

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175158		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/30/2025	
NAME OF PROVIDER OR SUPPLIER GARDEN TERRACE AT OVERLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7541 SWITZER ROAD , OVERLAND PARK, Kansas, 66214			
(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	
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #2690015. The 2567 was sent electronically on 01/14/26.		F0000				
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-		F0580				

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0580 SS = D	Continued from page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 141 residents. The sample included five residents, with three residents reviewed for dementia care. Based on record review and interviews, the facility failed to notify Resident (R) 1's provider of new or escalating behaviors. Findings included: - R1 admitted to the facility on 01/25/24 and transferred to the hospital on 12/23/25. R1's Electronic Medical Record (EMR) documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Annual Minimum Data Set (MDS)" dated 01/31/25 documented staff did not conduct a Brief Interview for			F0580			

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F0580 SS = D	Continued from page 2 Mental Status (BIMS) due to R1 being rarely or never understood. R1 wandered daily. R1 required substantial to maximal assistance with oral hygiene, toileting hygiene, showering, upper and lower body dressing, standing, and toilet transfers. R1 required dependence on staff for putting on shoes and personal hygiene. R1 required partial to moderate assistance with bed mobility, and he received antidepressant (a class of medications used to treat mood disorders) medications. The "Quarterly MDS" dated 10/23/25 documented staff did not conduct a BIMS due to R1 being rarely or never understood. R1 had physical behaviors directed towards others and wandering behaviors one to three days in the lookback period. R1 received antidepressant medications. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 01/31/25 documented R1 had a history and diagnosis of dementia with ongoing cognitive and physical impairments. R1 retained his ability to make his needs known. The EMR included a "Functional Abilities CAA" dated 02/03/25 which documented R1 required assistance with activities of daily living (ADL). The EMR included a "Behavioral Symptoms CAA" dated 02/03/25 which documented R1 exhibited wandering behavior due to advancing dementia. R1's 01/25/24 "Care Plan" revealed R1 had impaired cognitive ability and impaired thought processes due to dementia disease and included the following staff interventions: 01/25/24- Staff allowed extra time for R1 to respond to questions and instructions. 01/25/24- Staff faced R1 and spoke clearly when they communicated with R1. 01/29/25- The facility placed R1 on a secured unit. 05/15/25- Staff used R1's preferred name, identified themselves at each interaction, reduced any distractions, provided necessary cues, and stopped then returned if R1 became agitated.	F0580					

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F0580 SS = D	Continued from page 3 The care plan lacked individualized interventions related to R1's behaviors and triggers for behaviors. R1's EMR revealed the following: A "Behavior Note" dated 07/03/24 at 09:11 PM documented R1 became more aggressive with staff on redirection from common areas. R1 kept self-propelling in his wheelchair through the TV and dining room and rolled over other residents' shoes and toes. When staff redirected R1, he became increasingly violent and tried to strike staff with a closed fist. R1 became increasingly restless and became a higher fall risk. R1 tried to ambulate without assistance and when staff tried to intervene, R1 became angry and tried to kick and punch staff. A "Behavior Note" dated 07/04/24 at 10:16 PM document R1 transferred himself without assistance and tried to stand up in the hallway. Staff redirected R1 back to his wheelchair several times and R1 sat in the TV room with a Certified Nurse Aide (CNA) for increased supervision for safety. R1 continued to be aggressive with direction and tried to hit and punch staff with a closed fist. A "Behavior Note" dated 07/09/24 at 09:08 PM documented R1 continued to be very restless and an increased fall risk. R1 needed increased supervision from staff for safety. R1's medical record lacked evidence the facility notified R1's physician about his behaviors from 07/03/24 to 07/09/24. A "Behavior Note" dated 10/13/24 at 07:00 AM documented R1 rolled around in his wheelchair that morning and shook both hands in the air, stating he was scared, he wanted to kill himself, and he did not know. Staff provided ineffective verbal redirection. R1 attempted to get out of his wheelchair while he stated he was scared. The nurse applied a gait belt and allowed R1 to ambulate down the hallway with the railings, but he remained anxious. R1's medical record lacked evidence the facility	F0580					

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F0580 SS = D	Continued from page 4 notified R1's provider of his suicidal/death statements on 10/13/24. A "Behavior Note" dated 10/23/24 at 01:02 PM documented R1 kept trying to stand up and walk. R1 verbalized he did not understand, he wanted to die. Staff redirected and helped R1 take a few steps then sat him back in his wheelchair. The note included the redirection remained ineffective. R1's medical record lacked evidence the facility notified R1's provider of his death statements on 10/23/24. A "Behavior Note" dated 09/08/25 at 06:22 PM documented R1 rolled up to another resident in his wheelchair and grabbed his can of pop. The other resident became upset, staff redirected R1 and gave the other resident the pop back. R1 then grabbed the other resident's water cup and threw it at the window, which just missed another resident. Staff redirected R1 out of the dining room and R1 kicked staff and tried to bite them while he screamed all the way down the hallway. The activities staff took R1 off of the unit for about an hour to try to get R1 to relax. During dinner, R1 threw his tray of food down the hallway and poured his drinks on the wall and floor. The staff redirected R1 and he screamed, kicked, and tried to bite staff during redirection. R1 went down the hall and set off the alarm and when staff redirected R1, he called them names. During the meal, R1 tried to go through the dirty plates in the food warmer and when staff redirected him, he became very agitated and slammed the food warmer into the hallway wall. Staff redirected R1 to his room but R1 came back out quickly and began knocking over furniture in the dining room. After mealtime, R1 calmed down some but did propel his wheelchair into the common areas and ran over other residents' toes while saying sorry then did it again. R1's medical record lacked evidence the facility notified R1's provider of his behaviors on 09/08/25. A "Behavior Note" dated 09/09/25 at 09:01 PM documented R1 almost got through the unit doors while staff tried to redirect him. R1 grabbed both sides of the doors and tried to pull himself forward. R1 screamed, kicked staff, and tried to bite staff. Staff brought R1 back onto the unit and he began wandering. Staff asked R1 if	F0580					

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F0580 SS = D	Continued from page 5 he wanted to take a nap and R1 said yes. R1's representative visited for dinner. R1's medical record lacked evidence the facility notified R1's provider of his behaviors on 09/09/25. A "Physician/PA/NP" note dated 11/21/25 at 03:43 PM documented R1's representative was engaged with the facility regarding the release of R1's medical records and based on an email the provider received, R1's representative withdrew his consent on R1's Lexapro for depression/anxiety and trazodone (antidepressant medication) for insomnia and sleep. The provider attempted to contact R1's representative that day without any success. The provider planned to taper R1's trazodone down then discontinue, and he discontinued the Lexapro entirely with no taper required. A "Behavior Note" dated 11/30/25 at 07:32 PM documented R1 became very agitated during the shift and repeatedly tried to stand up, which created a fall risk. Staff had to be one-to-one with R1 at all times. Activities did R1's nails, which distracted him during that time. At bedtime, R1 tried to hit staff multiple times. A "Behavior Note" dated 12/03/25 at 09:44 PM documented R1 propelled around the unit in his wheelchair and got into other residents' personal space while taking their things. The other residents screamed repeatedly, and staff redirected R1 down the hallway or into his room with short-term results. At dinner, R1 parked his wheelchair in front of the open food cart and tried to grab and touch the food trays. R1 propelled into the dining room and tried to take other residents' drinks and plates. Staff redirected R1 into the closest room and he backed his wheelchair into the bedroom, which blocked him in. Staff managed to get R1 out of the room when his representative arrived. R1's representative assisted R1 to his bedroom with dinner and snacks. A "Behavior Note" dated 12/05/25 at 08:00 AM documented R1 attempted to go behind the nurse's desk and when the nurse tried to redirect R1, he kicked the nurse in the leg and proceeded to put his middle finger up. R1 appeared upset but his words made no sense due to being scrambled. A "Behavior Note" dated 12/09/25 at 08:41 AM documented	F0580					

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F0580 SS = D	Continued from page 6 R1 paced on the hallway, had exit seeking behaviors, and was uncooperative with calming down after reassurance or redirection. Staff left R1 alone to calm down and then R1 accepted a drink and his breakfast fairly well. A "Behavior Note" dated 12/10/25 at 07:43 AM documented the night shift CNAs reported R1 did not go to bed until 03:00 AM. Staff attempted to help him back to bed, but he stated no. A "Behavior Note" dated 12/11/25 at 06:43 AM documented the night shift CNAs reported R1 did not go to bed the whole night. Staff attempted to help him back to bed, but he stated no. R1 moved along the hallway without his wheelchair and pushed any item he met on his way. A "Behavior Note" dated 12/11/25 at 08:04 PM documented R1 repeatedly got out of his wheelchair and walked in the hallway while holding onto the handrail. Staff redirected every time with good short-term results. The facility made a therapy consult for the possible use of a walker. A "Behavior Note" dated 12/18/25 at 11:40 AM documented R1 refused to use his wheelchair and used a walker on and off. R1 became agitated and walked into other residents' rooms then hit two staff on different occasions. Staff redirected R1 and he later calmed down but still ambulated in the hallway. R1's clinical record lacked evidence the facility notified R1's provider of his behaviors following a gradual dose reduction of trazodone and a discontinuation of Lexapro between 11/22/25 and 12/21/25. A "Physician/PA/NP" note dated 12/22/25 at 02:19 PM documented the facility notified Consultant GG that R1 had increased anxiety and agitation recently. R1 was off his Lexapro and trazodone per R1's representative's wishes despite the Consultant GG's attempt to update R1's representative on R1's condition. The facility staff attempted to speak with R1's representative multiple times but he continued to refuse consent to allow appropriate treatment for R1. Consultant GG's plan included encouraging staff to follow behavior modifications and to continue to monitor and follow R1			F0580			

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F0580 SS = D	Continued from page 7 closely. The note documented an addendum that stated after Consultant GG left the facility, he received a phone call from the facility that R1 had increased agitation and anxiety and R1 hit staff members. R1 became so agitated that he had become an immediate danger to himself, staff, and other residents. The facility notified Consultant GG that R1's representative was in the building and called 911 to request police at the facility. Consultant GG spoke to R1's representative and explained R1's agitation and aggression placed him as a danger to himself and others. R1's representative became agitated with Consultant GG on the phone. Given the significant limitations for treatment and appropriate management of R1's psychosis (any major mental disorder characterized by a gross impairment in reality perception) at the facility, Consultant GG recommended that R1 be evaluated in an emergency department. An "Alert Note" on 12/23/25 at 04:13 PM documented the facility spoke with case management at the hospital around 09:00 AM regarding R1's current status in the hospital. The case manager stated she would call the facility back for further conversation and assistance with alternative placement for R1. On 12/29/25 at 11:59 AM, Licensed Nurse (LN) G stated R1's had increased behaviors after the provider discontinued his medications. R1 became aggressive, hit people, flipped people off, and tried to bite people. She stated staff immediately separated R1 and he was usually easily redirected. LN G stated she documented any behaviors and if R1 became physical, she notified the provider. She stated she never needed to notify the provider about R1 becoming physically aggressive since he did not have those behaviors on her shift. She stated if she notified the provider, she documented the notification in the EMR. LN G stated she received report that R1 was not sleeping prior to going to the hospital and she notified the provider. LN G confirmed she did not see any provider notification notes in R1's EMR from 11/22/25 to 12/21/25, following his increased behaviors. On 12/29/25 at 01:41 PM, LN H stated if a resident had increased behaviors, the care plan had interventions and if the interventions were ineffective, she called Administrative Nurse D and the provider. LN H stated she reported what interventions the staff tried and what worked. She stated if the behavior continued and interventions did not work, she called the provider and			F0580			

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F0580 SS = D	Continued from page 8 family. She stated she documented the behavior and notification in progress notes. On 12/30/25 at 12:28 PM, LN G stated if a resident made self-harming statements, she ensured their safety then notified the provider which she then documented in a progress note. She stated she placed the resident on one-to-one depending on the severity of the behaviors. LN G stated R1's behaviors started after he got off of some medications and he started hitting himself and said he wanted to die and kill himself. On 12/30/25 at 01:25 PM, Administrative Nurse D stated if a resident made suicidal statements or had increased behaviors, staff intervened to make sure they were safe then notified the provider. She stated the staff documented the physician notification. On 12/29/25 at 12:49 PM, Consultant GG stated he did not receive any notification of R1's increased behaviors from 11/22/25 to 12/21/25. He stated he expected the facility to follow their policies regarding notifications. The facility's "Changes in Resident's Condition or Status" policy, dated 11/26/18, directed the facility immediately informed the resident, resident's physician, and representative when a resident had a significant change in their physical, mental, or psychosocial status; and of the need to alter treatment significantly.		F0580				
F0744 SS = G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 141 residents. The sample included five residents, with three residents reviewed for dementia care. Based on record review and interviews, the facility failed to provide dementia care and services for Resident (R) 1 when the facility failed to assess, identify, record, respond to, and		F0744				

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F0744 SS = G	Continued from page 9 reassess R1's specific behaviors and triggers to promote an environment which supported R1's individualized care needs. This deficient practice resulted in ongoing and escalating behaviors, including aggression towards other residents. Findings included: - R1 admitted to the facility on 01/25/24 and transferred to the hospital on 12/23/25. R1's Electronic Medical Record (EMR) documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Annual Minimum Data Set (MDS)" dated 01/31/25 documented staff did not conduct a Brief Interview for Mental Status (BIMS) due to R1 being rarely or never understood. R1 wandered daily. R1 required substantial to maximal assistance with oral hygiene, toileting hygiene, showering, upper and lower body dressing, standing, and toilet transfers. R1 required dependence on staff for putting on shoes and personal hygiene. R1 required partial to moderate assistance with bed mobility, and he received antidepressant (a class of medications used to treat mood disorders) medications. The "Quarterly MDS" dated 10/23/25 documented staff did not conduct a BIMS due to R1 being rarely or never understood. R1 had physical behaviors directed towards others and wandering behaviors one to three days in the lookback period. R1 received antidepressant medications. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 01/31/25 documented R1 had a history and diagnosis of dementia with ongoing cognitive and physical impairments. R1 retained his ability to make his needs known.		F0744				

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F0744 SS = G	Continued from page 10 The EMR included a "Functional Abilities CAA" dated 02/03/25 which documented R1 required assistance with activities of daily living (ADL). The EMR included a "Behavioral Symptoms CAA" dated 02/03/25 which documented R1 exhibited wandering behavior due to advancing dementia.. R1's 01/25/24 "Care Plan" revealed R1 had impaired cognitive ability and impaired thought processes due to dementia disease and included the following staff interventions: 01/25/24- Staff allowed extra time for R1 to respond to questions and instructions. 01/25/24- Staff faced R1 and spoke clearly when they communicated with R1. 01/29/25- The facility placed R1 on a secured unit. 05/15/25- Staff used R1's preferred name, identified themselves at each interaction, reduced any distractions, provided necessary cues, and stopped then returned if R1 became agitated. The care plan lacked individualized interventions related to R1's behaviors and triggers for behaviors. R1's 02/07/24 "Care Plan" revealed R1 depended on staff for meeting emotional, intellectual, physical, and social needs due to his disease process and included the following staff interventions: 02/07/24- Staff established and recorded R1's prior level of activity involvement and interests by talking to R1, his caregivers, and family on admission and as necessary. 02/07/24- Staff invited R1 to scheduled activities. 02/07/24- R1 preferred coloring, simple puzzles, and watching his preferred television channels. 02/07/24- Staff reviewed R1's activity needs with his family/representative. R1's EMR revealed the following:			F0744			

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F0744 SS = G	Continued from page 11 A "Behavior Note" dated 07/03/24 at 09:11 PM documented R1 became more aggressive with staff on redirection from common areas. R1 kept self-propelling in his wheelchair through the TV and dining room and rolled over other residents' shoes and toes. When staff redirected R1, he became increasingly violent and tried to strike staff with a closed fist. R1 became increasingly restless and became a higher fall risk. R1 tried to ambulate without assistance and when staff tried to intervene, R1 became angry and tried to kick and punch staff. A "Behavior Note" dated 07/04/24 at 10:16 PM document R1 transferred himself without assistance and tried to stand up in the hallway. Staff redirected R1 back to his wheelchair several times and R1 sat in the TV room with a Certified Nurse Aide (CNA) for increased supervision for safety. R1 continued to be aggressive with direction and tried to hit and punch staff with a closed fist. A "Behavior Note" dated 07/09/24 at 09:08 PM documented R1 continued to be very restless and an increased fall risk. R1 needed increased supervision from staff for safety. A "Behavior Note" dated 10/13/24 at 07:00 AM documented R1 rolled around in his wheelchair that morning and shook both hands in the air, stating he was scared, he wanted to kill himself, and he did not know. Staff provided ineffective verbal redirection. R1 attempted to get out of his wheelchair while he stated he was scared. The nurse applied a gait belt and allowed R1 to ambulate down the hallway with the railings, but he remained anxious. R1's medical record lacked evidence the facility notified R1's provider or R1's representative of his suicidal/death statements on 10/13/24. A "Behavior Note" dated 10/23/24 at 01:02 PM documented R1 kept trying to stand up and walk. R1 verbalized he did not understand, he wanted to die. Staff redirected and helped R1 take a few steps then sat him back in his wheelchair. The note included the redirection remained ineffective.		F0744				

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F0744 SS = G	Continued from page 12 R1's medical record lacked evidence the facility notified R1's provider or R1's representative of his death statements on 10/23/24. A "Behavior Note" dated 10/29/24 at 01:06 PM documented R1 refused to eat lunch and refused to allow staff to assist him to the bathroom. R1 yelled loudly the entire time and staff provided ineffective verbal redirection. A "Weight Change Note" dated 11/11/24 at 11:58 AM documented staff reported R1 expressed feelings of wanting to die and being scared. The note documented a recommendation to refer R1 to the provider for reported issues with his mood. A "Physician/PA (Physician Assistant)/NP (Nurse Practitioner)" note dated 11/12/24 at 04:26 PM documented the provider reviewed the available medical records and the most recent laboratory results with a plan to continue to monitor and follow R1 closely. The note did not address R1's recent suicidal/death statements. A "Behavior Note" dated 12/03/24 at 02:32 PM documented R1 refused cares throughout the day and refused to eat lunch. The note included multiple staff reapproached R1 but were ineffective. A "Behavior Note" dated 12/10/24 at 04:11 AM documented R1 was up all night and resisted staff attempts to redirect him back to his bed. An "Order Note" dated 12/26/24 at 01:50 PM documented staff notified Consultant GG of R1's ongoing increased anxiety, agitation, and verbalizations of harming himself. Consultant GG gave a new order for Lexapro (antidepressant medication) 10 milligrams (mg) in the morning for mood disorder. A "Behavior Note" dated 06/30/25 at 01:29 PM documented R1 attempted to exit the unit and set off the alarms. The note included the staff provided ineffective verbal redirection and R1 refused to allow staff to take him to the shower, for his scheduled shower. A "Behavior Note" dated 07/24/25 at 04:23 PM documented		F0744				

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F0744 SS = G	Continued from page 13 R1 was very active and aggressive early in the shift. The note documented R1 screamed in the hallway, swung his arms around, pushed staff, and tried to bite staff. R1's representative tried to give R1 a snack and R1's mood escalated. R1's representative asked if the facility could give R1 a shot. The facility notified Consultant GG who ordered a one-time order for haloperidol (antipsychotic medication- [a class of medications used to treat major mental conditions that cause a break from reality]) 2 mg intramuscularly (IM- into the muscle). A "Physician/PA/NP" note dated 07/25/25 at 03:03 PM documented the provider saw R1 that day for increased agitation and anxiety. The note included R1 recently stopped his Lexapro and developed significant agitation the night prior. R1 suffered from dementia with agitation and was doing well up until the night prior. R1 required the administration of Haldol (haloperidol) 2 mg IM one time at the request of his representative. The provider ordered Lexapro 10 mg daily, and a recent urinalysis (UA- lab analysis of urine) for R1 was negative for an infection at that time. A "Behavior Note" dated 09/08/25 at 06:22 PM documented R1 rolled up to another resident in his wheelchair and grabbed his can of pop. The other resident became upset, staff redirected R1 and gave the other resident the pop back. R1 then grabbed the other resident's water cup and threw it at the window, which just missed another resident. Staff redirected R1 out of the dining room and R1 kicked staff and tried to bite them while he screamed all the way down the hallway. The activities staff took R1 off of the unit for about an hour to try to get R1 to relax. During dinner, R1 threw his tray of food down the hallway and poured his drinks on the wall and floor. The staff redirected R1 and he screamed, kicked, and tried to bite staff during redirection. R1 went down the hall and set off the alarm and when staff redirected R1, he called them names. During the meal, R1 tried to go through the dirty plates in the food warmer and when staff redirected him, he became very agitated and slammed the food warmer into the hallway wall. Staff redirected R1 to his room but R1 came back out quickly and began knocking over furniture in the dining room. After mealtime, R1 calmed down some but did propel his wheelchair into the common areas and ran over other residents toes while saying sorry then did it again. R1's medical record lacked evidence the facility	F0744					

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F0744 SS = G	Continued from page 14 notified R1's provider and representative of his behaviors on 09/08/25. A "Behavior Note" dated 09/09/25 at 09:01 PM documented R1 almost got through the unit doors while staff tried to redirect him. R1 grabbed both sides of the doors and tried to pull himself forward. R1 screamed, kicked staff, and tried to bite staff. Staff brought R1 back onto the unit and he began wandering. Staff asked R1 if he wanted to take a nap and R1 said yes. R1's representative visited for dinner. R1's medical record lacked evidence the facility notified R1's provider of his behaviors on 09/09/25. A "Behavior Note" dated 09/19/25 at 09:20 PM documented at 04:00 PM, staff saw R1 standing at the double doors with his pants down, urinating on the floor. Staff went to assist R1 with re-dressing and R1 became loud and violent. R1 pushed staff, kicked staff, and punched both CNAs with a closed fist. R1 propelled into the dining room and rolled up to another resident, who had coffee, and R1 swung at the other resident's head with a closed fist. The other resident managed to move his head enough to not get hit. Staff redirected R1 out of the common area while R1 screamed to kill him, kill him, you cannot kill me [expletive]. R1's screaming and sporadic loud noises escalated. Staff took R1 to his room for a lower stimulated environment, but he started throwing things around his room while screaming. The facility called R1's provider who gave an order for a UA during the weekend. The facility notified R1's representative. A "Behavior Note" dated 11/01/25 at 12:28 PM documented R1 wandered the unit and ran over a fellow resident's toes in his wheelchair. Staff could not easily redirect R1. Staff attempted to feed R1 breakfast and lunch, but he refused to eat a meal. A "Physician/PA/NP" note dated 11/21/25 at 03:43 PM documented R1's representative was engaged with the facility regarding the release of R1's medical records and based on an email the provider received, R1's representative withdrew his consent on R1's Lexapro for depression/anxiety and trazodone (antidepressant medication) for insomnia and sleep. The provider attempted to contact R1's representative that day without any success. The provider planned to taper R1's	F0744					

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F0744 SS = G	Continued from page 15 trazodone down then discontinue, and he discontinued the Lexapro entirely with no taper required. A "Behavior Note" dated 11/30/25 at 07:32 PM documented R1 became very agitated during the shift and repeatedly tried to stand up, which created a fall risk. Staff had to be one-to-one with R1 at all times. Activities did R1's nails, which distracted him during that time. At bedtime, R1 tried to hit staff multiple times. R1's clinical record lacked evidence the facility notified R1's provider or representative of his behaviors on 11/30/25. A "Behavior Note" dated 12/03/25 at 09:44 PM documented R1 propelled around the unit in his wheelchair and got into other residents' personal space while taking their things. The other residents screamed repeatedly, and staff redirected R1 down the hallway or into his room with short-term results. At dinner, R1 parked his wheelchair in front of the open food cart and tried to grab and touch the food trays. R1 propelled into the dining room and tried to take other residents' drinks and plates. Staff redirected R1 into the closest room and he backed his wheelchair into the bedroom, which blocked him in. Staff managed to get R1 out of the room when his representative arrived. R1's representative assisted R1 to his bedroom with dinner and snacks. R1's clinical record lacked evidence the facility notified R1's provider of his behaviors on 12/03/25. A "Behavior Note" dated 12/05/25 at 08:00 AM documented R1 attempted to go behind the nurse's desk and when the nurse tried to redirect R1, he kicked the nurse in the leg and proceeded to put his middle finger up. R1 appeared upset but his words made no sense due to being scrambled. A "Behavior Note" dated 12/09/25 at 08:41 AM documented R1 paced on the hallway, had exit seeking behaviors, and was uncooperative with calming down after reassurance or redirection. Staff left R1 alone to calm down and then R1 accepted a drink and his breakfast fairly well. A "Behavior Note" dated 12/10/25 at 07:43 AM documented	F0744					

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F0744 SS = G	Continued from page 16 the night shift CNAs reported R1 did not go to bed until 03:00 AM. Staff attempted to help him back to bed, but he stated no. A "Behavior Note" dated 12/11/25 at 06:43 AM documented the night shift CNAs reported R1 did not go to bed the whole night. Staff attempted to help him back to bed, but he stated no. R1 moved along the hallway without his wheelchair and pushed any item he met on his way. A "Behavior Note" dated 12/11/25 at 08:04 PM documented R1 repeatedly got out of his wheelchair and walked in the hallway while holding onto the handrail. Staff redirected every time with good short-term results. The facility made a therapy consult for the possible use of a walker. A "Behavior Note" dated 12/18/25 at 11:40 AM documented R1 refused to use his wheelchair and used a walker on and off. R1 became agitated and walked into other residents' rooms then hit two staff on different occasions. Staff redirected R1 and he later calmed down but still ambulated in the hallway. R1's clinical record lacked evidence the facility notified R1's provider of his behaviors following a gradual dose reduction of trazodone and discontinuation of Lexapro between 11/22/25 and 12/21/25. A "Physician/PA/NP" note dated 12/22/25 at 02:19 PM documented the facility notified Consultant GG that R1 had increased anxiety and agitation recently. R1 was off his Lexapro and trazodone per R1's representative's wishes despite the Consultant GG's attempt to update R1's representative on R1's condition. The facility staff attempted to speak with R1's representative multiple times but he continued to refuse consent to allow appropriate treatment for R1. Consultant GG's plan included encouraging staff to follow behavior modifications and to continue to monitor and follow R1 closely. The note documented an addendum that stated after Consultant GG left the facility, he received a phone call from the facility that R1 had increased agitation and anxiety and R1 hit staff members. R1 became so agitated that he had become an immediate danger to himself, staff, and other residents. The facility notified Consultant GG that R1's representative was in the building and called 911 to request police at the facility. Consultant GG spoke to	F0744					

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F0744 SS = G	Continued from page 17 R1's representative and explained R1's agitation and aggression placed him as a danger to himself and others. R1's representative became agitated with Consultant GG on the phone. Given the significant limitations for treatment and appropriate management of R1's psychosis (any major mental disorder characterized by a gross impairment in reality perception) at the facility, Consultant GG recommended that R1 be evaluated in an emergency department. An "Alert Note" on 12/23/25 at 04:13 PM documented the facility spoke with case management at the hospital around 09:00 AM regarding R1's current status in the hospital. The case manager stated she would call the facility back for further conversation and assistance with alternative placement for R1. On 12/29/25 at 01:51 PM, CNA M stated he knew what behaviors a resident had by studying them and reviewing the Kardex (nursing tool that gives a brief overview of the care needs of each resident). He stated the Kardex had behaviors with triggers and interventions. He stated if a resident had increased behaviors, he let the nurse know, tried to calm the resident down, and went back if the resident did not want help at that time. CNA M stated some interventions for behaviors included giving snacks, trying a different approach, and sitting down and talking to the resident. He stated the interventions depended on the resident. CNA M stated R1 liked to go around the unit in his wheelchair, so staff let him go up and down the hall. He stated R1 was sometimes difficult to work with but he liked pineapple juice and snacks which sometimes worked. CNA M stated in the last month, R1 would stand up from his wheelchair to walk on his own, he kicked staff during showers, stepped on other residents' toes with his wheelchair, and tried to hit other residents with his wheelchair. On 12/29/25 at 11:59 AM, Licensed Nurse (LN) G stated R1's had increased behaviors after the provider discontinued his medications. R1 became aggressive, hit people, flipped people off, and tried to bite people. She stated staff immediately separated R1 and he was usually easily redirected. LN G stated she documented any behaviors and if R1 became physical, she notified the provider. She stated she never needed to notify the provider about R1 becoming physically aggressive since he did not have those behaviors on her shift. She stated if she notified the provider, she documented the notification in the EMR. LN G stated she received			F0744			

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F0744 SS = G	Continued from page 18 report that R1 was not sleeping prior to going to the hospital and she notified the provider. LN G confirmed she did not see any provider notification notes in R1's EMR from 11/22/25 to 12/21/25 following his increased behaviors. On 12/29/25 at 01:41 PM, LN H stated if a resident had behaviors, she redirected them with something they enjoyed or needed like reading, a snack, or going the bathroom. She stated she tried to find out why the resident was upset then intervened. LN H stated she documented behaviors in the EMR and the care plans had triggers and what interventions the staff could try. She stated if a resident had increased behaviors, the care plan had interventions and if the interventions were ineffective, she called Administrative Nurse D and the provider. LN H stated she reported what interventions the staff tried and what worked. She stated if the behavior continued and interventions did not work, she called the provider and family. She stated she documented the behavior and notification in progress notes. On 12/30/25 at 12:28 PM, LN G stated if a resident made self-harming statements, she ensured their safety then notified the provider which she then documented in a progress note. She stated she placed the resident on one-to-one depending on the severity of the behaviors. LN G stated R1's behaviors started after he got off of some medications and he started hitting himself and said he wanted to die and kill himself. She confirmed R1's care plan did not have resident-specific interventions for his dementia. On 12/29/25 at 03:34 PM, Administrative Nurse D stated the Kardex had resident behaviors and the care plans had resident specific interventions for dementia. She stated the care plans identified what behaviors a resident had and possible interventions. Administrative Nurse D stated the care plan did not include triggers for behaviors. She stated R1 had minimal behaviors prior to medication changes and redirection worked with him. She stated after medication changes, R1 did not sleep well, he became agitated and anxious, he walked out of his wheelchair, propelled himself unsafely, went after other residents, and hit nursing staff during redirection. Administrative Nurse D stated R1 never physically contacted other residents because staff intervened and got hit instead. She stated residents with a diagnosis of dementia had a dementia care plan which included behaviors and interventions on what		F0744				

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F0744 SS = G	Continued from page 19 staff could do. On 12/29/25 at 12:49 PM, Consultant GG stated he did not receive any notification of R1's increased behaviors from 11/22/25 to 12/21/25. He stated he expected the facility to follow their policies regarding notifications. The facility's "Care of the Cognitively Impaired (Dementia Care)" policy, revised 08/29/22, directed the facility identified, addressed, and/or obtained necessary services for the dementia care needs of residents. The policy directed the facility developed and implemented person-centered care plans that included and supported the dementia care needs identified in the comprehensive assessment. The policy directed the facility developed individualized interventions related to the resident's symptomology and rate of progression. The policy directed the facility reviewed and revised care plans that were not effective and/or when the resident had a change in condition. The policy directed the facility modified the environment accommodated resident care needs. The policy directed the facility achieved expected improvements or maintained the expected stable rate of decline. This deficient practice was cited at a "G" (isolated, actual harm), based on reasonable person concept, when the facility did not address R1's escalating behaviors and R1 admitted to the hospital.		F0744				