STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	7541 SWITZER ROAD OVERLAND PARK, KS 66214

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 138. The sample included 15 residents. Based on observations, interviews and record review the facility failed to failed to ensure Resident (R) 2 was free from physical abuse when a staff member slapped R2 on the chest Findings included: - R2's electronic medical record (EMR), under the Medical [DIAGNOSES REDACTED]. The 02/07/20 Significant Change Minimum Data Set (MDS) assessment for R2 documented the resident had severely impaired cognition. Staff assessed the resident as having mild depression. The resident had physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) one to three days of the assessment period. She had other behavioral symptoms not directed towards others (hitting or scratching self, pacing, rummaging) daily. None of the identified symptoms put others at significant risk of injury, disrupted care or living environment or put others at significant risk of physical injury per the MDS. She rejected care one to three days of the assessment period. She required extensive assistance of one to two staff members for most of her activities of daily living (ADLs), with no limitations in range of motion. She received antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications for seven days of the assessment period. The Quarterly MDS for R2 dated 04/13/20 documented staff assessed resident as having long and short-term memory loss with severely impaired cognitive skills for daily decision making. Staff assessed the resident as having mild depression. The resident displayed physical behavioral symptoms directed towards other daily and required extensive assistance of one staff member for most of her ADLs. She received antipsychotic and antidepressant medications for seven days of the assessment period. The Cognitive loss/Dementia Care Area Assessment (CAA) for documented R2 had a history and [DIAGNOSES REDACTED]. The CAA for Behavioral Symptoms dated 02/10/20 documented she continued to be socially inappropriate (intrusive with peers and taking their personal items), verbally aggressive and wandered. The Care Plan for R2 recorded she was at risk for behaviors with physical aggression revised 03/23/20 directed staff to administer medications as ordered, assess and address for sensory deficits, assess and anticipate resident's needs, document resident's behavior and attempted interventions in the behavior log. Encourage her to rest when she is tired, redirect her away from peers when she becomes agitated. Her triggers were loudness and chaos. The Facility Investigation dated 04/25/20 revealed Activity Coordinator Z witnessed the agency Certified Medication Aide (CMA) R strike R2 on the chest with an open hand on 04/19/20 in the dining room area. Activity Coordinator Z reported the incident to the Director of Nursing (DON) on 04/20/19. The DON verbally educated Activity Coordinator Z on the policy for abuse, exploitation and neglect. The facility notified the staffing agency CMA R was employed through of the abuse. CMA R has not worked at the facility since finishing her shift on 04/19/20. A Progress Note under the Progress Note tab of the EMR documented on 4/20/2020 an activities staff member reported witnessing an agency CMA strike the resident across the chest with an open hand on the morning of 4/19/2020. The staff member quickly redirected the resident away from the CMA. Pain and skin assessments were completed, and family was notified. Agency staff person had not been in the building since notification of alleged abuse. Observation on 06/02/20 at 12:05 PM R2 sat in a chair in the dining room area. She smiled when spoken to. No behaviors were noted. During an interview on 06/02/20 at 09:00 AM Certified Nurse Aide (CNA) N stated she was not sure when she had last received training or education related abuse, neglect or exploitation training. CNA N stated she had not noticed any behavior changes in R2 since 04/20/20. During an interview on 06/02/20 at 09:30 AM Licensed Nurse (LN) L stated she had worked on English Ivy Avenue for only five shifts. LN L stated she completed dementia and abuse, neglect and exploitation training yearly through the agency she was employed through. During a phone interview on 06/02/20 at 04:30 PM with Activity Coordinator Z, she stated she had witnessed CMA R strike R2 on 04/19/20 at 11:00 AM with an open hand in the dining room area. Activity Coordinator Z stated she redirected R2 to a safe place. Activity Coordinator Z stated she asked other staff members about the witness statement to fill out to notify the Director of Nursing (DON) of the witnessed incident. The staff on duty had told her they did not know where to find the witness statement. Activity Coordinator Z stated that she had not involved the staff on duty on 04/19/20 about the abuse incident with R2 because she did not want staff to be gossiping about R2. Activity Coordinator Z then informed the DON of the witnessed abuse on 04/20/20. During an interview on 06/03/20 at 01:40 PM with Social Worker X, she stated she was out of the of the facility on 4/20/20 and had been informed of the incident on 06/02/20. During an interview on 06/03/20 at 02:13 PM. Administrative Nurse D stated she was notified of the allegation of abuse for R2 on 04/20/20 but confirmed the incident happened on 04/19/20. After Administrative Nurse D was notified of the alleged abuse, she notified the Administrator on 04/20/20. Administrative Nurse D stated she had verbally educated Activity Coordinator Z of the policy for abuse, neglect and exploration. Administrative Nurse D stated she notified the police of the abuse on 04/23/20. During an interview on 06/03/20 at 02:54PM, Administrative Staff A stated she was informed of the abuse incident late on 04/20/20 by the DON. She stated she notified the staffing agency where CMA R was employed. The facility policy The Protection of Residents: Reducing the Threat of Abuse and Neglect revised 05/15/20 documented residents must not be subjected to abuse by anyone. Including but not limited to staff, other residents . staff from other agencies . It directed facility staff to provide an environment free from abuse, neglect and exploitation. The facility failed to provide an environment free from physical abuse when an agency staff member slapped R2, who had dementia, on the chest. This deficient practice placed R2 at risk for physical abuse.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 138. The sample included 15 residents. Based on observation, interviews and record review a facility staff member failed to report an allegation of physical abuse of Resident (R) 2 to administrative staff. The facility also failed to report the allegation of abuse to the state agency within the required reporting timeframe. Findings included: - R2's electronic medical record (EMR), under the Medical [DIAGNOSES REDACTED]. The 02/07/20 Significant Change Minimum Data Set (MDS) assessment for R2 documented the resident had severely impaired cognition. Staff assessed the resident as having mild depression. The resident had physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) one to three days of the assessment period. She had other behavioral symptoms not directed towards others (hitting or scratching self, pacing, rummaging) daily. None of the identified symptoms put others at significant risk of injury, disrupted care or living environment or put others at significant risk of physical injury

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

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) per the MDS. She rejected care one to three days of the assessment period. She required extensive assistance of one to two staff members for most of her activities of daily living (ADLs), with no limitations in range of motion. She received antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications for seven days of the assessment period. The Quarterly MDS for R2 dated 04/13/20 documented staff assessed resident as having long and short-term memory loss with severely impaired cognitive skills for daily decision making. Staff assessed the resident as having mild depression. The resident displayed physical behavioral symptoms directed towards other daily and required extensive assistance of one staff member for most of her ADLs. She received antipsychotic and antidepressant medications for seven days of the assessment period. The Cognitive loss/Dementia Care Area Assessment (CAA) for R2 documented she had a history and [DIAGNOSES REDACTED]. The CAA for Behavioral Symptoms dated 02/10/20 documented she continued to be socially inappropriate (intrusive with peers and taking their personal items), verbally aggressive and wandered. The Care Plan revised 03/23/20 for R2 recorded she was at risk for behaviors with physical aggression and directed staff to administer medications as ordered, assess and address for sensory deficits, assess and anticipate resident's needs, document resident's behavior and attempted interventions in the behavior log. Encourage her to rest when she is tired, redirect her away from peers when she becomes agitated. Her triggers are loudness and chaos. The Facility Investigation dated 04/25/20 revealed Activity Coordinator (AC) Z witnessed an agency Certified Medication Aide (CMA) R strike R2 on the chest with an open hand on 04/19/20 at approximately 11:00 AM in the dining room area. Activity Coordinator Z reported the incident to the Director of Nursing (DON) on 04/20/19. The DON verbally educated AC Z on the policy for abuse, exploitation and neglect. The facility notified the staffing agency that CMA R was employed through of the allegation of abuse. CMA R has not worked at the facility since finishing her shift on 04/19/20. Law enforcement was notified on 04/23/20. A Progress Note under the Progress Note tab of the EMR documented on 4/20/2020 an activities staff member reported witnessing an agency CMA strike the resident across the chest with an open hand on the morning of 4/19/2020. The staff member quickly redirected the resident away from the CMA. Pain and skin assessments were completed, and family was notified. Certified Medication Aide R has not been in the building since notification of alleged abuse. Observation on 06/02/20 at 12:05 PM revealed R2 sat in a chair in the dining room area. She smiled when spoken to. No behaviors were noted. During an interview on 06/02/20 at 09:00 AM Certified Nurse Aide (CNA) N stated she was not sure when she last received training or education related abuse, neglect or exploitation training. CNA N stated she had not noticed any behavior changes in R2 since 04/20/20. During an interview on 06/02/20 at 09:30 AM Licensed Nurse (LN) L stated she had worked on English Ivy Avenue unit for only five shifts. LN L stated she completed dementia and abuse, neglect and exploitation training yearly through the staffing agency she was employed through. During a phone interview on 06/02/20 at 04:30 PM with AC Z, stated she witnessed CMA R strike R2 on 04/19/20 approximately 11:00 AM with an open hand in the dining room area. AC Z stated she redirected R2 to a safe place. Activity Coordinator Z stated she asked other staff members about the witness statement to fill out to notify the Director of Nursing (DON) of the witnessed incident. The staff on duty told her they did not know where to find the witness statement. Activity Coordinator Z stated she had not involved the staff on duty on 04/19/20 about the abuse incident with R2 because she did not want staff to be gossiping about R2. Activity Coordinator Z then informed the DON of the witnessed abuse on 04/20/20. During an interview on 06/03/20 at 01:40 PM with Social Worker X, stated she was out of the facility on 4/20/20 and had been informed of the incident on 06/02/20. During an interview on 06/03/20 at 02:13 PM. Administrative Nurse D stated she was notified of the allegation of abuse for R2 on 04/20/20 but confirmed the incident happened on 04/19/20. After Administrative Nurse D was notified of the alleged abuse, she notified the Administrator on 04/20/20. Administrative Nurse D stated she had verbally educated AC Z of the policy for abuse, neglect and exploration. Administrative Nurse D stated she notified the police of the allegation of abuse on 04/23/20. Administrative Nurse D stated that she was unsure of the required reporting timeframe for allegations of abuse, neglect and exploitation to the state agency. During an interview on 06/03/20 at 02:54 PM, Administrative Staff A stated she was informed of the allegation of abuse late on 04/20/20 by the DON. She stated she notified the staffing agency where CMA R was employed on 04/20/20. The facility policy The Protection of Residents: Reducing the Threat of Abuse and Neglect revised 05/15/20 documented residents must not be subjected to abuse by anyone. Including but not limited to staff, other residents . staff from other agencies . It directed facility staff to promptly report any incident or suspected incident of resident abuse and or neglect to the Administrator or DON. The Administrator or DON will complete an investigation of the incident including a written summary of the findings, no later than five working days after the oceanic. The facility failed to inform the Administrator or DON of an allegation of physical abuse of R2 by facility staff. The facility failed to follow the reporting requirements of reporting any allegation of abuse within the required timeframe to the state agency.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 138 residents. The sample included 15 residents. Based on observation, interviews and record review the facility failed to thoroughly investigate an allegation of physical abuse by facility staff to Resident (R) 2 when the facility failed to perform and document a psychosocial assessment of R2 after the incident occurred. The facility also failed to implement and document corrective action taken as a result of the physical abuse to R2. Findings included: - R2's electronic medical record (EMR), under the Medical [DIAGNOSES REDACTED]. The 02/07/20 Significant Change Minimum Data Set (MDS) assessment for R2 documented the resident had severely impaired cognition. Staff assessed the resident as having mild depression. The resident had physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) one to three days of the assessment period. She had other behavioral symptoms not directed towards others (hitting or scratching self, pacing, rummaging) daily. None of the identified symptoms put others at significant risk of injury, disrupted care or living environment or put others at significant risk of physical injury per the MDS. She rejected care one to three days of the assessment period. She required extensive assistance of one to two staff members for most of her activities of daily living (ADLs), with no limitations in range of motion. She received antipsychotic (class of medications used to treat [MEDICAL CONDITION] and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications for seven days of the assessment period. The Quarterly MDS for R2 dated 04/13/20 documented staff assessed resident as having long and short-term memory loss with severely impaired cognitive skills for daily decision making. Staff assessed the resident as having mild depression. The resident displayed physical behavioral symptoms directed towards other daily and required extensive assistance of one staff member for most of her ADLs. She received antipsychotic and antidepressant medications for seven days of the assessment period. The Cognitive loss/Dementia Care Area Assessment (CAA) for R2 documented she had a history and [DIAGNOSES REDACTED]. The CAA for Behavioral Symptoms dated 02/10/20 documented she continued to be socially inappropriate (intrusive with peers and taking their personal items), verbally aggressive and wandered. The Care Plan revised 03/23/20 for R2 recorded she was at risk for behaviors with physical aggression and directed staff to administer medications as ordered, assess and address for sensory deficits, assess and anticipate resident's needs, document resident's behavior and attempted interventions in the behavior log. Encourage her to rest when she is tired, redirect her away from peers when she becomes agitated. Her triggers are loudness and chaos. The Facility Investigation dated 04/25/20 revealed Activity Coordinator (AC) Z witnessed agency Certified Medication Aide (CMA) R strike R2 on the chest with an open hand on 04/19/20 at approximately 11:00 AM in the dining room area. AC Z reported the incident to the Director of Nursing (DON) on 04/20/19. The DON verbally educated AC Z on the policy for abuse, exploitation and neglect. The facility notified the staffing agency that employed CMA R of the allegation of abuse. CMA R has not worked at the facility since finishing her shift on 04/19/20. Law enforcement was notified on 04/23/20. A Progress Note under the Progress Note tab of the EMR documented on 4/20/2020 an activities staff member reported witnessing an agency CMA strike the resident across the chest with an open hand on the morning of 4/19/2020. The staff member quickly redirected the resident away from the CMA. Pain and skin assessments were completed, and family was notified. CMA R has not been in the building since notification of alleged abuse. R2's clinical record lacked evidence follow up assessments were completed during the facility investigation to assess for psychosocial impact of the event on R2. Review of an email sent on 04/20/20 by Administrative Nurse D at 06:10 PM recorded that an allegation of abuse by a Certified Nurses Assistant (CNA) toward a resident on Sunday. The email lacked the name of the resident, alleged perpetrator, date and time of the incident, the action taken for the alleged perpetrator and the type of alleged abuse. Observation on 06/02/20 at 12:05 PM revealed R2 sat in a chair in the dining room area. She smiled when spoken to. No behaviors were noted. During an interview on 06/02/20 at 09:00 AM Certified Nurse Aide (CNA) N stated she was not sure when she last received training or education related to abuse, neglect or exploitation. CNA N

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) stated she had not noticed any behavior changes in R2 since 04/20/20. During an interview on 06/02/20 at 09:30 AM Licensed Nurse (LN) L stated she had worked on English Ivy Avenue unit for five shifts. LN L stated she completed dementia and abuse, neglect and exploitation training yearly through the staffing agency she was employed through. During a phone interview on 06/02/20 at 04:30 PM with AC Z, stated she witnessed CMA R strike R2 on 04/19/20 at approximately 11:00 AM with an open hand in the dining room area. AC Z stated she redirected R2 to a safe place. AC Z stated she asked other staff members about the witness statement to fill out to notify the Director of Nursing (DON) of the witnessed incident. The staff on duty told her they did not know where to find the witness statement. AC Z stated she had not informed the staff on duty on 04/19/20 about the abuse incident with R2 because she did not want the staff to gossip about R2. AC Z then informed the DON of the abuse on 04/20/20. During an interview on 06/03/20 at 01:40 PM with Social Worker X, stated she was out of the facility on 4/20/20 and had been informed of the incident on 06/02/20. Social Worker X stated that under nomral circumstances, if she were aware of a potential abuse situation, she would visit with the resident involved on multiple occasssions. She stated she would follow up with staff to determine if the resident was displaying any negative outcomes as a result of the potantial abuse. Social Worker X stated the typical follow up had not been completed because Social Service staff were off work at the time and not aware of the allegation or potential abuse. During an interview on 06/03/20 at 02:13 PM with Administrative Nurse D stated she was notified of the allegation of abuse for R2 on 04/20/20 but confirmed the incident happened on 04/19/20. After Administrative Nurse D was notified of the alleged abuse, she notified the Administrator on 04/20/20. Administrative Nurse D stated she verbally educated AC Z of the policy for abuse, neglect and exploitation but did not have any documentation of the education nor were there any follow up training done with remaining staff regarding the abuse. Administrative Nurse D stated she was unsure of the required reporting timeframe for allegations of abuse, neglect and exploitation to the state agency. During an interview on 06/03/20 at 02:54 PM, Administrative Staff A stated she was informed of the allegation of abuse late on 04/20/20 by the DON. She stated she notified the staffing agency where CMA R was employed on 04/20/20. The facility policy The Protection of Residents: Reducing the Threat of Abuse and Neglect revised 05/15/20 documented residents must not be subjected to abuse by anyone including but not limited to staff, other residents . staff from other agencies . It directed facility staff that the victim be examined for any sign of injury, including a physical and psychosocial assessment. The facility failed to thoroughly investigate an allegation of physical abuse by facility staff to Resident (R) 2 when the facility failed to perform and document a psychosocial assessment of R2 after the incident occurred. The facility also failed to implement and document corrective action taken as a result of the physical abuse to R2.
F 0744 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 138. The sample included 15 residents. Based on record review, observation, and interviews, the facility failed to provide the needed dementia (progressive mental disorder characterized by failing memory, confusion) care and services to Resident (R) 1. The facility failed to develop and implement personalized care plan interventions for R1, who was severely cognitively impaired and had a history of [REDACTED]. The facility failed to implement care planned interventions for R1 which included 30-minute checks, redirection of R1 to supervised areas, and staff supervision for R1 when he was awake. On [DATE] at 01:30 AM, staff observed R1 on his roommate's side of the room, having an altercation with the roommate (R3). Staff directed back R1 to bed. Staff observed R1 awake and out of bed again at 02:30 AM. Staff again placed R1 into bed. At 04:00 AM, staff found R1 in his room, in a semi standing position with the privacy curtain twisted around his neck. The privacy curtain was cut down, and staff lowered R1 to the floor. Staff assessed the resident and determined he died . The facility's deficient practice created an immediate jeopardy which affected all 16 residents who resided on the 1200 hall, a locked dementia unit. Findings included: - R1's electronic medical record (EMR), under the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] recorded the Brief Interview for Mental Status (BIMS) did not occur. The staff interview revealed R1 had short and long-term memory problems. He had severely impaired ability to make decision regarding his daily life. The MDS documented R1 had physical behaviors towards others (hitting, kicking, pushing, scratching and /or grabbing) for one to three days of the look back period. The Quarterly MDS dated [DATE] recorded R1 had disorganized thinking and inattention. R1 had a BIMS score of zero which indicated severe cognitive impairment. The MDS documented R1 had no behaviors during the look back period. He required extensive two-person assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. He also required extensive one-person assistance with eating and ambulated with supervision/set up. The Cognition Care Area assessment dated [DATE] documented d R1 was [AGE] years old and had early onset dementia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). He had cognitive and memory impairments. He had difficulty making himself understood and understanding others. R1's Care Plan dated [DATE] recorded R1 was at risk for self-care deficit due to impaired cognition, decreased mobility, and behaviors. It documented R1 may have difficulty with pulling up/down pants, providing peri cares, brushing his hair and teeth, and shaving. It directed staff to ensure completion of those tasks daily. It further instructed if R1 became resistive with cares to allow time to self-calm. The Care Plan documented R1 needed supervision to extensive assistance with bed mobility, transfers, eating with tray set up, toileting, ambulation without devices, dressing, personal hygiene, and showers. His level of care depended on mood/behaviors The Care Plan dated [DATE] recorded R1 had a history of [REDACTED]. The interventions dated [DATE] instructed staff to administer medications as ordered and to anticipate and meet R1's needs. It further directed to educate staff, family, and caregivers regarding successful interaction strategies such as (specify). The Care Plan lacked a specified intervention. The Care Plan revised on [DATE] recorded R1 was physically aggressive towards his peers due to dementia. An intervention dated [DATE] directed, when R1 became agitated: staff were to intervene before agitation escalated guide R1 away from source of distress, and engage calmly in conversation. The Care Plan, revised on [DATE] recorded R1 was at risk for falls and had a fall with an actual injury. An intervention dated [DATE] directed staff to provide supervision to extensive assistance with bed mobility, transfers, and ambulation without devices. It directed staff to provide assistance of one to two persons depending on R1's behavior. An intervention dated [DATE] instructed staff to redirect R1 to observable areas for staff supervision and assist with transfers as needed. An intervention dated [DATE] instructed staff to assist R1 out of bed and into observable areas when awake. An intervention dated [DATE] directed staff not to lay the resident in bed until he showed signs of being tired. The Care Plan revised on [DATE] documented R1 was at risk for elopement due to his impaired cognition. An intervention dated [DATE] instructed staff to provide education related to a secure unit and to provide 30-minute checks to R1. Another intervention dated [DATE] directed staff to provide frequent monitoring, every 30 minutes. An Event Note, under the Progress Note tab in R1's EMR dated [DATE] at 06:00 AM documented the Certified Nurse Aids (CNA) responded to R1's roommate yelling help, help. When the CNAs entered the room, they saw R1's hands wrapped around his roommate's neck while the roommate was lying in bed. The roommate had a scratch above his nose that had not been there before. The CNAs separated the residents by having R1 walk in the hallway and living room with them. An Interdisciplinary Team (IDT) Note under the Progress Note tab in R1's EMR dated [DATE] at 06:08 PM documented the IDT met to discuss the altercation on [DATE]. R1 had his hands wrapped around another resident's neck. The note documented the root cause analysis as the following: It is reasonable that what triggered this resident was a night terror as resident has woke up in an aggressive state before and staff intervened. An IDT Note in R1's EMR under the Progress Note tab dated [DATE] documented the IDT team met to discuss an unwitnessed fall on [DATE]. Staff observed R1 on the floor with bedsheets around his feet. The note documented the following root cause analysis: Resident was not ready/sleepy when put to bed. The note directed the staff were not to put R1 to bed until he became tired. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] at 07:25 AM documented the CNA heard shouting coming from R1's room. Upon checking, the CNA observed R1 on top of his roommate, who was on the floor next to his bed. R1 was held in a headlock position by his roommate. R1 was last seen in his bed resting at about 06:30 AM prior to the incident. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] documented R1 remained on neurochecks (assessment of neurological status) after R1 was found on floor/resident to resident altercation. R1 remained alert with profound confusion when awake. R1 continued to pace the hallways and rooms, yelling and hitting objects for no apparent reason. An IDT Note in R1's EMR under the Progress Note tab dated [DATE] at 01:16 PM documented the IDT team met to discuss an altercation on [DATE] where R1 sat on top of another resident and the resident

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F 0744 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) had R1 in a head lock. The note recorded the root cause analysis as R1 awoke in an agitated state and struck out at the nearest person. The note documented the plan was to move the roommate to another room. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] at 10:38 PM documented when the nurse arrived on the unit R1 paced back and forth aggressively. He went into his room and started hitting his bed and wall. Staff redirected R1 away from his peers for his and his peer's safety. The nurse walked with R1 in his room and he eventually calmed down after 10 minutes. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] at 08:19 PM recorded R1 slapped the CNA while she assisted with his toileting needs. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] 0528 recorded R1 was quiet most of the shift until a peer awakened him in the common area. The residents were separated before a conflict resulted. R1 charged at the nurse two times and staff redirected him back to the common area to calm down. After the resident sat in a recliner, the nurse gave R1 a cookie and juice and his mood shifted. No other problems were noted during the shift. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] at 10:43 PM recorded R1 continued to exhibit intermittent agitation towards peers and staff. Staff had to redirect R1 multiple times throughout the shift. Staff were to monitor for behaviors. A Nurse Note under the Progress Note tab in R1's EMR dated [DATE] at 07:06 AM documented R1 was found with the curtains in his room wrapped around his neck several times. Consultant GG cut the curtains from around R1's neck and CNA O guided R1 to floor. An assessment revealed no pulse, no respirations, and no heart rate. The floor was not wet and no clutter noted in the room. R1 was last seen by CNA O and/or P at 02:30 AM. Staff notified law enforcement and emergency services. Staff also notified R1's physician, family, and Administrative Staff A as well. A Notarized Witness Statement dated [DATE] by CNA P recorded CNA P and CNA O went into R1's room to check his temperature and oxygen at midnight on [DATE]. R1 was in a bad mood and very aggressive. CNA P and CNA O managed to calm R1 down and put him back in his bed. At 01:30 AM CNA P and CNA O heard a loud noise coming from R1's room. They rushed in there and found R1 fighting with his roommate, R3. The CNAs were able to get R1 away from R3's side of the room and back in R1's bed. CNA P and CNA O went back to R1's room around 02:30 AM for rounds. They provided peri cares and put him back in bed, turned off the light and left the door slightly ajar. At 03:55 AM Consultant GG and his assistant called CNA P and CNA O to R1's room. R1 was found in his room hanging in his curtain. CNA P called the nurse . A Notarized Witness Statement dated [DATE] by CNA O documented at approximately 03:55 AM on [DATE] Consultant GG summoned CNA O to R1's room. CNA O documented when he arrived in R1's room he saw R1 hanging from the curtain which was twisted around his neck. CNA O immediately picked up R1 and Consultant GG cut the curtain from the top of the curtain frame. CNA O then placed R1 on the floor to check for a pulse. CNA O recorded CNA P went to get the charge nurse, who called 911. The statement documented CNA O and CNA P checked on R1 several times because of R1's agitation. The statement recorded the last time CNA O checked on R1 was at 02:30 AM when CNA O and CNA P put R1 in bed because R1 was up walking around. A Notarized Witness Statement dated [DATE] by Consultant GG documented at approximately 04:00 AM Consultant GG opened the door to R1's room to find R1 hanging by his neck from his curtain. The curtain had been twisted tightly. Consultant GG yelled for the facility staff to come to R1's room. Consultant GG recorded CNA O came to R1's room and held R1 while Consultant GG used his pocketknife to cut down the curtain. CNA O laid R1 on the floor and checked for vital signs. Consultant GG documented he heard CNA O state CNA O could not detect a pulse. A Notarized Witness Statement dated [DATE] by Licensed Nurse (LN) H documented LN H was called to come immediately to hall to see R1. When LN H entered R1's room, R1 was lying on floor with his legs stretched out towards the door, and his head on a pillow. An assessment revealed no pulse, no respirations, and no heart rate. R1 had a red line visible around the left side of his neck. Consultant GG reported to LN H R1 had several wraps of the privacy curtain around his neck. Consultant GG cut the curtain from around R1's neck with help of CNA O holding R1's body. An observation on [DATE] at 08:47 AM, with CNA Q present, revealed R1's room had a privacy curtain hanging between R1's former bed and R3's bed. The curtain was knotted, with the knot at approximately five feet from the floor. The knot was easily undone by gentle pulling. CNA Q stated the curtains were knotted in order to prevent the residents from messing with the curtains or tugging them. CNA Q stated over the years of being employed at the facility, he witnessed several occasions of the residents pulling on the curtains so hard the curtains would come down, or the entire curtain track would pull loose. The privacy curtain between R1's side of the room and the door was missing. All the hooks, meant to hold the privacy curtain, were intact and slid to end of the track closest to the bed. In an interview on [DATE] at 09:24 AM Social Services Y stated she worked with R1 for over one year. She stated R1 and R3 roomed together because they were both frequently up at night. Prior to this, R1 had been in a room by himself due to multiple resident to resident altercations involving R1 and his roommates. She said R1's behaviors were typical, and his aggressiveness was nothing new. Social Services Y stated R1 was always up moving. He was nonverbal. He would grunt and maybe say yes or no. She said he could walk, and he paced up and down the halls. His coordination was minimal, if handed something even minimally heavy he would drop it. He could not bop a balloon in activities. She stated no one reported anything to her about a change in R1's behaviors or demeanor. She learned of R1's incident when she arrived at work that morning. She was told by Administrative Staff A that a tragedy occurred. She said Administrative Staff A said R1 became wrapped up in the curtains and h suffocated. Social Service Y stated she was also informed during that conversation of the resident to resident altercation which occurred on [DATE] between R1 and R3. In an interview on [DATE] at 04:00 PM, CNA P stated she was familiar with R1 though she was not always assigned specifically to his unit. She stated staff were aware of how to care for the residents, or changes, by verbal report and walking rounds with off going staff. CNA P stated R1 had a history of [REDACTED]. She stated R1 became agitated on the night of ,[DATE] at midnight. Staff calmed him and placed him in bed. At 01:30 AM on [DATE] CNA P stated she heard a noise coming from R1's room. CNA P said that CNA O and she entered R1's room and observed R1 standing on R3's side of room. R3 was in bed and R1 was standing over him, hitting him. R3 was hitting R1 in response. CNA P said the privacy curtain going side to side, dividing the room, was pulled but R1 was able to get through the curtain to R3's side of room. Staff redirected R1 back to his side of the room. CNA P stated she did not think anyone had injuries and they reported the resident to resident altercation to the charge nurse on duty. She stated both CNAs left the room and did not reenter the room until 02:30 AM, when doing routine rounds. CNA P said when they entered the room, the dividing privacy curtain was still pulled and R1's privacy curtain was in place and not in use. CNA P said she saw R1 up, walking around in the room when they entered. R1 became agitated and difficult to redirect back to bed, but they were able to redirect him to bed and change his brief. CNA P stated that during the time they were attending to R1, changing his brief, R1 was agitated, yelling, and hitting his headboard. CNA P said that was normal behavior for R1. CNA P stated R1 seemed more on edge than usual that night although he was always aggressive and agitated and up at night. CNA P said R1 was usually able to be redirected or calmed down after 30 minutes, but on that night he was very agitated and would not calm down. CNA P stated they did not reenter R1's room until around 04:00 AM when the lab people came and alerted them that R1 was hanging from his privacy curtain. CNA P stated when she entered the doorway, she could see R1 hanging. His feet touched the floor, but he was slumped over and had the curtain twisted around him. She stated she could not see if the curtain was twisted or actually knotted because the lab people were blocking her direct line of vision. During an interview on [DATE] at 04:11 PM Consultant GG stated he entered R1's room at around 04:00 AM the morning of the [DATE] in order to draw blood for lab work for R1. Consultant GG said as soon as he entered the doorway, he could see R1 right there, hanging by the neck, facing toward the other side of the room. R1's feet were touching the floor, and he was slumped over. Consultant GG stated R1's shoulders were approximately chest high to Consultant GG. Consultant GG said R1 was about three feet away from the bed and any other furniture. There was a chair in R1's room, but it was not nearby. Consultant GG stated he entered R1's room and told his trainee to get help. Consultant GG stated a male CNA came to R1's room right away and held R1's lower body steady as Consultant GG cut the curtain. He stated he reached up and cut the curtain at the netting part, close to the top. Consultant GG stated the curtain appeared to be twisted, not knotted. On [DATE] CNA O was unable to be reached for interview. On [DATE] LN H was unable to be reached for interview. In an interview on [DATE] at 02:14 PM Administrative Nurse D stated staff completed dementia training during orientation for all new hires. She reported for all other staff, dementia training was ongoing. Administrative Nurse D stated she does not do the training personally, so she was unsure how often it is done, but then stated she was certain it was more than the required amount. She reported the facility used Hand in Hand training on the virtual training site. She stated staff know how to care for each resident by reviewing the care plan and also each residents' Kardex (a tool in the EMR which describes resident care needs). She reported the facility's Abuse, Neglect and Exploitation training included resident to resident altercations. Administrative Nurse D stated for all resident to resident altercations, staff should immediately separate the residents and monitor each resident closely. She also stated resident behaviors should be monitored, and changes or increased behaviors should be reported to the physician. Administrative Nurse D stated she was aware of R1's behaviors. She stated she believed R1's physician prescribed some medication last fall to treat his night terrors, but was uncertain what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	**7541 SWITZER ROAD OVERLAND PARK, KS 66214**

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 0744 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) medication the physician ordered. She said she was notified of R1's death the morning of [DATE]. Administrative Nurse D said she felt staff had not implemented all of R1's care planned interventions on the morning of [DATE]. Administrative Nurse D stated the facility started knotting the privacy curtains on R1's unit in response to R1's death. She stated no other corrective action had been implemented in response to the occurrence. In an interview on [DATE] at 02:55 PM, Administrative Staff A stated she was familiar with R1 but did not know the specifics of his plan of care. She stated she was not aware of any issues or changes in his behavior or mood. She stated R1 did not communicate well and she was uncertain about his specific habits. Administrative Staff A reported R1 had some altercations with roommates in the past. She reported staff moved him from his previous room into a shared room with R3 due to the COVID -19 pandemic. Administrative Staff A stated she was not informed of any altercation between R1 and R3 on the morning of [DATE]. She reported she was aware the staff had heard a noise in the room, but no one mentioned an altercation. Administrative Staff A stated she read CNA P's witness statement since she was the one to notarize it, but because CNA P did not use the word fighting in her verbal statement, Administrative Staff A did not think it required follow up at that time. She said she did not think it involved any type of physical altercation. Administrative Staff A reported the events of the morning placed an emotional toll on her and under normal circumstances, she would certainly follow up on any allegation of residents fighting. Administrative Staff A said she arrived at the facility within 15 minutes of receiving the news regarding the death of R1. She said she spoke with Consultant GG that morning. Administrative Staff A stated, Consultant GG told her R1's privacy curtain was wrapped around R1 up by his neck and R1's feet were still on the ground. Administrative Staff A reported the coroner arrived at the building at around 06:30 AM. She reported as a result of the incident, the facility was looking into break away privacy curtains. Administrative Staff A stated all staff received dementia training as well as training on how to deal with resident behaviors and resident to resident altercations. She stated she was uncertain how the trainings were conducted or how often they were conducted. The undated document Dementia provided by the facility lacked direction on how to care for residents diagnosed with [REDACTED]. provide supervision and assistive devices to each resident to prevent avoidable accidents. The policy listed the following as Events: verbal and physical aggression. The undated facility policy Behavioral Health Management documented the resident who was diagnosed with [REDACTED]. The policy directed the facility to monitor the resident closely for expression or indications of distress. It directed the facility to assess and plan care concerns based on resident assessments. The policy directed the facility must ensure the services for behavioral health were person centered. The facility failed to provide needed dementia care and services and failed to develop and implement personalized care plan interventions for R1. The facility also failed to implement care planned interventions for R1. This deficient practice placed the residents with a [DIAGNOSES REDACTED]. The immediate jeopardy was abated on [DATE] at 10:49 AM when the facility implemented the following actions: The Director of Nursing or Designee will evaluate all residents with dementia for aggressive behavior. Any resident identified as having aggressive behaviors will have their care plan reviewed for person centered interventions to mitigate aggressiveness, and behaviors and their care plan will be updated accordingly. The Staff Development Coordinator or Designee will re-educate all facility staff on the use of the Kardex and care plan to meet the individualized needs of the resident. All facility staff, including agency staff, will be educated prior to working their next scheduled shift. The Staff Development Coordinator or Designee would reeducate all staff including agency staff on protections of the residents and event management system which included implementing immediate interventions following incidents to keep residents safe. The deficient practice remained at a scope and severity of G.