

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2022
NAME OF PROVIDER OR SUPPLIER DELMAR GARDENS OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 12100 W 109TH STREET OVERLAND PARK, KS 66210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 09/27/22. 2567 revised on 10/13/22.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/27/2022

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to provide respect and dignity during the meal for Resident (R) 83. This placed the resident at risk for impaired psychosocial well-being. Findings included: - On 09/12/22 at 12:00 PM, observation during meal service revealed R83 seated at a dining table. Further observation revealed Certified Nurse Aide (CNA) M loudly asked R83, "Do you want me to feed you?" CNA M then stated loudly across the dining room to CNA N, "I will feed R83." CNA M yelled to the dietary staff, "I need R83's tray, I am feeding her." On 09/15/22 at 08:33 AM, Administrative Nurse D verified the staff are to not holler across the dining room regarding feeding a resident. The facility's "Resident Rights" policy, not dated, documented the residents have the right to be treated with respect and dignity.	F 550			

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F 550	Continued From page 2	F 550			
F 585 SS=E	The facility failed to provide dignity and respect during dining for R83, placing her at risk for an undignified experience. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585			

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F 585	Continued From page 3 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585			

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F 585	Continued From page 4 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to follow-up or resolve resident grievances. This deficient practice placed residents at risk for unresolved concerns. Findings included: - On 09/14/22 at 10:00 AM, during private discussion with the residents of the resident council, residents verbalized an ongoing and unpleasant experience due to a resident who was disruptive and threatening toward the residents residing in the facility. Council members verbalized there had been no resolution from the facility regarding the council's grievance.	F 585			

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F 585	Continued From page 5 Review of the resident council meeting minutes for the past year revealed grievances that were never discussed with the council. The council minutes lacked documentation of the facility's action to resolve resident grievances. Review of the facility's grievance log lacked documentation of the grievances verbalized by the council. The council verbalized Resident (R) 87 hollered at other residents and was threatening to residents and resident families. The council stated they have not had any response from management staff regarding what the facility was doing to correct the grievance. Residents verbalized that facility administration did not get back to them or follow up when they do have grievances in the resident council. On 09/13/22 at 01:30 PM, R87 sat on a couch in the front entry of the facility. R87 yelled loudly when residents would walk by her, "Pig, pig." R87 continued to yell, "Pig, pig!" at numerous staff members who walked past her. Staff did not attempt to calm or redirect R87. This behavior was observed for approximately 45 minutes. On 09/14/22 at 11:50 AM, R87 ambulated with her walker on the upper floor area of the facility. She hollered loudly, "Hello, hello, you idiots." R87 continued to yell this for approximately 15 minutes before staff intervened. On 09/14/22 at 12:40 PM, Social Service staff verified R87 was disruptive and loud. Social Service staff stated R87 needed one-on-one intervention from staff. Social Service staff also	F 585			

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F 585	Continued From page 6 verified that the resident council concerns had not been addressed by the facility. The facility's "Grievance Policy," dated June 2021, stated residents may present any concerns they have through a grievance resolution procedure. This facility attempted to resolve all concerns promptly. Residents had the right to receive prompt efforts by management. Grievances were to be followed up on and the response provided to the individual or group with the resolution of the concern. The facility's "Resident Council" policy, dated June 2021, stated that residents shall meet once a month to discuss any problems they may have had and the facility worked towards alleviating those grievances. The facility failed to respond to resident council grievances, placing the residents in the facility at risk for unresolved concerns.	F 585			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with four reviewed for behaviors. Based on observation, record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) to reflect Resident (R) 87's behaviors and as a result did not capture the affect the behaviors had on R87 and other residents. This placed the	F 641			

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F 641	Continued From page 7 resident at risk for continued and worsened behaviors. Findings included: - The "Physician Order Sheet," dated 09/02/22, recorded R87 had diagnoses dementia (progressive mental disorder characterized by failing memory and confusion), bipolar disorder (major mental illness that causes people to have severe episodes of high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, fragmented thoughts and impaired language communication), anxiety (mental health disorder characterized by worry and fear that interferes with daily life), obsessive-compulsive disorder (anxiety disorder characterized by recurrent and persistent behaviors that significantly interfere with social and interpersonal relationships) and impulse control disorder (mental disorder characterized by lack of behavior control). The "Quarterly Minimum Data Set" (MDS), dated 08/24/22, recorded R87 had a Brief Interview for Mental Status score of three (severe cognitive impairment). The MDS recorded R87 had no physical behaviors such as hitting, no verbal behaviors such as yelling or cursing, and no other behaviors such as screaming or smearing bodily wastes. The sections (E0500 and E0600) regarding behavior impact on R87 and other residents was blank. The MDS recorded R87 required limited staff assistance with activities of daily living (ADLs) and walked independently with a wheeled walker. The "Behavior Care Plan," dated 09/02/22, recorded R87 had frequent disruptive behaviors	F 641			

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F 641	Continued From page 8 due to her diagnoses of bipolar disorder, schizophrenia, and obsessive-compulsive disorder. The care plan directed staff to redirect R87's attention seeking and demanding behaviors, record and monitor her behaviors, and ensure R87 and other residents were safe during her angry outbursts. Review of R87's care plan lacked documentation of new behavior interventions after 12/29/21. A note in R87's clinical record documented by Licensed Nurse (LN) J on 08/19/22 at 02:05 PM recorded the nurse spoke to the doctor regarding R87's behaviors and a request for inpatient psychiatric stay for R87 due to the noted behaviors of name calling, hitting, anxious, and a new behavior of defecating on the [furniture]. On 09/13/22 at 02:37 PM, observation revealed R87 walked to the couch near the entry door and reception desk, and repeatedly yelled "pig", "ugly pig" and "you are an ugly pig" over a span of approximately 35 minutes. On 09/14/22 at 11:21 AM, observation revealed R87 walked up to staff, repetitively yelled "give me your pen," refused redirection, and staff walked away. On 09/13/22 at 02:33 PM, Certified Medication Aide (CMA) R stated R87 had disruptive behaviors every day, and the nurses record and monitor the resident's behaviors. On 09/13/22 at 02:10 PM, Licensed Nurse (LN) G stated R87 had frequent disruptive behaviors that were difficult to redirect, and nursing staff recorded the targeted behaviors on the MAR.	F 641			

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F 641	Continued From page 9 On 09/15/22 at 08:42 AM, Administrative Nurse D stated R87's quarterly MDS, dated 08/24/22, was not accurate for the resident's behavior status. Administrative Nurse D stated nursing staff should record and monitor R87's targeted behaviors on the MAR. The facility's "Behavior Policy," dated February 2021, directed staff to record and monitor the residents' behaviors, complete accurate assessments, and implement intervention to prevent and/or redirect the behaviors. The facility failed to complete an accurate MDS assessment to reflect the behavior status for R87, placing the resident at risk for continued and worsened behaviors.	F 641			
F 675 SS=E	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with four residents reviewed for behaviors. Based on observation, record review, and interview, the facility failure to provide the necessary behavior cares and services for Resident (R) 87 (refer to F740)	F 675			

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F 675	Continued From page 10 affected the quality of life for R16, R35, R53, R60 who were affected by R87's behaviors. This placed the affected residents at risk for increased stress, discomfort and social isolation. Findings included: - The "Physician Order Sheet," dated 09/02/22, recorded R87 had diagnoses dementia (progressive mental disorder characterized by failing memory and confusion), bipolar disorder (major mental illness that causes people to have severe episodes of high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, fragmented thoughts and impaired language communication), anxiety (mental health disorder characterized by worry and fear that interferes with daily life), obsessive-compulsive disorder (anxiety disorder characterized by recurrent and persistent behaviors that significantly interfere with social and interpersonal relationships) and impulse control disorder (mental disorder characterized by lack of behavior control). The "Quarterly Minimum Data Set" (MDS), dated 08/24/22, recorded R87 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment and she had no behaviors in the assessment period (refer to F641). R87 required limited staff assistance with activities of daily living (ADLs) and walked independently with a wheeled walker. The "Behavior Care Plan," dated 09/02/22, recorded R87 had frequent disruptive behaviors due to her diagnoses of bipolar disorder, schizophrenia, and obsessive-compulsive disorder. The "care plan" directed staff to monitor	F 675			

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F 675	Continued From page 11 R87's attention seeking, disruptive behaviors, identify causative factors for the behaviors, and develop intervention to prevent or redirect the resident's behaviors On 09/13/22 at 02:37 PM, R87 walked to the couch near the entry door and reception desk. She repeatedly yelled "pig," "ugly pig," and "you are an ugly pig" for approximately 35 minutes. On 09/14/22 at 11:21 AM, R87 walked up to staff and repetitively yelled, "give me your pen." She refused redirection and staff walked away. On 09/12/22 at 12:10 PM, R35 stated he was angered by R87's racial insults directed toward staff. He stated the insults would be criminal outside the facility and he limited his access in the facility to avoid R87's yelling and screaming. On 09/13/22 at 02:33 PM, Certified Medication Aide (CMA) R stated R87 had disruptive behaviors every day that disrupted other residents' quality of life and staff ignored or refused to redirect the resident's behavior most of the time. On 09/13/22 at 02:10 PM, Licensed Nurse (LN) G stated R87 had frequent disruptive behaviors that agitated other residents and were difficult to redirect. LN G stated staff often ignore R87's behaviors to avoid further escalation and racial insults. On 09/13/22 at 03:04 PM, R16 stated R87 has stopped her visitors and/or family in the halls and yelled obscenities at them. R16 stated she limited her access in the facility to avoid R87, frequently kept her room door closed due to R87's yelling,	F 675			

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F 675	Continued From page 12 and was fearful of interaction with R87. On 09/13/22 at 03:17 PM, R60 stated she limited her access in the facility to avoid R87's behaviors. On 09/14/22 at 12:38 PM, R53 stated she used to do art projects outside her room at times but stopped due to several confrontations with R87 who attempted to take her art supplies. R53 stated she closed her room door most of the time and limited her access in the facility to avoid R87's yelling and screaming. On 09/15/22 at 08:42 AM, Administrative Nurse D stated R87 had frequent disruptive behaviors that impacted other residents and she expected staff to supervise and redirect R87's behaviors to avoid conflict with other residents. The facility's "Resident Rights Policy," not dated, directed staff to provide a safe environment with safeguards against any kind of abusive treatment and behaviors. The facility's "Behavior Policy," dated February 2021, directed staff to record and monitor the residents' behaviors, complete accurate assessments, and implement intervention to prevent and/or redirect the behaviors. The facility failure to provide the necessary behavior cares and services for R87 created the risk for decreased quality of life, increased mental stress, and social isolation for R16, R35, R53, R60 who were affected by the behaviors.	F 675			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689			

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F 689	Continued From page 13 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to secure chemicals in a safe, locked area out of reach of the 19 cognitively impaired, independently mobile residents. This deficient practice placed the affected residents at risk for accidents. Findings included: - On 09/12/22 at 08:30 AM, observation revealed an unlocked cabinet in the spa room in the upper level of the facility. Further observation revealed a full, quart-size spray bottle which contained non-acid disinfectant. The label stated, "keep out of reach of children, hazardous to humans and can cause eye irritation, harmful if swallowed." On 09/12/22 at 08:40 AM, Licensed Nurse (LN) G verified the spray bottle of disinfectant was not locked in the cabinet. LN G stated the disinfectant was to be in a locked cabinet. On 09/15/22 at 08:33 AM, Administrative Nurse D verified the spray bottle of disinfectant was to be stored in a locked cabinet. Administrative Nurse D verified the upper level of the facility had 19 cognitively impaired independently mobile	F 689			

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F 689	Continued From page 14 residents. The facility's "Chemical Storage" policy, dated June 2021, documented chemicals with a hazard warning were stored in a secured area. The facility failed to store chemical disinfectant in a secured area. This deficient practice placed the 19 cognitively impaired, independently mobile residents at risk for accidents.	F 689			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with four residents reviewed for behaviors. Based on observation, record review, and interview, the facility failed to implement interventions in an attempt to redirect or de-escalate Resident (R) 87's behaviors as directed by her plan of care. This placed the resident at risk for continued and worsened behaviors. Findings included:	F 740			

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F 740	Continued From page 15 - The "Physician Order Sheet," dated 09/02/22, recorded R87 had diagnoses dementia (progressive mental disorder characterized by failing memory and confusion), bipolar disorder (major mental illness that causes people to have severe episodes of high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, fragmented thoughts and impaired language communication), anxiety (mental health disorder characterized by worry and fear that interferes with daily life), obsessive-compulsive disorder (anxiety disorder characterized by recurrent and persistent behaviors that significantly interfere with social and interpersonal relationships) and impulse control disorder (mental disorder characterized by lack of behavior control). The "Quarterly Minimum Data Set" (MDS), dated 08/24/22, recorded R87 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment and had no behaviors in the assessment period.(refer to F641) R87 required limited staff assistance with activities of daily living (ADLs) and walked independently with a wheeled walker. The "Behavior Care Plan," dated 09/02/22, recorded R87 had frequent disruptive behaviors due to her diagnoses of bipolar disorder, schizophrenia, and obsessive-compulsive disorder. The care plan directed staff to monitor R87's attention seeking, disruptive behaviors, identify causative factors for the behaviors, and develop intervention to prevent or redirect the resident's behaviors. Approaches dated 09/02/20 directed staff to praise R87's acts of kindness and to offer her activities to promote socialization. The care plan listed ways to calm	F 740			

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F 740	Continued From page 16 R87 which included counting, and singing a song like "You are My Sunshine." Approaches dated 04/29/21 directed staff that R87 should have frequent visual checks; R87 had notably better behaviors when someone sat with her. An approach dated 04/14/21 recorded R87 received weekly psychotherapy services. An approach dated 07/29/21 directed R87 had increased behaviors between the hours of 02:30 PM and bedtime and instructed staff to provide immediate intervention to help de-escalate behaviors. On 09/13/22 at 02:37 PM, R87 walked to the couch near the entry door and reception desk. She repeatedly yelled "pig," "ugly pig," and "you are an ugly pig" for approximately 35 minutes. On 09/14/22 at 11:21 AM, R87 walked up to staff and repetitively yelled, "give me your pen." She refused redirection and staff walked away. On 09/14/22 at 12:08 PM R87 sat near the nurse station, and repeatedly yelled "come on" for seven minutes. There were four staff in the area, though no staff responded or attempted to redirect R87. On 09/13/22 at 02:33 PM, Certified Medication Aide (CMA) R stated R87 had disruptive behaviors every day that disrupted other residents' quality of life and staff ignored or refused to redirect the resident's behavior most of the time. On 09/13/22 at 02:10 PM, Licensed Nurse (LN) G stated R87 had frequent disruptive behaviors that agitated other residents and were difficult to redirect. LN G stated staff often ignore R87's	F 740			

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F 740	Continued From page 17 behaviors to avoid further escalation and racial insults. On 09/15/22 at 08:42 AM, Administrative Nurse D stated R87 had frequent disruptive behaviors that impacted other residents. Administrative Nurse D stated staff should monitor the resident's behaviors to identify causative factors and develop new interventions to prevent and/or redirect R87's behaviors. The facility's "Behavior Policy," dated February 2021, directed staff to record and monitor the residents' behaviors, complete accurate assessments, and implement intervention to prevent and/or redirect the behaviors. The facility failed to implement interventions in response to behaviors for R87 as directed in R87's plan of care This deficient practice placed the resident at risk for continued and worsened behaviors.	F 740			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756			

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F 756	Continued From page 18 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the facility the staff's failure to correctly hold or administer blood pressure medication for Resident (R) 18, as directed by the physician. This deficient practice placed R18 at risk for uncontrolled blood pressures and unnecessary medication use. Findings included:	F 756			

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F 756	Continued From page 19 - R18's medical record included diagnoses of hypotension (low blood pressure) and hypopituitarism (deficiency of one or more of the pituitary hormones which can affect any number of your body's routine functions, such as growth or blood pressure). The "Quarterly Minimum Data Set (MDS)," dated 07/07/22, documented a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognition. R18 required supervision for eating; limited assistance for locomotion; and extensive assistance of one to two staff for bed mobility, transfers, toileting, hygiene, and dressing. The "Medication Care Plan," dated 07/12/22, directed staff to administer medication as ordered, watch for orthostatic hypotension, and notify the doctor of any adverse side effects as needed. The "Care Plan" directed the pharmacy would review R18's medications monthly and as needed (PRN), providing recommendations as indicated. The "Physician Order," dated 11/29/21, directed staff to administer midodrine (medication used to treat hypotension) 7.5 milligram (mg) three times daily. The order directed staff to hold the medication if the resident's systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than 120 millimeters of mercury (mmHg). Review of R18's August 2022 "Medication Administration Record (MAR)" revealed R18's SBP was documented below 120 mmHg 18	F 756			

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F 756	Continued From page 20 times. Midodrine was not administered as ordered for those 18 times. Review of R18's September 2022 "MAR" revealed R18's SBP was greater than 120 mmHg five times with midodrine administered instead of held, as ordered. The "MAR" revealed four times where no blood pressure was documented. The monthly "Pharmacist Review," dated 08/30/22, documented no irregularities. On 09/13/22 at 08:40 AM, Certified Medication Aide (CMA) S administered medications to R18 at the dining table. R18 took the medication whole, without problems. On 09/14/22 at 10:35 AM, Licensed Nurse (LN) H stated staff were to hold midodrine if R18's SBP was greater than 120. On 09/14/22 at 10:58 AM, Administrative Nurse D verified the physician directed staff to hold the medication if the SBP was greater than 120 mmHg and stated staff had not followed those directions several times. She stated the resident had problems with his blood pressure. Administrative Nurse D verified the facility's CP had not notified her of the incorrect administration of midodrine. The facility's policy titled "Pharmacist Consultant Duties and Responsibilities" last reviewed 05/21 recorded the consultant pharmacist reviewed each residents' medications for any irregularities and to ensure appropriate medication monitoring to maximize safety and efficacy. The facility failed to ensure the CP identified and	F 756			

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F 756	Continued From page 21 reported to facility the staff's failure to correctly hold or administer blood pressure medication for R18, as directed by the physician. This deficient practice placed R18 at risk for uncontrolled blood pressures and unnecessary medication use.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to correctly hold or administer blood pressure medication for Resident (R) 18, as	F 757			

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F 757	Continued From page 22 directed by the physician. This deficient practice placed R18 at risk for uncontrolled blood pressures and unnecessary medication use. Findings included: - R18's medical record included diagnoses of hypotension (low blood pressure) and hypopituitarism (deficiency of one or more of the pituitary hormones which can affect any number of your body's routine functions, such as growth or blood pressure). The "Quarterly Minimum Data Set (MDS)," dated 07/07/22, documented a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognition. R18 required supervision for eating; limited assistance for locomotion; and extensive assistance of one to two staff for bed mobility, transfers, toileting, hygiene, and dressing. The "Medication Care Plan," dated 07/12/22, directed staff to administer medication as ordered, watch for orthostatic hypotension, and notify the doctor of any adverse side effects as needed. The "Care Plan" directed the pharmacy would review R18's medications monthly and as needed (PRN), providing recommendations as indicated. The "Physician Order," dated 11/29/21, directed staff to administer midodrine (medication used to treat hypotension) 7.5 milligram (mg) three times daily. The order directed staff to hold the medication if the resident's systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than 120 millimeters of	F 757			

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F 757	Continued From page 23 mercury (mmHg). Review of R18's August 2022 "Medication Administration Record (MAR)" revealed R18's SBP was documented below 120 mmHg 18 times. Midodrine was not administered as ordered for those 18 times. Review of R18's September 2022 "MAR" revealed R18's SBP was greater than 120 mmHg five times with midodrine administered instead of held, as ordered. The "MAR" revealed four times where no blood pressure was documented. On 09/13/22 at 08:40 AM, Certified Medication Aide (CMA) S administered medications to R18 at the dining table. R18 took the medication whole, without problems. On 09/14/22 at 10:35 AM, Licensed Nurse (LN) H stated staff were to hold midodrine if R18's SBP was greater than 120. On 09/14/22 at 10:58 AM, Administrative Nurse D verified the physician directed staff to hold the medication if the SBP was greater than 120 mmHg and stated staff had not followed those directions several times. She stated the resident had problems with his blood pressure. The "Medication Administration" policy, dated January 2021, directed staff to read labels on medications three times. The facility failed to correctly administer a blood pressure medication according to the physician ordered parameters. This deficient practice placed R18 at risk for uncontrolled blood pressures and unnecessary medication use.	F 757			

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758			

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NAME OF PROVIDER OR SUPPLIER DELMAR GARDENS OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 12100 W 109TH STREET OVERLAND PARK, KS 66210		
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F 758	Continued From page 25 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to provide a stop date or a rationale for extended use for an as needed (PRN) psychotropic medication (medication used to treat moods and behaviors) for Resident (R) 2, and a stop date for a PRN antipsychotic medication (medication used to treat psychosis and other mental conditions) for R87. This placed the residents at risk for unnecessary psychotropic medications and adverse side effects. Findings included: - The "Physician Order Sheet," dated 09/02/22, recorded R2 had diagnoses of dementia (progressive mental disorder characterized by failing memory and confusion), bipolar disorder (major mental illness that causes people to have severe episodes of high and low moods), and Parkinson's disease (progressive neurological disorder characterized by tremors, muscle rigidity and weakness). The "Annual Minimum Data Set (MDS)," dated 06/05/22, recorded R2 had a Brief Interview for	F 758			

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F 758	Continued From page 26 Mental Status (BIMS) score of ten which indicated moderate cognitive impairment, had rejected cares, and had verbal behaviors. R2 required extensive staff assistance with activities of daily living (ADLs), used a wheelchair for mobility, and received an antianxiety medication (medication used to treat excessive anxiety, nervousness, and stress) three days in the seven-day lookback period. The "Behavior Care Plan," dated 09/12/22, recorded R2 had frequent disruptive behaviors that were difficult to redirect. The "care plan" directed staff to administer psychotropic medications as ordered by the physician and monitor for adverse side effects. The "Physician Order," dated 08/27/22, directed staff to administer Ativan (medication used to treat excessive anxiety, nervousness, and stress) 0.5 milligrams (mg) every 6 hours PRN to R2 for anxiety with behaviors. The physician order did not indicate a stop date. Review of R2's "Medication Administration Record (MAR)" revealed the medication order for PRN Ativan was open ended with no stop date. On 09/14/22 at 09:35 AM, R2 sat in her wheelchair in the hall and yelled "no" at staff when asked to participate in a group exercise activity. On 09/15/22 at 08:45 AM, Administrative Nurse D stated R2's PRN Ativan should have a 14 day stop date or physician rationale for extended use. The facility's "Behavior Policy," dated February 2021, directed staff to ensure PRN psychotropic	F 758			

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F 758	Continued From page 27 medications had a 14 day stop date or a physician's rationale for extended use. The facility failed to provide a stop date or rationale for extended use for an PRN psychotropic medication for R2. This deficient practice placed the resident at risk for unnecessary psychotropic medications and adverse side effects. - The "Physician Order Sheet," dated 09/02/22, recorded R87 had diagnoses of dementia (progressive mental disorder characterized by failing memory and confusion), bipolar disorder (major mental illness that causes people to have severe episodes of high and low moods), schizophrenia (psychotic disorder characterized by gross distortion of reality, fragmented thoughts and impaired language communication), anxiety (mental health disorder characterized by worry and fear that interferes with daily life), obsessive-compulsive disorder (anxiety disorder characterized by recurrent and persistent behaviors that significantly interfere with social and interpersonal relationships) and impulse control disorder (mental disorder characterized by lack of behavior control). The "Quarterly Minimum Data Set (MDS)," dated 08/24/22, recorded R87 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment and no behaviors (refer to F641). R87 required limited staff assistance with activities of daily living (ADLs), walked independently with a wheeled walker, and received an antipsychotic medication seven days in the seven-day lookback period. The "Behavior Care Plan," dated 09/02/22,	F 758			

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F 758	Continued From page 28 recorded R87 had frequent disruptive behaviors due to her diagnoses of bipolar disorder, schizophrenia, and obsessive-compulsive disorder. The care plan directed staff to administer psychotropic medications as ordered by the physician and monitor for adverse side effects. The "Physician Order," dated 09/03/22, directed staff to administer Seroquel (antipsychotic medication used to treat significant mental illnesses with behaviors) 25 milligrams (mg) every day PRN to R87 for schizophrenia (psychotic disorder characterized by gross distortion of reality and fragmented thoughts) with behaviors. The physician order did not have a stop date. Review of R87's "Medication Administration Record (MAR)" revealed the medication order was open ended with no stop date. On 09/13/22 at 02:37 PM, R87 walked to the couch near the entry door and reception desk and repeatedly yelled "pig", "ugly pig" and "you are an ugly pig" for approximately 35 minutes. On 09/14/22 at 11:21 AM, R87 walked up to staff and repetitively yelled "give me your pen." She refused redirection and staff walked away. On 09/15/22 at 08:45 AM, Administrative Nurse D stated R87's PRN Seroquel should have a 14 day stop date. The facility's "Behavior Policy," dated February 2021, directed staff ensured PRN psychotropic medications had a 14 day stop date or a physician's rationale for extended use.	F 758			

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F 758	Continued From page 29 The facility failed to provide a stop date or rationale for extended use for an PRN psychotropic medication for R87. This deficient practice placed the resident at risk for unnecessary psychotropic medications and adverse side effects.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on	F 761			

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F 761	Continued From page 30 observation, interview, and record review the facility failed to dispose of expired Juven (therapeutic nutrition powder) and antibiotic (medication used to treat infections caused by bacteria) medication. This deficient practice had the risk for physical complications and ineffective treatment for affected residents. Findings included: - On 09/13/22 at 07:44 AM, lower level A/B medication cart had four Juven packets 0.9 ounces (oz), with an expiration date of 03/01/22. On 09/13/22 at 07:44 AM, Certified Medication Aide (CMA) S verified the Juven packets were expired and should have been disposed of. On 09/13/22 at 08:17 AM, the lower level medication room had 11 vials of amikacin sulfate (antibiotic), 500 milligram (mg)/2 milliliters (ml), expiration date of April 2022 and a box of Juven packets, expiration date of March 2022 . On 09/13/22 at 08:17 AM, Licensed Nurse (LN) I verified the amikacin vials and the Juven were expired and should have been disposed of. On 09/15/22 at 08:30 AM, Administrative Nurse D verified staff should have disposed of the expired medication and the Juven. She stated CMAs and nurses were to check for expired medications each week. The facility's "Storage of Medications" policy, dated November 2020, stated discontinued, outdated, or deteriorated drugs or biologicals were returned to the pharmacy.	F 761			

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F 761	Continued From page 31 The facility failed to dispose of expired Juven and antibiotic medication. This deficient practice had the risk for physical complications and ineffective treatment for affected residents.	F 761			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to follow a recipe during puree preparation for five residents who received a pureed diet. This deficient practice had the risk for altered nutritional status, unpalatable food, and unwarranted physical complications. Findings included: - On 09/13/22 at 09:58 AM, Dietary BB prepared a pureed diet. Dietary BB placed ten ounces of cooked chicken breast into a blender with one quarter cup chicken broth, blended, then emptied the chicken into a bowl. He placed eight ounces of cooked zucchini slices with four tablespoons of water into a blender, blended, and then emptied into a bowl. Dietary BB placed a dinner roll and four tablespoons of water into a blender, blended,	F 804			

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F 804	Continued From page 32 and then emptied into a bowl. Dietary BB did not follow a puree recipe. On 09/13/22 at 10:10 AM, Dietary BB stated he was unaware he needed to follow a puree recipe. On 09/13/22 at 10:30 AM, Administrative Staff A verified dietary staff should use a puree recipe when preparing a pureed diet. The facility's "Therapeutic Diet" policy, dated November 2014, documented to follow a prescribed diet by the resident's physician and to use a puree diet recipe when preparing a pureed diet. The facility failed to follow a recipe during puree preparation for five residents who received a pureed diet. This deficient practice had the risk for altered nutritional status, unpalatable food, and unwarranted physical complications.	F 804			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812			

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F 812	Continued From page 33 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 88 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food in accordance with professional standards for the 84 residents who received their meals from the facility kitchen. This placed the 84 residents at risk for foodborne illness. Findings included: - On 09/12/22 at 11:33 AM, Dietary CC reached into a clear plastic container of jumbled up silverware and placed residents' silverware on place settings in the dining area. Dietary CC handled some of the silverware by the eating surface while rummaging for what she needed. Dietary CC held dishes against her soiled apron while transporting them from the cabinet to the steam table. - On 09/12/22 at 11:24 AM, there were several unbagged, soiled clothing protectors on the floor by the wall in the upper level dining room. - On 09/12/22 at 11:27 AM, Dietary CC verified the clothing protectors were soiled and should not be on the floor. She stated she would take care of them in a minute as she continued to place paper place mats and napkins on the table. - On 09/12/22 at 01:30 PM, Dietary CC tossed	F 812			

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F 812	Continued From page 34 residents' soiled clothing protectors from the noon meal on the floor in the upper level dining room near the nurse's station. On 09/13/22 at 09:20 AM, the sink sprayer was on the floor with approximately ten-foot area of water on the floor in front of the dishwasher. The pipes under the dishwashing area had flaky black debris on them. On 09/13/22 at 10:00 AM, Dietary BB verified the facility had four residents who did not receive meals from the facility kitchen. Dietary BB verified the sink spray handle had been leaking for approximately a week and needed repair. On 09/15/22 at 08:30 AM, Administrative Nurse D verified staff should not handle silverware by the eating surface and should not carry dishes against her apron. The facility's "Dining Services" policy, dated 2014, documented silverware would be held by the handles with no bare hand contact to the tines. Plates are to be held by the rim. The facility's "Cleaning Rotation," policy dated 2014, directed kitchen staff items were to be cleaned daily, weekly and monthly. The facility failed to properly handle silverware and dishes in a cleanly manner to prevent the spread of infection, failed to ensure there was a functioning sink sprayer, and failed to ensure clean pipes under the sink. This deficient practice placed affected residents at risk for foodborne illness and unnecessary complications.	F 812			