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	175478	A. BUILDING _____ B. WING _____	08/06/2020

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BROOKDALE ROSEHILL	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 and Complaint Investigations #KS00154050, KS00152411, KS00152068, KS00151764, KS00141318, KS00148453, KS00152139, KS00152010, KS00148672 and KS00151442. The 2567 was sent electronically to the facility on 8/18/20.	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 identified a census of 72. The sample included 21 residents. Based on observation, record reviews, and interviews, the facility failed to ensure Resident (R) 101 received the necessary care and services to maintain his highest practicable level of health and hygiene Findings included: - The "Diagnoses" tab of the electronic medical record (EMR) documented diagnoses of displaced fracture of base of neck of left femur (fracture of thigh bone) and unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion). The "Admission Minimum Data Set" (MDS) dated 03/23/2020 revealed R101's Brief Interview for	F 677		

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

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

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Mental Status (BIMS) score was six. R101 required extensive one-person physical assistance with personal hygiene, toileting, and dressing. R101 required total assistance of one-person with bathing. R101 required supervision with one-person physical assistance with eating.

The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/23/2020 revealed resident required total assistance of up to two staff for bathing. R101 needed supervision and occasionally more assistance with eating during the assessment period related to eating not initiated.

The "Nutritional Status" CAA dated 03/23/2020 revealed R101 had an increased risk for malnutrition and dehydration. R101 was on a puree diet due to swallow safety and coughed at meals which increased his risk of poor intake.

The "Care Plan" initiated 03/17/2020 revealed R101 had a decline in his ADLs from his previous level of function due to recent hospitalization, after a fall with left hip fracture. The care plan directed staff to offer bathing assistance Wednesday and Friday evenings and as needed.

The "Care Plan" initiated 03/18/2020 revealed R101 had a potential for aspiration and dysphagia (difficulty swallowing) and directed staff to supervise or assist R101 with oral intake as needed and needed help feeding.

The "Task" tab of the EMR revealed a task for bathing on Wednesday and Friday. The documentation survey report documented a bed bath was given on 03/18/2020 then no bathing

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charted for 03/20/2020, 03/25/2020, 03/27/2020, and 04/01/2020. The bathing was charted as "activity did not occur" on 04/03/2020.

The EMR lacked documentation for 23 out of 61 meals during R101's stay at the facility.

The "Weights/Vitals" tab of the EMR revealed a 8.6 pound weight loss during R101's stay at the facility.

In an interview on 08/06/2020 at 03:21 PM, Certified Nurse Aide (CNA) N stated tasks are done and documented prior to the end of the shift. If there was a blank on the task report the task was not done. She stated at 04:25 PM the CNAs assigned to that hall charted meal percentages and if they weren't charted then it wasn't done.

In an interview on 08/06/2020 at 04:23 PM, Licensed Nurse (LN) I stated the CNAs knew the bathing schedule, if the resident refused then the nurse tried to see why the resident refused and tried to get resident to take a bath. CNAs charted the bathing.

In an interview on 08/06/2020 at 02:54 PM, Administrative Nurse D stated she was not sure what a "blank" on the tasks meant. She stated bathing, eating, pain, skin issues showed up on the nurse's dashboard so if something was not charted then the nurse had to chart on it. She stated she reviewed the dashboard every morning to see what showed up and addressed it with the nurse managers.

The "Activities of Daily Living Care Documentation Policy" last revised November

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F 677	Continued From page 3 2018 directed ADL care not performed during a shift was reported to the manager on duty and to the incoming associates of the next shift. The facility failed to provide the necessary care and services related to bathing and eating per the care plan to R101. This placed the resident at risk for a decline in health status, hygiene and function.	F 677		
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 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 identified a census of 72 residents. The sample included 21 residents. Based on interviews, observations, and record reviews the	F 692		

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facility failed to record the percentages of meals eaten for one of four Residents, (R)44. The facility also failed to record the amount of fluid consumed by one resident (R99) on a fluid restriction for R101 who was to be monitored closely for fluid intake due to dehydration.

Findings included:

- R44's electronic medical record (EMR) documented diagnoses of cellulitis (skin infection caused by bacteria characterized by heat, redness, and swelling) of both legs and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The 07/27/20 "Admission Minimum Data Set" documented a Brief Interview for Mental Status core of 15, which indicated intact cognition. She required limited to extensive staff assistance with her "Activities of Daily Living." She had sustained a weight loss of five percent or more in the last month or more than 10 percent in the last six months and was not on a physician prescribed weight loss program. She held food in her mouth at times.

The 07/29/20 "Nutritional Status Care Area Assessment" documented R44 had a weight loss of 8.9 percent since her admission on 07/21/20. She was on a modified textured diet to ensure safe swallowing.

The "Care Plan" revised on 07/31/20 documented R44 was on a modified textured diet and had a weight loss of 8.9% since admission. The staff assisted in meeting her extensive food preferences. Nutritional supplements had been

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added to her medications.

The "Nutrition Risk Review" on 07/27/20 documented R44 was very particular on the food she liked, and the staff worked with her to get as many types of food as she wanted.

The EMR documented R44 weighed 127.8 pounds on 07/21/20 and 112.6 pounds on 08/05/20

The EMR lacked documentation for the percentages of meals eaten for:
Two of three meals on 07/23/20 and 07/24/20, 07/27/20, 07/29/20, 07/30/20, 08/01/20 and 08/04/20.
One of three meals on 07/25/20.
Three of three meals on 07/26/20, 08/02/20, and 08/03/20.

On 08/05/20 at 07:30 AM R44 sat in her room as she watched television. She stated she had little appetite in the last few months but, thought it was improving. She used to like cheese but had lost her taste for it. She didn't like meat unless it was in goulash. She never liked eggs before but, she did like the facility's poached eggs.

On 08/05/20 at 12:30 PM R44 ate lunch in the dining room. She was not noted to have trouble chewing or swallowing. She asked for several extra food items which the staff brought to her.

On 08/06/20 at 01:45 PM Certified Nurse Aide (CNA) M stated the CNAs documented the percentages of meals eaten on everyone.

On 08/06/20 at 02:00 PM Licensed Nurse H stated the CNAs documented the percentages of

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meals eaten by the residents.

On 08/06/20 at 02:31 PM Administrative Nurse D stated meal percentages eaten are documented by the CNAs and are cross checked by the nurses.

The facility's "Routine Clinical Documentation" policy dated January 2018 documented all services routinely provided to the resident are documented in the resident's record The CNAs documented the amount eaten by the residents.

The facility failed to ensure the percentages of meals eaten by R44. This failure had the potential for the inability of the facility staff to properly evaluate the reason for her substantial weight loss.

- R99's electronic medical record (EMR) documented diagnoses of chronic kidney disease and atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls).

The EMR documented an admission date of 08/03/20.

The "Care Plan" dated 08/04/20 documented R99 was on a 2,000 milliliter per day fluid restriction.

The EMR documented an order for a 2,000 mls. per day fluid restriction dated 08/03/20.

The EMR, reviewed 08/03/20 through 08/05/20, lacked documentation for fluid R99 had consumed from 08/03/20 through 08/05/20.

On 08/05/20 at 09:42 AM R99 sat upright in his

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bed. He became short of air with his speech. He stated he felt short of air when he did anything.

On 08/06/20 at 01:45 PM Certified Nurse Aide M stated fluid restrictions are broken down to the amount given for each meal in the "Tasks" function of the EMRs. There is also a chart which indicated the amount of fluid in each type of glass provided by the facility. Each staff member was responsible for the documentation of the amount of fluid they noted the resident drank.

On 08/05/20 at 02:00 Licensed Nurse H stated fluid restrictions were noted on the residents' "Medication/Treatment Administration Record" (MAR/TAR). She asked the CNAs how much fluid the resident received which she added to the amount she gave the resident, prior to the daily prior to the daily total documented.

On 08/06/20 at 02:31 PM Administrative Nurse D stated the dietician broke down the amount of fluid a resident, on a fluid restriction, received throughout the day.

On 08/06/20 at 03:39 PM Administrative Nurse E stated she placed the fluid restrictions in a resident's care plan and on the MAR/TAR when an order was received.

The facility's "Fluid Restriction Policy" dated October 2015 documented fluid intake was documented in the EMR.

The facility failed to document the fluids R99 consumed. This had the potential for unwarranted side effects from possible fluid overload or dehydration.

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- The "Diagnoses" tab of the Electronic Medical Record (EMR) documented diagnoses of displaced fracture of base of neck of left femur (fracture of thigh bone), unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS) dated 03/23/2020 revealed R101's Brief Interview for Mental Status (BIMS) score was six, which indicated severely impaired cognition. R101 required supervision with one-person physical assist with eating.

The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/23/2020 revealed R101 required supervision and occasionally more assistance with eating.

The "Nutritional Status CAA" dated 03/23/2020 revealed R101 had an increased risk for malnutrition and dehydration.

The "Care Plan" initiated 03/18/20 directed staff to encourage good nutrition and hydration in order to promote healthier skin.

The "Task" tab of the EMR directed staff to offer fluids three times a day. The documentation survey report revealed 28 scheduled fluid times were not documented and there were 12 fluid times documented as not offered.

In an interview on 08/06/2020 at 09:41 PM, Anonymous reporter TT stated a family member of R101 reported to her that when resident discharged from facility, he smelled, was dirty,

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had food in his beard, wasn't shaved, hair was greasy, and had significant weight loss. Upon review of lab results from hospital admission on 04/08/2020 provided by Anonymous reporter TT, R101 had BUN 31, creatinine 1.3, lactic acid 6.2. Anonymous reporter TT reported R101 was admitted to hospital on 04/08/2020 with urinary tract infection (infection in any part of your urinary system including kidneys, ureters, bladder, and urethra) and pneumonia (inflammation of the lungs).

In an interview on 08/06/2020 at 02:54 PM, Administrative Nurse D stated she expected staff to chart fluids weren't offered if they weren't. She stated she expected staff to offer fluids during usual cares and if the resident that normally accepts fluids, declines then she expected staff to assess why they refused for possible change.

In an interview on 08/06/2020 at 04:23 PM, Licensed Nurse (LN) I stated residents were given fresh ice water every shift. He stated the CNAs have a report sheet that showed resident's fluid preferences and if they were thickened liquids.

In an interview on 08/06/2020 at 04:25 PM, Certified Nurse Aide (CNA) N stated residents are offered fluids a few times throughout the shift unless on a fluid restriction. She stated she took cups of water to the resident's room to offer fluids.

The "Hydration Program" Policy last revised October 2019 documented residents should drink at least eight to ten eight-ounce glasses of total fluids each day, at least four of the total eight to ten glasses should be water.

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F 692	Continued From page 10 The facility failed to offer fluids and document fluid intake for R101 which had the potential for unwarranted physical complications due to decreased fluid intake.	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The sample included 21 residents. Based on record reviews and interviews, the facility failed to prevent a significant medication error when they failed to transcribe and administer Digoxin (a medication used to treat a rapid, irregular heartbeat) for Resident (R) 100. Findings included: - R100's signed "Physician's Order Sheet (POS)" dated 04/11/20, documented the diagnoses of coronary artery disease (abnormal condition that may affect the flow of oxygen from the heart) and atrial fibrillation (rapid, irregular heartbeat). The "Admission Minimum Data Set" (MDS), dated 04/17/20, documented R100 required extensive assistance of one to two staff for all activities of daily living. The MDS documented R100 had a Brief Interview for Mental Status (BIMS) score of six, indicating moderately impaired cognition.	F 760		

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The "Digoxin Care Plan", dated 04/13/20, documented R100 would be free from signs/symptoms or complications of cardiac problems and instructed staff to administer medications as ordered.

Review of R100's "Electronic Health Record", dated 04/11/20 at 04:30 PM, documented R100 returned from the hospital.

The "POS", dated 04/11/20, instructed staff to administer Digoxin 0.125 micrograms (mcgs,) one tablet, by mouth, one time daily, for atrial fibrillation. The "POS" instructed staff to hold the medication for a heart rate below 60 beats per minute (BPM).

Review of R100's "Medication Administration Record (MAR)", from 04/01/20 to 04/30/20, lacked documentation of Digoxin administration from 04/11/20, on return from the hospital, to 04/23/20, when R100 died.

On 04/20/20 at 03:28 PM, the "MAR" documented a heart rate of 84 and irregular.

The "Physician's Progress Note" dated 04/22/20 at 05:00 PM, documented R100 reported he did not feel well.

On 08/05/20 at 09:30 AM, LN J stated each charge nurse was responsible for transcribing admission or readmission orders.

On 08/05/20 at 02:05 PM, Administrative Nurse D confirmed the charge nurse responsible for transcribing the readmission orders for R100 failed to transfer the complete set of orders received from the hospital, upon discharge.

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F 760	Continued From page 12 Administrative Nurse D stated staff education was completed and a nurse manager was responsible for the safety measures currently in place. On 08/05/20 at 04:48 PM, Consultant GG stated R100's cause of death, listed on the death certificate, was atrial fibrillation. The facility's "Medical Management Overview - Med One" policy, dated 03/2019, documented the facility would administer medications as prescribed by the health care provider. The facility failed to administer Digoxin as prescribed by the health care provider placing R100 at risk for adverse reactions related to medication omission.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		

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storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72. The sample included 21 residents. Based on observation and interview the facility failed to ensure insulin pens (medication that regulated the amount of sugar in the blood) were properly dated in two of five medication carts.

Findings included:

- On 08/04/20 at 09:19 AM, on initial tour, observation of 100 Hall medication cart revealed two Lantus insulin pens (long acting insulin), one Levemir insulin pen (long acting insulin that worked several hours after administration) undated when opened and two Novolog (insulin that worked 15 minutes after injection) with no resident name or opened date.

On 08/04/20 at 09:19 AM, observation of 200 Hall medication cart revealed one Levemir pen and one Novolog pen not dated when opened.

A review of the manufacturer's instructions for Novolog insulin at https://fda.gov documented Novolog insulin should be discarded 28 days after opening, Lantus insulin discarded 28 days after opening, and Levemir insulin discarded 42 days after opening.

On 08/04/20 at 09:20 AM, Licensed Nurse (LN) G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175478	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ROSEHILL	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
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stated nursing staff would normally date insulin pens when opened and the two Novolog pens contained no resident names or opened dates.

On 08/06/20 at 02:43 PM, Administrative Nurse D stated she would expect insulin pens to be labeled with the resident's name and dated upon opening.

The facility's "Medication and Treatment - Storage" policy, dated 10/2018, documented medications would be stored in accordance with the manufacturers' and states' regulations.

The facility failed to properly label and store insulin pens. This deficient practice placed residents at risk for decreased medication effectiveness.