

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 02/23/22.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included 19 residents with three reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide bathing services for one sampled resident, Resident (R) 62. This placed the resident at risk for poor hygiene. Findings included: - The "Electronic Medical Record (EMR)" for R62 recorded diagnoses of femur fracture (broken thighbone), osteoarthritis (the breakdown of joint cartilage [flexible connective tissue] causing pain and stiffness), and hypertension (high blood pressure). R62's "Admission Minimum Data Set" (MDS), dated 01/26/22, documented the resident had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting and ambulation. The MDS further documented R62 required extensive assistance	F 677			

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

TITLE

(X6) DATE

02/23/2022

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.

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 677	Continued From page 1 of one staff for bathing. The "ADL Care Plan," dated 01/21/22, directed staff to provide R62 with a sponge bath when a full bath or shower could not be tolerated, promote dignity by providing privacy, and allow the resident sufficient time for dressing and undressing. The "January 2022 Bathing Record" documented R62 requested showers twice a week and documented he had not received a bath or shower during the following days: 01/21/22-02/03/22 (12 days) On 02/09/22 at 10:24 AM, observation revealed R62 unshaven and long fingernails with a brownish black substance underneath them. On 02/16/22 at 08:01 AM, observation revealed the resident had long fingernails with a brownish black substance underneath them. On 02/09/22 at 10:24 AM, R62 stated he had only had one shower since his admission on 01/20/22 and stated the facility did not have a good chair he could use while showering. On 02/16/22 at 10:35 AM, Certified Nurse Aide (CNA) N stated the resident sometimes refused his showers and the refusals are documented in his electronic record. CNA N further stated they do have shower sheets for resident's who refuse, they have the resident sign the sheet, and then the sheet was given to the nurse manager. On 02/16/22 at 10:49 AM, Licensed Nurse (LN) H stated the resident often refused his showers, the refusal should be documented in his electronic	F 677			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 677	Continued From page 2 record, and verified she had not received any shower sheets regarding the resident refusals of his showers. On 02/17/22 at 03:00 PM, Administrative Nurse D stated the staff document if the resident refused showers and stated the resident should get two showers a week as requested. The facility's "Activities of Daily Living" policy, dated March 2018, documented resident would be provided with care, treatment and services as appropriate to maintain or improve their adl's. Residents who are unable to carry out activities of daily living independently, would receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 70 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to provide supervision and assistance for one of four residents reviewed for	F 689			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 689	Continued From page 3 accidents, Resident (R) 230 who was at risk for falls. This placed R230 at risk of injury. Findings included: - R230's "Physician Order Sheet," dated 01/27/22, documented diagnoses of chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure, dependence on supplemental oxygen, chronic pain, dyspnea (difficulty breathing), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), repeated falls, lack of coordination, difficulty in walking, and urinary tract infection. The "Admission Minimum Data Set" (MDS), dated 02/02/22, documented R230 had moderately impaired cognition, required supervision and limited assistance of one staff with bed mobility, transfers, walking in the corridor, and mobility on and off unit. The resident was not steady, but able to stabilize without staff assistance, and used a walker and wheelchair. The MDS further documented R230 had oxygen therapy while not a resident and while a resident, and received speech, occupational, and physical therapy. The "Fall Care Area Assessment" (CAA), dated 02/08/22, documented R230 was at risk for falls due to a history of falls, weakness, decreased mobility, and medication side effects. The "Fall Care Plan," dated 02/09/22, documented the resident was at risk for falls due to a history of falls, weakness, decreased	F 689			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 689	Continued From page 4 mobility, medication side effects and pain. The "Fall Care Plan" directed staff to provide R230 with a safe environment with cues and supervision. The "COPD Care Plan," dated 02/09/22, directed staff to administer oxygen therapy as ordered by the physician and to monitor for signs and symptoms of acute respiratory insufficiency of anxiety, confusion, restlessness, and shortness of breath. The "Physician Order," dated 01/27/22, documented respiratory order for oxygen at 2 Liters (L) per nasal cannula. The "Physician Order," dated 01/28/22, directed staff to walk with R230 to and from the restroom. The "Physician Visit Progress Note," dated 01/31/22, documented the resident had been seen in her room, alert and oriented with confusion noted. R230 sat without oxygen though she reportedly used continuously. The note further documented the provider did assist with placing the oxygen back on and the facility staff had a concern for elopement due to confusion. The "Progress Note," dated 01/28/22 at 10:44 PM, recorded R230 was found wandering in the hall by the beauty shop. R230 had no shoes on, no walker, and was holding her oxygen tubing. The note further recorded R230 had been identified by her wristband, assisted back to her room, and staff would check on resident frequently. On 02/16/22 at 04:14 PM, observation revealed R230 sat in a chair in a commons area behind	F 689			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 689	Continued From page 5 the chapel, outside of her unit. The resident was without oxygen, wheelchair or walker, and reported she planned to check into assisted living option for when she was discharged. The resident then ambulated to her unit holding onto the handrails. The resident walked past her room, stopping at other residents' doorways and looking into the rooms. She proceeded to walk to the farthest table in the dining room and sat briefly at a table. Staff approached the resident and provided her with a mask. R230 remained without oxygen, walker or wheelchair. On 02/16/22 at 04:18 PM, observation revealed R230 ambulated out of the dining room and she briefly spoke to the other residents at their doorways. She held on to the wall rails, leaned against the wall, and appeared short of breath. R230 then sat on the couch in the commons area of her unit with apparent shortness of breath and poor balance. Two staff members had been seated at the dining room tables as R230 passed through the dining room, left the table, and proceeded down another hall. On 02/16/22 at 04:24 PM, observation revealed R230 walking back to other resident's rooms, she entered rooms and spoke to the other residents briefly. The staff intercepted her in the commons area as she was having difficulty with walking and shortness of breath. The staff inquired what she was doing, asked her name, and directed her to a couch. R230 stated she was there to see her mother and incorrectly gave staff her name. Staff did not know the residents' name or what room she occupied. The surveyor gave information to staff of the residents' name and room number, and shared R230 needed a walker, and used oxygen. Staff retrieved her walker and placed it in	F 689			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 689	Continued From page 6 front of her. The staff then returned to sitting at a dining room table. R230 commented she came to visit her mother, remained short of breath, anxious, talkative, and changed positions frequently on the couch. On 02/09/22 at 04:43 PM, staff from the dining room table approached R230, encouraged the resident to return to her room, and walked with her. R230 remained without oxygen therapy for 29 minutes. On 02/09/22 at 04:30 PM, License Nurse (LN) H stated staff at the dining room table had been agency staff, did not know the resident, and should have been supervising and assisting the resident with walking and use of oxygen to prevent falls. On 02/17/22 at 03:00 PM, Administrative Nurse D verified the resident should have been supervised, wearing her oxygen, and staff should be aware of the resident's needs and safety. The facility's "Fall Prevention" policy, dated October 2021, documents residents will be evaluated for the risk of falling so that intervention may be considered in order to promote resident safe, appropriate clinical and multidisciplinary assessment of falls. The interdisciplinary team will discuss the investigation and where reasonable and appropriate, modify the plan of care. The facility failed to provide supervision and assistance for R230, placing the resident at risk for decline and accidents.	F 689			
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care	F 691			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 691	Continued From page 7 CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included 19 residents, with one reviewed for urostomy (an artificial opening in an organ of the body) care. Based on observation, record review, and interview, the facility failed to provide urostomy care for one sampled resident, Resident (R) 178. This placed the resident at risk for inappropriate care and unnecessary complications. Findings included: - The "Electronic Medical Record (EMR)" documented R178 had diagnoses of hypertension (high blood pressure), cellulitis (inflammation of the deepest layer of the connective tissue), and pain. R178's "Admission Minimum Data Set" (MDS), dated 02/08/22 was in progress. The "Urostomy Care Plan," dated 02/07/22, directed staff to change the appliance (bag) as needed, cleanse with soap and water, pat dry, apply skin prep (an antimicrobial skin cleanser), and appliance. The "Urostomy Care Plan" further directed staff to maintain universal precautions	F 691			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 691	Continued From page 8 when providing resident care. The "Urostomy Care Plan" lacked documentation the resident would care for his urostomy without staff assistance and lacked documentation the resident would use his own urostomy supplies from home. The "Physician's Order," dated 02/05/22 directed staff to change the urostomy appliance as needed, cleanse with soap and water, pat dry, apply skin prep and appliance. The "Physicians Order," dated 02/08/22, directed staff to apply gentamicin sulfate cream (a topical antibiotic used to treat skin infections) 0.1%, one time a day every three days for urostomy care. The "Nurse's Note," dated 02/04/22 at 04:34 PM, documented the resident was alert and oriented for person, place, time and situation, was skilled due to a fall at home, and had a urostomy for his bladder. The note further stated the urostomy bag leaked and needed changed after dinner. The "Physician's Note," dated 02/07/22 at 10:35 AM, documented the resident was concerned with his urostomy care and that several certified nurse aides (CNA) and licensed nurses (LN) were not familiar with urostomy care and had to change the bag several times due to persistent leaking. The note further documented the skin prep that was used had left his skin sticky so the urostomy bag leaked and the resident had to replace the bag himself which was quite difficult. The "Nurse's Note" dated 02/14/22 at 08:16 AM, documented the gentamicin cream was used last night when the resident changed his urostomy bag.	F 691			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 691	Continued From page 9 Review of the "Treatment Administration Record" for February 2022 lacked documentation staff assisted the resident with urostomy care. On 02/09/22 at 11:55 AM, observation revealed the resident seated in his room. He had a box of urostomy appliances and a mirror with a light attached to use when changing his urostomy bag. On 02/09/22 at 11:55 AM, R178 stated the staff had a hard time changing his urostomy bag and none of the staff on duty knew how to change the bag. R178 further stated he was unable to use the bags the facility had, so he had to use his own supply. R178 stated the first day they went through 11 bags and they cost \$12.00 apiece. R178 stated he was providing his own urostomy care, had his daughter bring in his mirror with the light so he could see what he was doing, and he was not happy about it, but the staff didn't know how to change the bag correctly. On 02/16/22 at 08:09 AM, R178 stated he was discharged to home today and stated the staff had not helped him with his urostomy bag the whole time he was at the facility. R178 stated staff would hand him the supplies while he changed his own bag. On 02/16/22 at 10:50 AM, LN H stated staff should assist the resident with his urostomy care but the resident did not want to use the skin prep as ordered. LN H further stated she was unaware the resident was using his own bags, providing his own urostomy care was his choice, and should be documented in the care plan or in his medical record.	F 691			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 691	Continued From page 10 On 02/17/22 at 03:12 PM, Administrative Nurse D stated staff should have assisted the resident with his urostomy care and that the facility would reimburse the resident if they found that he had to use his own supplies. The facility's "Urostomy Care" policy, dated October 2010, documented staff review the resident's care plan to assess for any special needs of the resident and assemble the equipment and supplies as needed. The policy further documented staff record the date and time the procedure was performed, name and title of who performed the procedure, the condition of the skin surrounding the stoma, and the type of appliance utilized. Staff documented all assessment data obtained during the procedure and how the resident tolerated the procedure and if the resident refused. The facility failed to assist R178 with his urostomy care as directed by the physician, placing the resident at risk for inappropriate care and unnecessary complications.	F 691			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 11 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included 19 residents, with three reviewed for hydration. Based on observation, record review, and interview, the facility failed to monitor hydration status for one sampled resident, Resident (R) 69, who was on a physician ordered fluid restriction, and failed to establish a fluid restriction as ordered for R176. This placed the residents at risk for dehydration or fluid overload. Findings included: - The "Electronic Medical Record (EMR)," documented R69 had diagnoses of chronic kidney disease stage two (minor kidney damage), cirrhosis of the liver (liver damage), atrial fibrillation (irregular, rapid heart rate), hypertension (high blood pressure), and congestive heart failure (the heart doesn't pump blood as well as it should). R69's "Admission Minimum Data Set" (MDS), dated 01/30/22, documented the resident had intact cognition and required extensive assistance of two staff for bed mobility and transfers and independent with eating.	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022	
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL				STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216			
(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 692	Continued From page 12 The "Urinary Tract Infection Care Plan," dated 01/27/22, documented the resident was on a 2000 milliliters (ml) fluid restriction and directed clinical staff to provide 340 ml in the morning, 240 ml in the afternoon and 120 ml's of fluids at night. The "Urinary Tract Infection Care Plan" directed dining service staff to provide 720 ml at breakfast, 240 ml at lunch, and 240 ml's of fluid at dinner. The "Dehydration Care Plan," dated 02/14/22, documented the resident had potential for dehydration or fluid deficit and had received intravenous fluids at times during her stay. The "Dehydration Care Plan" directed staff to notify the physician of any abnormal laboratory results, monitor her weights, and monitor for any signs or symptoms of decreased or no urine output, concentrated urine, strong odor, or cracked lips. The "Physician's Order," dated 01/27/22, directed staff to implement a fluid restriction for R69 consisting of clinical staff to provide 340 ml in the morning, 240 ml in the afternoon and 120 ml's of fluids at night. The order directed dining service staff to provide 720 ml at breakfast, 240 ml at lunch, and 240 ml's of fluid at dinner. Review of the "Medication Administration Record" for January 2022 documented the following daily fluid totals: 01/26/22 - 240 ml 01/28/22 - 960 ml 01/31/22 - 1320 ml Review of R69's "January 2022 Daily Fluid Intake" lacked documentation of a daily fluid intake total.			F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 13 Review of the "Medication Administration Record" for February 2022 documented the following daily fluid totals: 02/01/22 - 930 ml 02/03/22 - 1080 ml 02/06/22 - 2140 ml 02/07/22 - 5097 ml 02/08/22 - 2097 ml 02/09/22 - 1090 ml Review of R69's "February 2022 Daily Fluid Intake" lacked documentation of a daily fluid intake total. On 02/10/22 at 08:17 AM, observation revealed three 12-ounce (oz) paper cups with lids on R69's bedside table. On 02/09/22 at 12:22 PM, R69 stated the staff tell her to drink more because her urine is darker and then they put her on a fluid restriction. R69 stated she is getting mixed messages from staff. On 02/10/22 at 08:25 AM, Certified Nurse Aide (CNA) N stated R69 was on a fluid restriction and wasn't sure how many ml's were in the resident's paper cups. CNA N further stated she just pours the fluid R69 hadn't drank into another paper cup and will tell the nurse how many cups are full of fluid. On 02/10/22 at 11:30 AM, Licensed Nurse (LN) J stated she goes into R69's room at mealtimes and looks to see how many cups of fluid R69 had been delivered. LN J stated she eyeballed the cups to see how much the resident had drank before staff took R69's meal tray with the fluids. On 02/16/22 at 10:50 AM, LN H stated the nurse	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 14 was responsible for totaling up R69's daily fluid intake and that each cup of fluid was removed after each meal. LN H verified there were no daily fluid intake totals. On 02/16/22 at 02:29 PM, Consultant GG stated the computer program does not have a line to document the daily fluid intake totals but stated someone should monitor the fluid totals at the end of the shift. On 02/17/22 at 03:12 PM, Administrative Nurse D stated staff should monitor daily fluid totals to make sure R69 was not getting dehydrated or getting too many fluids. The facility's "Fluid Restriction" policy, dated October 2015, documented the fluid restriction policy was to provide adequate monitoring of residents with prescribing health care provider orders for a fluid restriction. The policy documented clinical services would determine the amount of daily fluid that would be provided by dining services and the amount of fluid provided by clinical services from the total amount of fluid per the health care provider order. Clinical services would monitor for signs and symptoms of dehydration and identify and develop or update the plan of care for those that are dehydrated or at risk of dehydration. The residents on a fluid restriction would be identified in the computer under the resident's profile and fluid intake should be documented in point click care. The facility failed to monitor hydration status for R69, who was on a physician ordered fluid restriction, placing the resident at risk for dehydration.	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 15 - The "Electronic Medical Record (EMR)" documented R176 had diagnoses of congestive heart failure (a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic respiratory failure (inability to effectively exchange carbon dioxide and oxygen). R176's "Admission Minimum Data Set" (MDS), dated 02/22/22, documented the resident had intact cognition and required extensive assistance with bed mobility, dressing, transfers, toileting, and personal hygiene. The MDS further documented the resident was independent with eating. The "Nutrition Care Plan," dated 01/28/22, documented the resident was on a 2000 milliliters (ml) fluid restriction and directed clinical staff to provide 340 ml in the morning, 240 ml in the afternoon and 120 ml's of fluids at night. The "Nutrition Care Plan" directed dining service staff to provide 720 ml at breakfast, 240 ml at lunch, and 240 ml's of fluid at dinner. The "Preadmission Orders," dated 01/27/22, directed staff to limit the amount of the residents daily fluids to 2000 milliliters (ml). Review of the "Medication Administration Record" for January and February 2022 lacked documentation the resident was on a fluid restriction. On 02/10/22 at 08:15 AM, observation revealed the resident had two paper cups with lids on her	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 16 bedside table. On 02/10/22 at 08:15 AM, R176 stated she thought she was supposed to be on a fluid restriction but no one had said anything about it to her. On 02/10/22 at 11:28 AM, Certified Nurse Aide (CNA) N stated R176 was not on a fluid restriction and that information would be on her CNA paperwork. On 02/10/22 at 11:30 AM, Licensed Nurse (LN) J stated there was only one resident on a fluid restriction and it was not R176. On 02/10/22 at 02:45 PM, Consultant GG stated R176 was supposed to be on a fluid restriction and verified it was missed upon admission. On 02/16/22 at 10:43 AM, LN H stated the admission nurse was responsible for the orders and the fluid restriction was missed when R176 was admitted to the facility. On 02/17/22 at 03:30 PM, Administrative Nurse D stated the admission nurse should have checked and made sure the fluid restriction order was on the MAR. The facility's "Fluid Restriction" policy, dated October 2015, documented the fluid restriction policy was to provide adequate monitoring of residents with prescribing health care provider orders for a fluid restriction. The policy documented clinical services would determine the amount of daily fluid that would be provided by dining services and the amount of fluid provided by clinical services from the total amount of fluid	F 692			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 692	Continued From page 17 per the health care provider order. Clinical services would monitor for signs and symptoms of dehydration and identify and develop or update the plan of care for those that are dehydrated or at risk of dehydration. The residents on a fluid restriction would be identified in the computer under the resident's profile and fluid intake should be documented in point click care. The facility failed to implement R176's physician's ordered fluid restriction, placing the resident at risk for fluid overload.	F 692			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included 19 residents, with three reviewed for pain. Based on observation, record review, and interview, the facility failed to ensure that pain management was provided to one sampled resident, Resident (R) 62. This placed the resident at risk for pain and discomfort. Findings included: - The "Electronic Medical Record (EMR)" for R62 recorded diagnoses of femur fracture (broken thighbone), osteoarthritis (the breakdown of joint cartilage [flexible connective tissue] causing pain and stiffness), and hypertension (high blood	F 697			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 697	Continued From page 18 pressure). R62's " Admission Minimum Data Set" (MDS), dated 01/26/22, documented the resident had intact cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. The MDS further documented the resident had frequent pain and received pain medication. The "Pain Care Plan," dated 02/02/22, directed staff to administer pain medication as ordered, anticipate R62's need for pain relief, provide interventions, and follow up for effectiveness of interventions. The "Pain Care Plan" directed staff to notify the physician if interventions were unsuccessful and if current complaint was a significant change from residents past experience of pain. The "Physician's Order," dated 01/20/22, directed staff to apply biofreeze gel (a topical analgesic), four percent, apply topically to the back, every day and night shift for back pain. The "Physician's Order," dated 01/21/22, directed staff to administer Tylenol (a mild pain medication), 325 milligrams (mg), two tablets by mouth, every 8 hours as needed for pain. The "Physician's Order," dated 01/22/22, directed staff to apply a Lidocaine patch (a transdermal [adheres to the skin] patch used to relieve pain), four percent, apply to the right knee, daily for pain. Review of the "Medication Administration Record" for January 2022 documented Lidocaine patches were unavailable for the following days:	F 697			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 697	Continued From page 19 01/21/22 01/22/22 Review of the "Medication Administration Record" for February 2022 documented Lidocaine patches were unavailable for the following days: 02/05/22 02/11/22 02/12/22 02/13/22 On 02/16/22/at 08:01 AM observation revealed the resident seated in his wheelchair eating breakfast. On 02/16/22 at 10:49 AM, Licensed Nurse (LN) H stated the Lidocaine patches are always available through their central supply and stated some of the as needed nurse's may not know that information. On 02/16/22 at 01:45 PM, LN I stated the nurses are able to get the Lidocaine patches from the central supply. On 02/17/22 at 03:10 PM, Administrative Nurse D stated R62 should receive his pain patch as ordered. The facility's "Pain Management" policy, dated June 2020, documented the policy was to identify, treat and manage the resident's pain levels and provide a systematic approach to data collection using objective measurements of the pain level and effectiveness of the pain relief medication, pain management, needs to be addressed on the resident's care plan and monitored by the interdisciplinary team.	F 697			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 697	Continued From page 20	F 697			
F 757	The facility failed to provide pain management to R62, placing the resident at risk for further pain.				
SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757			
	§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 70 residents. The sample included 19 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold insulin (a hormone which regulates the amount of sugar in the blood) for Resident (R) 40 when blood sugars were lower than the physician ordered parameter, did not provide interventions when R22 had five days				

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 21 without a bowel movement, and did not hold blood pressure medication for R69 when blood pressures were out of the physician ordered parameters. This deficient practice placed three of six residents at risk for adverse side effects from medications. Findings included: - R40's "Physician Order Sheet" (POS), dated 02/09/22, documented a diagnosis of diabetes mellitus (an impairment in the way the body regulates and uses sugar as a fuel). The "Admission Minimum Data Set" (MDS), dated 01/17/22, documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS documented R40 required supervision for eating, extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and total staff assistance for locomotion. The MDS documented R40 received insulin medication six days of the lookback period. The "Diabetes Care Plan," dated 01/13/22, directed staff to provide medication as ordered, Glargine (long acting insulin) and Lispro (fast acting insulin), monitor for side effects and document effectiveness. The "Diabetes Care Plan" directed staff to obtain fasting blood sugar before meals and at bedtime as ordered by the doctor. Physician orders for insulin included: Glargine, 20 units at bedtime, Only IF AM (morning) glucose was above 130 mg/dL (milligrams per deciliter). Lispro, 7 units with meals, Only IF glucose was	F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022	
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL				STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216			
(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 757	Continued From page 22 above 130 ml/dL and she was eating well. Review of the "Medication Administration Record" (MAR) revealed the following blood sugars below 130 ml/dL and Lispro insulin administered: 13 times 01/14/22 at 08:00 AM = 96 01/15/22 at 08:00 AM = 107 01/16/22 at 08:00 AM = 121 01/19/22 at 05:00 PM = 113 01/21/22 at 08:00 and 11:00 AM = 109 01/22/22 at 11:00 AM = 120 01/26/22 at 08:00 AM = 95 02/01/22 at 08:00 AM = 100 02/04/22 at 08:00 AM = 100 02/07/22 at 05:00 PM = 128 02/08/22 at 08:00 AM = 121 02/15/22 at 08:00 AM = 114 On 02/10/22 at 08:35 AM, Licensed Nurse (LN) G obtained R40's blood sugar of 101 mg/dL and verified staff were to hold the Lispro insulin per physician orders. On 02/16/22 at 11:55 AM, Administrative Nurse D verified staff documented they administered the Lispro insulin even though the resident's blood sugar was below the physician ordered parameters. The facility's "Insulin Administration" policy, dated September 2014, documented staff must verify the type of insulin, dose, strength, and method of administration to assure that it corresponds with the order on the medication sheet and the health care provider's order. The facility failed to hold the insulin medication when R40's blood sugar was below 130 mg/dL			F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 23 per physician orders, which placed the resident at risk for adverse effects of the medication. - R22's "Physician Visit Sheet," dated 01/12/22, documented diagnoses of dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and constipation (condition in which there is difficulty in emptying the bowels). The "Quarterly Minimum Data Set" (MDS), dated 12/30/21, documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired decision-making skills. The MDS documented R22 required supervision for eating, walking in room, locomotion, and limited staff assistance with toileting, dressing, and transfers. The MDS documented R22 frequently incontinent of bowels. The "Medication Care Plan," dated 01/06/22, directed staff to monitor medications for side effects of constipation and keep physician informed of any problems. R22 required staff assistance to use the toilet. The "Medication Care Plan" directed staff to record R22's bowel movement (BM) pattern each day, describe amount, color and consistency, encourage fluid intake with meal tray and offer between meal fluids. The "Medication Care Plan" documented R22 at risk for complications such as constipation related to decreased mobility and needed assist of one staff member for bed mobility, toileting and bathing. The "Medication Care Plan" directed staff to administer Miralax (laxative) as ordered and encourage R22 to sit on the toilet to evacuate her bowels if possible.	F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 24 The "Physician Order," dated 12/02/20, directed staff to administer Miralax, 17 grams daily. On 12/18/20 the physician ordered Miralax 17 grams prn (as needed) every 24 hours. Review of R22's "Electronic Medical Record" revealed: No BM 02/08/22 through 02/12/22 (five days) and no PRN laxative administered, or record of nursing assessment related to bowels. 01/31/22 through 02/05/22 revealed no or small BMs (six days), no PRN laxative administered, or record of nursing assessment related to bowels. On 02/10/22 at 09:40 AM, observation revealed Licensed Nurse (LN) G administered Miralax 17 grams in water to the resident. On 02/10/22 at 01:57 PM, Certified Nurse Aide (CNA) M stated R22 had dementia and staff gently told her she needed to go to the bathroom and though she may argue at first, she would cooperate. On 02/16/22 at 11:55 AM, Administrative Nurse D verified staff were to investigate whether the resident had BMs if the BM report showed no BMs for three days. Administrative Nurse D stated if the resident had no BMs for three days, the nurse should assess bowel sounds, check for PRN treatments and provide the treatment. Administrative Nurse D verified staff provided no prn treatment in February and stated nursing should have notified the physician of the need to use PRN orders. The facility's "Change of Condition" policy, dated September 2019, stated when a resident is evaluated or assessed as having a change in	F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 25 condition, including constipation, the nurse would follow through in documenting notification of the healthcare provider and other licensed nurses in order to facilitate the appropriate plan of care. When a difference in the resident's usual physical, emotional, or cognitive patterns is noted the charge nurse would be notified. The licensed nurse would perform a comprehensive evaluation or assessment. The facility failed to adequately monitor the effectiveness of Miralax and provide treatment for the side effect of medications, placing R22 at risk for complications from constipation. - The "Electronic Medical Record (EMR)," documented R69 had diagnoses of chronic kidney disease stage two (minor kidney damage), cirrhosis of the liver (liver damage), atrial fibrillation (irregular, rapid heart rate), hypertension (high blood pressure), and congestive heart failure (the heart doesn't pump blood as well as it should). R69's "Admission Minimum Data Set" (MDS), dated 01/30/22, documented the resident had intact cognition and required extensive assistance of two staff for bed mobility and transfers. The MDS documented R69 received diuretic (medication to promote the formation and excretion of urine), antianxiety (medication that calm and relax people with excessive anxiety, nervousness, or tension), and antidepressant (medication used to treat mood disorders and relieve symptoms of depression) medications for four days of the look back period. The "Hypertension Care Plan," dated 01/27/22, directed staff to administer antihypertensive	F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 26 (medication to lower blood pressure) medications as ordered and monitor for side effects, orthostatic hypotension (blood pressure dropping without change of position) and increased heart rate, give antihypertensive medication and obtain blood pressure readings as ordered. The "Physicians Order," dated 01/27/22, directed staff to administer diltiazem hcl (antihypertensive medication), 30 milligrams (mg), three times a day. The staff were directed to hold the medication if R69's systolic blood pressure (sbp-the pressure caused by the heart contracting and pushing out the blood) was less than 110 beats per minute (bpm) or the diastolic blood pressure (dbp-the pressure in the arteries when the heart rests between beats) was less than 60 bpm. The "Medication Administration Record" (MAR) dated 01/29/22, documented R69's sbp was 106/64. The record documented the diltiazem medication was given. The "MAR" dated 02/07/22, documented R69's sbp was 108/66. The record documented the diltiazem medication was given. The "MAR" dated 02/09/22, documented R69's sbp was 109/64. The record documented the diltiazem medication was given. The "MAR" dated 02/15/22, documented R69's sbp was 108/70. The record documented the diltiazem medication was given. The "MAR" dated 02/16/22, documented R69's sbp was 104/60. The record documented the diltiazem medication was given.	F 757			

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

PRINTED: 02/23/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
(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 757	Continued From page 27 On 02/16/22 at 09:00 AM, observation revealed R69 in bed with her eyes closed. On 02/16/22 at 10:50 AM, Licensed Nurse (LN) H stated the nurses would often see R69's blood pressure was out of parameters, hold the medication, recheck the resident's blood pressure, and if it was within normal range, give R69 the medication. LN H stated the nurse should document they were rechecking the blood pressure and verified the nurse did not document she was rechecking the blood pressure, then giving the medication. On 02/16/22 at 01:37 PM, LN I stated she did not hold R69's medication when her sbp was out of parameters because she had read the order wrong. On 02/17/22 at 03:35 PM, Administrative Nurse D stated the nurse should hold the medication if R69's blood pressure was out of the ordered parameters. Upon request a policy for medication administration for out of parameter blood pressure was not provided by the facility. The facility failed to hold the diltiazem medication for R69's out of parameter sbp, placing the resident at risk for physical decline.	F 757			