer lift into the hallway and walked away from the Hoyer lift. CNA M did not sanitize the Hoyer lift. On 06/02/25 at 11:30 AM, L N G stated she should have performed hand hygiene prior to the finger stick for R163 and at the end of the task. On 06/02/25 at 12:31 PM, LN G stated hand hygiene should be performed before entering a resident's room, and hand hygiene should be performed going from dirty to clean task when administrating IV medications. On 06/04/25 at 11:20 AM, LN I stated the nursing staff disinfected the sit-to-stand. LNI stated nursing staff do not always sanitize the Hoyer, because the resident does touch the lift. LN I stated the neighborhood keeps the sanitizing wipes in the medication cart, and nursing staff could just ask for those. On 06/04/25 at 11:22 AM, CNA M stated nursing staff are trained to sanitize lifts. CNA M stated sit to stands were always sanitized because the residents touch the lift. CNA M stated she does not clean the Hoyer as often, because the residents were in slings with their arms crossed and are not touching the lift. On 06/05/25 at 01:13 PM Administrative Nurse D stated all shared equipment should be sanitized between resident use. Administrative Nurse D stated staff should perform hand hygiene before entering a resident room and going from dirty to clean tasks. The facility's Hand Hygiene policy revised on 01/05/22 documented that all staff members would (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of heal associated infections (HAIs). When hands were visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. Handwashing may also be used for routine decontamination hands in the following clinical situations, before and after having direct contact with patients. When moving from a contaminated body site to a clean body site during elder care before and after contact with inanimate objects including medical equipment in eh immediate vicinity of the elder and after removing gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 identified a census of 65 residents. Based on record review and interviews, the facility failed to ensure that direct care staff had received the required in-service education for nurse aide training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 06/03/25, a review of the provided training for facility staff Certified Nurses Aid (CNA) M, CNA N, and Certified Medication Aide (CMA) R and CMA S revealed the following: CNA M's facility-provided credentialing file lacked evidence of the required 12 hours of nurse aid in-service training. CNA N's facility-provided credentialing file lacked evidence of the required 12 hours of nurse aid in-service training. CMA R's facility-provided credentialing file lacked evidence of the required 12 hours of nurse aid in-service training. CMA S's facility-provided credentialing file lacked evidence of the required 12 hours of nurse aid in-service training. On 06/03/25 at 02:56 PM, Administrative Staff A stated the nurse aide in-services had been the responsibility of the facility scheduler previously, but it had been noticed that CNAs and CMA's had not completed the required number of yearly educations. Administrative Staff A stated that the director of nursing (DON) was now responsible to ensure the nursing staff completed the required number of hours of education/training yearly. The facility policy CNA Required Training and In-services last revised on 05/05/25 documented that all direct care staff was required to attend twelve (12) hours of continuing education and demonstrate competency annually, including but not limited to: o Infection Control, including bloodborne pathogens and Antibiotic Stewardship o Health Insurance Portability and Accountability Act (HIPAA) and confidentiality o Resident rights and facility responsibilities o Prevention of abuse, neglect, exploitation, and mistreatment of residents o Compliance and ethics o Advance directives and the Patient Self-Determination Act o Emergency preparedness o Quality Assurance/Performance Improvement (QAPI) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Shalom Inc	5500 West 123rd St Overland Park, KS 66209

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Communication o Safety and hazard training program o Behavioral Health including but not limited to Trauma-Informed Care and Substance Use Disorder as identified in Facility Assessment o Non-Pharmacological Interventions