

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

PRINTED: 01/01/2024
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 12/19/2023
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 and complaint investigation KS00183559.	F 000			
F 550 SS=D	The 2567 was sent electronically on 01/02/24. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550			

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.

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

PRINTED: 01/01/2024
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 12/19/2023
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 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with one resident reviewed for dignity. Based on observation, interview and record review, the facility failed to ensure a dignified care environment for Resident (R) 47 related to her incontinence management. This deficient practice placed R47 at risk unnecessary embarrassment and decreased psychosocial wellbeing. Findings included: - On 12/14/23 at 02:05 PM an inspection of R47's room revealed a heavy urine smell. R47's room floor had a wet substance leading around the room and into the restroom. Parts of R47's floor had a dried / sticky substance covering it. On 12/18/23 at 12:34 PM R47 was in her room standing next to the closet in her room. R47 had a pair of white pants on the floor next to her recliner. R47 stated she just changed her pants and was going to lunch. R47 had a pile of clothing in her laundry basket. She reported she could do most things for herself but needed staff assistance from time to time. Staff were not in the room to assist her changing. R47 smelled of urine	F 550			

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

PRINTED: 01/01/2024
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 12/19/2023
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 550	Continued From page 2 as she went to the dining room. On 12/19/23 at 12:31PM Certified Nurse Aid (CNA) stated she was not sure if R47 was incontinent, but all residents were checked on every three hours. She stated if a resident or their room smelled like bladder or bowel incontinence staff was to immediately ask the resident if they need assistance using the restroom and check them. She stated soiled clothing and linen should be immediately sent to the laundry services to be washed to prevent the room from smelling. At 12/19/23 at 01:08PM Administrative Nurse D stated staff should be assisting residents with incontinence and providing frequent toileting to prevent incontinent episodes. She stated if a resident or their rooms smells of urine the staff should assess them to ensure they were not incontinent. A review of the facility's "Dignity" policy revised 10/2022 indicated each resident shall be care for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. The facility failed to ensure a dignified care environment for R47 related to her incontinence management. This deficient practice placed R47 at risk unnecessary embarrassment and decreased psychosocial wellbeing.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.	F 565			

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

PRINTED: 01/01/2024
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 12/19/2023
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 565	Continued From page 3 (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility reported a census of 76. Based on observations, record review, and interviews, the facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the	F 565			

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

PRINTED: 01/01/2024
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 12/19/2023
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 565	Continued From page 4 residents at risk for decreased psychosocial wellbeing and impaired quality of life. Findings included: - A review of the facility's "Resident Council Minutes" from 12/2022 through 11/2023 indicated the council had recurring concerns with call light response times. The "Resident Council Minutes" for 01/2023 noted under new business concerns over call light response time. The form did not list actions taken or resolutions provided. No other issues were reported on the minutes. The "Resident Council Minutes" for 02/2023 noted under old business the previous call light concern was resolved and noted no other new/old concerns. No other issues were reported on the minutes. The "Resident Council Minutes" for 03/2023 noted long call light waits under new business concerns. The form did not list actions taken or resolutions provided. No other issues were reported on the minutes. The "Resident Council Minutes" for 04/2023 noted under old business the previous the long call light wait was "better." The form did not list actions taken or resolutions provided. No other issues were reported on the minutes. The "Resident Council Minutes" for 05/2023 noted under old business the previous the long call light wait was resolved. The form did not list actions taken or resolutions provided. No other issues were reported on the minutes.	F 565			

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

PRINTED: 01/01/2024
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 12/19/2023
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 565	Continued From page 5 The "Resident Council Minutes" for 06/2023 noted under new business concerns the Hoyer (full body mechanical lift) lifts were being left in the resident's rooms. The form did not list actions taken or resolutions provided. This issue was not addressed by the facility. No other issues were reported on the minutes. The "Resident Council Minutes" for 08/2023 noted long call light waits under new business concerns. The form did not list actions taken or resolutions provided. No other issues were reported on the minutes. The "Resident Council Minutes" for 09/2023 noted under old business the previous the long call light wait was resolved. The form did not list actions taken or resolutions provided. No other issues were reported on the minutes. On 12/18/23 at 02:00PM, the Resident Council reported ongoing concerns with staffing, call light response times, and activities of daily living not being completed. The council reported it took sometimes over 30 to 45 minutes for staff to respond to call lights. The council reported the facility staffing was lower on weekends and the wait times could go up to an hour. The council reported the facility was working on finding permanent staff and getting rid of agency staff. The council reported the Hoyer lifts were still being left in resident rooms. The council reported the staffing concerns were affecting bathing, toileting, activities, and meals. On 12/19/23 at 02:45PM Social Service X stated the concerns were directed to the appropriate department listed to resolve the issues or	F 565			

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

PRINTED: 01/01/2024
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 12/19/2023
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 565	Continued From page 6 concerns. She stated the forms were signed off as resolved once the actions had been taken and improvement occurred. On 12/19/23 at 03:16PM Administrative Nurse D stated the facility was currently working to replace agency staff with more permanent staffing to improve resident care and response times. She reported call light response times was an ongoing issue and she felt it had improved recently. A review of the facility's "Resident Council" policy indicated the resident response form were to be utilized to track council concerns and facility resolution. The policy indicated the department related to any issue will be responsible for addressing the concerns. The facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial wellbeing and impaired quality of life.	F 565			
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582			

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

PRINTED: 01/01/2024
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 12/19/2023
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 582	Continued From page 7 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582			

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

PRINTED: 01/01/2024
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 12/19/2023
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 582	Continued From page 8 This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with three residents reviewed for Beneficiary Notification. Based on record review and interview the facility failed to ensure they issued the correct CMS (Center for Medicare/Medicaid Services) form 10055 "Advance Beneficiary Notice of Non-coverage (ABN)" form for Resident (R) 25 and R53. Findings included: - Review of R25's Electronic Medical Record (EMR) documented the Medicare Part A episode began on 05/08/23 and ended on 06/03/23. R25 remained in the facility. The facility-issued R25 form CMS-R-131 instead of the required CMS 10055. Review of R53's EMR documented the Medicare Part A episode began on 05/25/23 and ended on 07/24/23. R53 remained in the facility. The facility-issued R53 form CMS-R-131 instead of the required CMS 10055. On 12/19/23 at 11:40 AM Social Services X stated the ABN form she provided (CMS-R-131) was the form that was on her hard drive and the one that the facility used. On 12/19/23 at 12:00 PM Administrative Staff A stated that the ABN form that was used for R25 and R53 was the form that the corporate office provided them. Administrative Staff A stated staff were not provided with the correct form. The facility policy "Advanced Beneficiary Notice	F 582			

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

PRINTED: 01/01/2024
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 12/19/2023
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 582	Continued From page 9 Policy and Procedure" last revised June 2018 documented: An ABN must be given when Medicare was expected to deny payment (entirely or in part) for the item or service because it was not reasonable and necessary under Medicare Program standards or because it was considered custodial care. CMS required the use of the ABN form CMS-10055 for Part A services. The notice would be delivered to the resident or responsible party and explained to them. The form would be explained in its entirety and all questions related to the ABN was answered signed and dated by the beneficiary or his/her representative after he/she had selected one option box on the notice.	F 582			
F 585 SS=E	The facility failed to issue R25 and R53 the correct ABN form CMS-10055. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585			

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

PRINTED: 01/01/2024
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 12/19/2023
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 585	Continued From page 10 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585			

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

PRINTED: 01/01/2024
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 12/19/2023
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 585	Continued From page 11 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample include 18 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow	F 585			

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

PRINTED: 01/01/2024
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 12/19/2023
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 585	Continued From page 12 residents and/or their representative to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial wellbeing. Finding Included: - On 12/18/23 at 07:05AM an inspection of the facility revealed no designated grievance drop-box or alternative system available accessible to the residents and visitors of the facility to allow submission of grievances anonymously.. On 12/18/23 at 02:00PM, the Resident Council members reported they were not aware if the facility provided a way to complete an anonymous grievance. The council reported Social Services X was responsible for complaints or grievances. The council stated they would contact staff or social services. On 12/19/23 at 12:30PM Certified Nurses Aid (CNA) O reported she was not aware of an anonymous way the residents could report grievances other than giving staff the forms directly. She stated she was not aware of a drop box or secured area the forms could be placed anonymously by the residents or their representatives. On 12/19/23 at 01:05PM Social Services Staff X stated that facility had grievance forms at the front desk. She stated there was no drop box for the forms to be placed anonymously but staff could slide the forms under her door. A review of the facility's "Grievance" policy revised 10/2022 indicated the facility must enable each resident the right to file grievances verbally,	F 585			

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

PRINTED: 01/01/2024
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 12/19/2023
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 585	Continued From page 13 orally, and anonymously to the designated officer, administrator, or staff member for review. The facility failed to implement a system to allow anonymous grievances. This deficient practice placed all the residents at risk for decreased psychosocial wellbeing.	F 585			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 14 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 15 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with two residents reviewed for transfers. Based on observation, record review and interview, the facility failed to provide written notification of facility-initiated transfers with the required information to Resident R165 or their family/durable power of attorney (DPOA) in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R165.	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 16 Findings included: - The electronic medical record (EMR) for R165 documented diagnoses of chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic respiratory failure (a condition when your body does not have enough oxygen), and dependence on supplemental oxygen. The "Admission Minimum Data Set (MDS)" dated 09/26/23 for R165 documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated a moderately impaired cognition. R165 required partial/moderate to substantial/maximal staff assistance for functional abilities. R165 utilized the use of a wheelchair for mobility assistance. R165 required oxygen therapy while a resident. The "Discharge MDS" dated 11/19/23 for R165 documented a discharge to short term stay hospital. The "Activities of Daily Living (ADL) Care Area Assessment" dated 10/05/23 for R165 documented she was a long-term care resident due to heart failure. R165 was weak and had other co-morbidities that impaired her ability to perform ADL and personal cares. R165 was on oxygen and staff monitored her for oxygen needs as needed. The "Respiratory Failure Care Plan" last revised 11/25/23 directed staff to monitor for difficulty in breathing on exertion. Staff was to monitor/document changes in orientation,	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 17 increased restlessness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and air hunger (form of respiratory distress characterized by gasping and labored breathing). Staff was to monitor for signs and symptoms of respiratory distress and report to physician. A "Nursing Progress Report" dated 11/19/23 at 11:17 PM for R165 documented it was reported that R165 was not feeling well that day. The nurse noted the resident was very weak, lethargic (an appearance of sluggishness, lack of energy) or less interactive. R165 was reassessed and was moaning and not opening eyes and did not respond to questions. The telehealth provider was notified and recommended the resident be sent to the hospital for further evaluation. R165's sister was notified of the change in condition. Emergency services was called and arrived at the facility around 11:00 PM and R165 was transported out of the facility at 11:20 PM. A "Progress Note" dated 11/20/23 at 03:57 PM documented R165 was admitted to the hospital due to pneumonia (inflammation of the lungs). A "Progress Note" dated 11/24/23 documented R165 readmitted after return from the hospital. The facility lacked written notification of transfer for R165's facility-initiated transfer to the hospital on 11/19/23. On 12/18/23 at 12:01 PM staff propelled R165 in her wheelchair to the dining room for lunch. R165 had her supplemental oxygen on via nasal cannula (a hollow tube used to deliver supplemental oxygen) that was connected to a	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 18 portable oxygen tank. R165 had no complaints at that time. On 12/19/23 at 02:29 PM Administrative Nurse F stated that the nurses initiated transfers for a resident when sent out to the hospital. Administrative Nurse F stated the nurse called the physician to get the order to send resident to the hospital. Administrative Nurse F stated the hospital was called to give report on the resident and then the family/representative would be called to notify of transfer to the hospital. Administrative Nurse F stated she was not aware that written notification of transfer had to be sent to the family/representative for hospital transfers. On 12/19/23 at 03:16 PM Administrative Nurse D stated she was unaware that a written notification of transfer was required to be sent to the family/representative upon transfer to the hospital. The facility policy "Resident Transfer and Discharge" last revised August 2023 documented: Prior to transfer or discharge of a resident, the resident and resident's representative should be notified in writing of the reason, effective date, the location to which the resident was transferred or discharged, a statement of the resident's appeal rights, the name, address, and telephone number of the office of the stated long-term care ombudsman. A copy of the notice should be sent to the representative of the Office of the State Long-Term Care Ombudsman at the time the notice was provided to the resident and the resident representative, or as soon as practicable after an emergency transfer or discharge.	F 623			

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

PRINTED: 01/01/2024
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 12/19/2023
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 623	Continued From page 19 The facility failed to provide written notification of transfer with the required information to R165 or their family/DPOA in a practicable amount of time. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R165.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625			

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

PRINTED: 01/01/2024
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 12/19/2023
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 625	Continued From page 20 This REQUIREMENT is not met as evidenced by: The facility had a census of 76 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to provide a copy of the "Bed Hold" notice to Resident (R)63, or her representative, upon discharge to a hospital in November 2023. This deficient practice placed R63 at risk to not be allowed to return to their same room upon discharge from the hospital. Findings included: - R63's Electronic Medical Record documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle weakness, difficulty walking and reduced mobility. R63's "Entry Tracker" documented she admitted on 10/30/23. R63's "Care Plan" with an initiated date of 10/31/23 documented R63 had an activities of daily living (ADLs) self-care performance deficit. An "eINTERACT SBAR Summary for Providers" note dated 11/02/23, documented R63 had an unwitnessed fall in her room. The note further documented R63 was found on the floor on her left side with no injury at the time of assessment. A "Nursing Progress Note" dated 11/02/23, documented R63 developed a bruise to her left eyebrow and side of her head. The note further documented R63 was sent to the hospital for further evaluation per R63's daughter's request.	F 625			

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

PRINTED: 01/01/2024
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 12/19/2023
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 625	Continued From page 21 The note documented R63 left the facility at 11:00 AM via Emergency Medical Services (EMS). R63's clinical record lacked evidence and the facility failed to provide evidence the resident or representative was provided a "Bed Hold" notice after discharge to a hospital. On 12/19/23 02:43 PM Social Services X stated she handled the written notice for transfers if a resident was being discharged home. She said the nurses were supposed to have completed the written notice for transfer and bed hold notifications if a resident discharged to a hospital. Social Services X stated if a resident was discharged to a hospital the notifications did not always make it onto the sheet, they used to track them to ensure they were done. On 12/19/23 at 03:17 PM Administrative Nurse D stated nurses completed notification of discharge and "Bed Hold" notifications when residents were discharged to the hospital. Administrative Nurse D stated nurse managers were responsible for following up to ensure "Bed Hold" notifications were being done. The facility provided "Resident Bed-Hold" policy dated 12/2008, documented residents may exercise their right to secure a bed-hold during hospitalization or therapeutic leave from the community in accordance with applicable state and federal laws, including the requirements of participation for states and long-term care facilities. A notice of the community's bed-hold policy should be provided at the times of a resident's transfer for hospitalization or therapeutic leave, or as soon as possible thereafter. The manner of providing the notice	F 625			

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

PRINTED: 01/01/2024
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 12/19/2023
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 625	Continued From page 22 should be documented.	F 625			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph	F 655			

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

PRINTED: 01/01/2024
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 12/19/2023
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 655	Continued From page 23 (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with one resident reviewed for baseline care plan. Based on observation, record review, and interviews, the facility failed to develop a person-centered baseline care plan to include an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) for Resident (R) 115. This deficient practice placed R115 at risk of impaired care related to uncommunicated care needs. Findings included: - R115's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, disorder of kidney and ureter (duct that urine passes from the kidney to the bladder), femur (thigh bone) fracture (broken bone) of left leg, and encounter for fitting and adjustment of urinary device.	F 655			

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

PRINTED: 01/01/2024
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 12/19/2023
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 655	Continued From page 24 The "Admission Minimum Data Set" (MDS) was in progress. R115's "Care Area Assessment" (CAA) was in progress. R115's "Baseline Care Plan" dated 12/10/23 documented staff would provide catheter care per facility policy. R115's "Care Plan" dated 12/13/23 documented staff would place catheter drainage bag below the level of R115's bladder every shift related left femur fracture. The plan of care for R115 lacked reason for the indwelling catheter. R115's clinical record lacked evidence of catheter cares provided for the indwelling catheter. On 12/19/23 at 11:39 AM Certified Nurse Aide (CNA) P stated she had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident) which would provide the information for each resident's care needs. On 12/19/23 at 11:52 AM Licensed Nurse (LN) J stated the admission nurse would start the baseline care plan which would include an information related an indwelling catheter care. LN J stated the baseline care plan would include the type of indwelling catheter and diagnosis for the catheter. LN J stated the care plan information was what information was on the Kardex that directed the staff to meet the resident's individual care needs. On 12/19/23 at 03:15 PM Administrative Nurse D stated the baseline care plan was started on each resident at the time of admission. Administrative Nurse D stated the interdisciplinary team (IDT)	F 655			

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

PRINTED: 01/01/2024
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 12/19/2023
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 655	Continued From page 25 would review the baseline plan of care to make revision and additions added to the plan of care from each department to develop a person-centered care plan for each resident. Administrative Nurse D stated the care plan information was what would build the information for the Kardex for the staff to know what care was needed for each resident. The facility's "Interim Care Plan Policy" last revised 02/2023 documented an Interim baseline care plan would be developed for each resident within forty-eight (48) hours of admission to the skilled healthcare community. Within forty-eight (48) hours of admission to the skilled healthcare community, an interim baseline care plan would be developed which includes the minimum healthcare information necessary to care for the resident's immediate health and safety needs. The interim care plan would be developed by the admission nurse with the assistance of interdisciplinary team members. The Interim care plan would use but not be limited to, the resident's initial goals of care, physician's orders, dietary orders and instructions, therapy orders, resident cognitive, physical, and psycho-social needs. The Interim care plan would be person-centered and include services and treatments administered by the community. The interim care plan would be used until the completion of the comprehensive assessment and the comprehensive care plan is developed. The Interim Care Plan would be maintained and updated as needed until the Comprehensive Care Plan is developed. The facility failed to develop a person-centered baseline care plan to include an indication and type of indwelling catheter for R115. This deficient	F 655			

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

PRINTED: 01/01/2024
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 12/19/2023
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 655	Continued From page 26	F 655			
F 676	practice placed R115 at risk of impaired care related to uncommunicated care needs.				
SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676			
	§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including				

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

PRINTED: 01/01/2024
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 12/19/2023
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 676	Continued From page 27 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to provide adequate care and services for activities of daily living (ADL) when staff failed to provide supervision with eating during meals for Resident (R)43. This deficient practice placed R43 at risk for complication related to aspiration (inhaling liquid or food into the lungs) and decline of overall abilities. Findings included: - The electronic medical record (EMR) for R43 documented diagnoses of hemiplegia (paralysis of one side of the body), dysphagia (difficulty swallowing), cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), aphasia (condition with disordered or absent language function), and hemiparesis (muscular weakness of one half of the body). R43 "Quarterly Minimum Data Set (MDS)" completed 11/16/23 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe impairment. The MDS indicated she required setup or clean-up assistance with her meals. The MDS indicated no swallowing disorders. The MDS indicated she was totally dependent on staff assistance for toileting, dressing, and bed mobility. The MDS indicated R43 was rarely or never understood.	F 676			

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

PRINTED: 01/01/2024
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 12/19/2023
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 676	Continued From page 28 R43's "Cognitive Loss Care Area Assessment (CAA)" completed 06/15/23 indicated she was non-verbal and frequently lacked psychical responses or reactions to questions. The CAA noted she had a cognitive communication deficit related to her medical diagnoses. The CAA indicated staff will anticipate her care needs. R43's "Functional Abilities CAA" completed 06/15/23 indicated she had right sided hemiplegia, aphasia, and cognitive communication deficits. The CAA noted she had functional limitations in her range of motion. The CAA noted she had decreased independence and safety, right lower extremity weakness, and right facial drooping. The CAA noted she communicated by nodding her head when asked questions. The CAA noted she required extensive assistance from two staff related to toileting, personal hygiene, and bathing. The CAA noted she required supervision and set-up assistance during meals due to swallowing difficulties. R43's "Care Plan" initiated 06/23/23 indicated she was at risk for aspiration related to difficulty swallowing. The plan instructed staff to ensure she maintained an appropriate position during meals. The plan indicated she was to be served a regular diet with small bites/sips and provided distant supervision due to difficulty swallowing. On 12/18/23 at 12:43PM R43 sat in her bed with her bedside table pulled overlap. Staff delivered and prepped her meal. Staff then left the room with the door slightly propped open. R43 had bit sized meat and cut potatoes on her tray. R43 began eating her meal. From 12:45PM to 01:20PM no supervision or check-in was provided	F 676			

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

PRINTED: 01/01/2024
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 12/19/2023
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 676	Continued From page 29 to R43 during her meal. On 12/19/23 at 07:20AM R43 ate her breakfast without staff supervision in her room with her door barely open. On 12/19/23 at 12:34PM Certified Nurse Aid (CNA) O reported that R43 liked to eat in her room but was not sure if she was at risk for aspiration. She stated she was not sure what "distant supervision" meant but thought maybe that staff should watch her from a distance. She stated all staff had access to the care plans and reviewed the interventions. On 12/19/23 at 01:05PM Licensed Nurse (LN) I stated R43 preferred to eat in her room due to not wanting to eat around the other residents. She stated R43 was aphasic (difficulty communicating) and got anxious (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) around large groups of residents. She was not sure what "distant supervision" meant but stated it had to do with risk of aspiration and staff should not stand close to her while she ate. On 12/19/23 at 03:16PM Administrative Nurse D stated residents at risk for aspiration should be monitored closely during meals. She was unsure what "distant supervision" meant but stated it may have had to do with R43's difficulty communicating her needs. A review of the facility's "Supporting Activities of Daily Living" policy revised 04/2022 indicated each resident would be provided with the care, services, and treatment as appropriate to safely maintain or improve their ability to carry out	F 676			

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

PRINTED: 01/01/2024
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 12/19/2023
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 676	Continued From page 30 activities. The policy indicated each resident would receive the appropriate level of assistance to maintain hygiene, mobility, dining, toileting, and communication. The policy noted each resident's abilities will be monitored, measured, and tracked. The facility failed to provide adequate ADL cares when staff failed to provide supervision during meals for R43. This deficient practice placed R43 at risk for complication related to aspiration and overall decline.	F 676			
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 76 residents. The sample included 18 residents with four reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, The facility failed to provide consistent bathing opportunities for Residents (R)19, R13, and R37. This deficient practice placed the residents at risk for complications related to hygiene and infections and impaired psychosocial wellbeing. Findings included: - The electronic medical record (EMR) for R19 documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), irritable bowel syndrome	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 31 (IBS- abnormally increased motility of the small and large intestines), chronic kidney disease, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R19 "Significant Change Minimum Data Set (MDS)" completed 11/03/23 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating mild cognitive impairment. The MDS noted she was totally dependent on staff for toileting, bathing, dressing, grooming, and transfers. The MDS indicated she was always incontinent of bowel and frequently incontinent of bladder with no toileting program. The MDS indicated she was at risk for developing pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and utilized pressure reducing devices (chair and bed) as preventative treatments. The MDS indicated she started hospice services. R19's "Cognitive Loss Care Area Assessment (CAA)" completed 11/03/23 indicated she displayed moderate cognitive impairment related to poor memory recall. The CAA noted staff were to provide cues and guidance. R19's "Functional Abilities CAA" completed 11/10/23 indicated she was at risk for potential decline of her ADL related to her prior level of function. The CAA noted she recently started hospice services. The CAA noted she was dependent on staff assistance for toileting, bathing, bed mobility, transfers, and personal	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 32 hygiene. R19's "Care Plan" initiated 09/29/23 indicated she required assistant from staff for bed mobility, grooming, bathing, transfers, and personal hygiene. The plan noted she required a Hoyer (full body mechanical lift) lift and two staff for transfers. The plan noted staff were to provide a bed bath or sponge bath if R19 could not tolerate transferring. The plan indicated R19 preferred her bathing on Mondays and Thursdays during day shift. R19's plan indicated she began hospice services on 12/03/23 and was provided bathing opportunities as preferred by R19. R19's "Documentation Survey Report" from 11/01/2023 through 12/18/23 (48 days reviewed) indicated she received a bath on three occasions (11/09/23, 11/27/23, and 11/30/23) with no refusals documented. On 12/14/23 at 01:10PM R19 reported the facility was slow to get her up and had not given her a bath in weeks. She stated the only one who bathed her was hospice services because the facility staff repeatedly told her they didn't have enough staff. She stated since starting hospice services, the visiting nurse ensured she was bathed and provided hygiene care. R19 reported she preferred to be bathed more than twice weekly and did not understand why the facility could not do it. On 12/18/23 at 09:00AM R19 reported she received her bath from hospice but not from the facility over the previous week. On 12/19/23 at 12:31PM Certified Nurse Aid (CNA) O stated hospice comes to the facility	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 33 twice weekly to provide R19 with bathing but was not sure if the facility was still providing her baths since hospice does it. She stated all bathing occurrences should be documented in the EMR even if the resident refused or was not available. She stated staff should provide bathing if residents want bathing on days outside of their regular days. She stated some days the facility was short on staff and resident cares were delayed as a result. On 12/19/23 at 12:55PM Licensed Nurse (LN) I stated R19 was heavily dependent on staff to complete her ADL. She stated R19 was on hospice and should have received her scheduled baths in addition to her extra baths provided by hospice. She stated the facility was often short on staff and the resident's requiring assistance for ADL or Hoyer lifts had to wait for staff. She stated all bathing should be documented in the EMR and reviewed by the interdisciplinary team if missed occurrences are found. On 12/19/23 at 03:17PM Administrative Nurse D stated all residents should be bathed per their scheduled days and hospice baths should be completed separately. She stated direct care staff were expected to document the bathing and nurse were expected to ensure the tasks were being completed. She stated the residents should never be told they could not have a bath or not enough staff were available. She stated she had not received concerns of resident not receiving baths. A review of the facility's "Supporting Activities of Daily Living" policy revised 04/2022 indicated each resident would be provided with the care, services, and treatment as appropriate to	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 34 maintain or improve their ability to carry out activities. The policy indicated each resident would receive the appropriate level of assistance to maintain hygiene, mobility, dining, toileting, and communication. The policy noted each resident's abilities will be monitored, measured, and tracked. The facility failed to ensure R19 received consistent bathing opportunities from the facility in addition to the supplemental services provided by hospice. This deficient practice placed R19 at risk for complications related to hygiene and infections. - The electronic medical record (EMR) for R13 documented diagnoses of hypertension (elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid) and dementia (progressive mental disorder characterized by failing memory, confusion). The "Annual Minimum Data Set (MDS)" dated 05/24/23 documented R13 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R13 was total dependent on staff for bathing. R13 was at risk for developing a pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). The "Quarterly MDS" dated 11/04/23 for R13 documented a BIMS score of 12 which indicated intact cognition. R13 was dependent on staff for all aspects of transfer and bathing activity. R13	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 35 utilized the use of a manual wheelchair to assist with mobility. R13's "Activities of Daily Living (ADL) Care Plan" last revised 10/19/23 directed staff that R13 needed assist of up to two staff members for transfers, toileting, and bathing. R13's preferred bath time was on Thursday and Sunday mornings. The "Skin Integrity Care Plan" last revised 10/7/23 directed staff to evaluate R13's skin condition on a daily and weekly basis. Staff was directed to keep R13's skin clean and dry and to use lotion on dry skin. Review of R13's "Documentation Survey Report" for the month of September 2023 with scheduled bath days on Thursday and Sunday revealed R13 lacked documentation for bathing on three opportunities (09/07/23, 09/24/23, and 09/28/23). Review of R13's "Documentation Survey Report" for the month of October 2023 with scheduled bath days on Thursday and Sunday revealed R13 lacked documentation for bathing on eight opportunities (10/01/23, 10/05/23, 10/08/23, 10/15/19, 10/22/23, 10/26/23, and 10/29/23). Review of R13's "Documentation Survey Report" for the month of November 2023 revealed R13 lacked documentation for bathing except on 11/30/23 which documented task as activity did not occur and not applicable. An "Alert Note" for R13 dated 11/13/23 at 11:40 AM by Licensed Nurse (LN) H documented there was no documented bath for greater than four days. The Certified Nurse Aide (CNA) was notified to give a bath.	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 36 On 12/18/23 at 07:48 AM, R13 rested comfortably in her bed in her night gown, call light in reach, no signs of distress. On 12/19/23 at 10:06 AM CNA Q stated the nurse made out the list of daily baths at the beginning of the shift. CNA Q stated the aides charted in the bathing task when a bath was given and how much assistance was provided for a resident. CNA Q stated the unit normally had enough staff to provide bathing for the residents. CNA Q stated the aides should notify the nurse when a resident refused a bath or if the bath was not given. On 12/19/23 at 10:18 AM LN H stated each resident had baths scheduled per their preference. LN H stated she made out the list for daily baths and gave the list to the CNA's each morning. LN H stated the aides were to inform the nurse when a bath was refused or had not been given so the nurse could chart a progress note for the missed bath. On 12/19/23 at 03:15 PM Administrative Nurse D stated staff should always be documenting when a bath was given, missed, or refused. Administrative Nurse D stated residents were asked on admission about their bathing day preference. Administrative Nurse D stated the nurses should be going back to ask the resident if they refused a bath could be given later or the next day. The facility policy "Supporting Activities of Daily Living (ADL) dated April 2022 documented: Residents should be provided with care, treatment, and services such that their ADLs do not diminish unless the circumstances of their	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 37 clinical condition(s) demonstrate that diminishing ADLs was unavoidable. Appropriate care and services should be provided for residents who were unable to carry out ADLs independently and in accordance with the plan of care including appropriate support and assistance with hygiene (bathing, grooming, and oral care). The facility failed to ensure consistent bathing was provided to dependent R13. This deficient practice placed R13 at risk for skin breakdown and possible injury/infection. This deficient practice placed the resident at risk of skin breakdown, infection, and impaired psychosocial wellbeing. - R37's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set" (MDS) dated 01/11/23 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented bathing activity itself did not occur during the observation period. The "Quarterly MDS" dated 10/14/23 documented a BIMS score of six which indicated severely impaired cognition. The MDS documented that	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 38 R37 required set up or clean up assistance for bathing activity during the observation period. R37's "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 01/17/23 documented R37 was at risk of ADL decline related to dementia. R37's "Care Plan" dated 12/01/23 documented R37 required staff assistance with bathing/showering. The plan of care lacked documentation of R37's refusal of bathing/showering. The plan of care lacked person centered interventions for R37's lack of bathing/showering. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the following dates for R37 from 08/01/23 to 12/18/23 (140 days) documented seven "Shower" (S) on 08/05/23, 09/16/23, 11/08/23, 11/15/23, 11/22/23, 11/30/23, and 12/07/23. "Activity Did Not Occur" was documented nine times on 08/12/23, 08/19/23, 08/26/23, 08/30/23, 09/20/23, 10/25/23, 11/05/23, 12/04/23, and 12/18/23. The clinical record lacked documentation of R37's refusals for bathing. Observation on 12/19/23 at 01:06 PM R37 laid on her right side on the bed. R37's was uncombed and matted upward. On 12/19/23 at 12:35PM Certified Nurse's Aide (CNA) O stated R37 often refused cares and staff would have to approach her multiple times. CNA O stated refusals were documented in the EMR and the nurse was notified. CNA O stated all missed bathing would be offered on another day.	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 39 She stated due to low staffing often caused delays in care for the residents. On 12/19/23 at 12:55PM Licensed Nurse (LN) I stated direct care staff would notify the nurses of refused cares and it would be documented in the EMR. LN I stated the facility was often short on staff and the resident's requiring assistance for ADLs or Hoyer (total body mechanical lift) lifts had to wait for staff. On 12/19/23 at 03:17PM Administrative Nurse D stated all residents should be bathed per their scheduled days and hospice baths should be completed separately. She stated direct care staff were expected to document the bathing and nurse were expected to ensure the tasks were being completed. She stated the residents should never be told they could not have a bath or not enough staff were available. She stated she had not received concerns of resident not receiving baths. The facility's "Supporting Activities of Daily Living" policy revised 04/2022 indicated each resident would be provided with the care, services, and treatment as appropriate to maintain or improve their ability to carry out activities. The policy indicated each resident would receive the appropriate level of assistance to maintain hygiene, mobility, dining, toileting, and communication. The policy noted each resident's abilities will be monitored, measured, and tracked. The facility failed to provide consistent bathing for R37. This deficient practice placed R37 at risk for complications related to poor hygiene and impaired dignity.	F 677			

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

PRINTED: 01/01/2024
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 12/19/2023
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 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility reported a census of 76 residents. The sample included 18 residents. Based on interview and record review, the facility failed to establish and maintain a system to ensure nursing staff maintained current cardiopulmonary resuscitation (CPR- a life-saving medical procedure that consists of chest compressions to allow oxygenated blood to circulate to vital organs, such as the brain and heart and artificial ventilation) certification for healthcare providers. This deficient practice placed all residents who desired CPR at risk for inadequate resuscitative measures. Findings included: - On 12/19/23 Licensed Nurse (LN) K's CPR certification had an issue date of 10/11/21 and a renew (expiration) date of 10/2023. On 12/19/23 at 03:43 PM Administrative Staff A stated LN K was a newer nurse and had previously worked at the facility as a Certified Nurse Aide. Administrative Staff A stated that LN K's CPR certification expired at the end of October. Administrative Staff A stated the facility had had not self-identified LN K's expired CPR certification.	F 678			

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

PRINTED: 01/01/2024
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 12/19/2023
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 678	Continued From page 41 The facility failed to establish and maintain a system to ensure nursing staff maintained current CPR certification for healthcare providers. This deficient practice placed all residents who desired CPR at risk for inadequate resuscitative measures.	F 678			
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample include 18 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities. This deficient practice placed the affected residents at risk for decreased psychosocial wellbeing and boredom. Findings included: - A review of the facility's "Activity Calendar" for September, October, and November 2023 was completed. The review revealed two consistent activities of "movie matinee" and "activities connection" as shown for both Saturday and Sundays. The calendar indicated church services	F 679			

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

PRINTED: 01/01/2024
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 12/19/2023
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 679	Continued From page 42 were provided Sunday mornings. The calendar indicated the activity "B-fit" was provided by the therapy department on weekends. On 12/18/23 at 02:05PM, Resident Council members reported activities minimally occurred on weekends compare to the weekdays. The council reported due to the low staffing in the facility and limited activities provided, the resident usually watched television or wheeled themselves around to see each other. The council reported the facility did provide an "Activities Connection" basket that had crossword puzzles and coloring pages the residents could complete. The council reported they wanted the facility to provide more engagement activities like Bingo or interactive groups for the residents on the weekend. On 12/14/23 at 08:12AM Resident (R)216 sat in her room. She reported she was not aware the facility provided activity on the weekend. She stated she did attend some of the activities during the week. She reported she did not have a calendar in her room to know there were activities on Saturday and Sunday. An inspection of her room revealed no activity calendar. On 12/18/23 at 11:30AM the facility had a "Caroling" group singing next to the piano area for the 300 hallway residents. R19 reported she was not informed about the event and would have liked to see it. On 12/19/23 at 12:35PM Certified Nurses Aid (CNA) O stated some activities staff do come in on the weekends. She stated the residents were often provided with the activity connection stuff or therapy would come in the have exercise (B-fit) groups. She stated movies would be played on	F 679			

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

PRINTED: 01/01/2024
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 12/19/2023
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 679	Continued From page 43 television. On 12/19/23 at 02:34 Activities Staff Z reported stated weekend activities were mainly one-one with the residents and completing activities assessments. She stated the facility was often staffed less on the weekends and residents were frequently provided solitary activities such as coloring, puzzle, and electronic tablets to play games. A review of the facility's "Quality of Life" policy revised 10/2021 indicated the residents will be provided and encourage to attend activities that meet each resident's interest, hobbies, worship, beliefs, and social needs. The facility failed to provide consistent activities for the residents during weekends. This deficient practice placed the affected residents at risk for decreased psychosocial wellbeing and boredom.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents. Based on observation, record review, and interview, the	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 44 facility failed to ensure staff physician ordered daily weights were obtained and monitored for Resident (R) 164 who had congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). The facility also failed to ensure staff applied R52's thrombo-embolic deterrent (TED - a stocking that helps prevent blood clots and swelling in your legs) hose. This deficient practice placed R164 at risk for unwanted weight/fluid gain and R52 at risk for swelling and possible complications. Findings included: - The electronic medical record (EMR) for R164 documented diagnoses of hypertension (elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), and CHF. The "Admission Minimum Data Set (MDS)" dated 11/24/23 documented R164 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R164 was dependent on staff for toileting, showering, and lower body dressing. R164 utilized a manual wheelchair for mobility. R164 was on a therapeutic diet. R164 received a diuretic (medication to promote the formation and excretion of urine) and an anticoagulant (a class of medications that thin the blood) medication. The "Nutrition Care Area Assessment (CAA)" dated 11/29/23 documented R164 had altered nutrition related to obesity (excessively overweight) and was on a therapeutic diet for CHF. R164 was to continue with weights as ordered, two-gram sodium diet to reduce water retention, aid blood pressure, and promote overall health.	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 45 The "Congestive Heart Failure Care Plan" for R164 initiated on 11/21/23 directed staff to do weight monitoring as ordered. Staff was directed to obtain daily weight and notify physician if weight gain or loss of three pounds in 24 hours or five pounds in one week. Staff was to monitor/document/report to physician any signs/symptoms of CHF (swelling of legs and feet, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake). The "Orders" tab of R164's EMR documented a physician's order dated 11/21/23 for a daily weight- notify physician or loss of three pounds in 24 hours or five pounds in one week related to CHF. Review of R164's November 2023 "Medication Administration Record (MAR)/Treatment Administration Record (TAR)" lacked evidence R164's daily weight was obtained and documented on seven of 10 opportunities. Review of R164's December 2023 MAR/TAR lacked evidence R164's daily weight was obtained and recorded on 12 of 18 opportunities. On 12/18/23 at 12:04 PM R164 sat in her wheelchair at the dining table. R164 was provided with a built-up plate and utensils to assist her with eating. R164 had two drinks provided with her meal. On 12/19/23 at 09:27 AM, Certified Nurse Aide (CNA) Q stated that daily weight was done by the aides and reported to the nurse to put into the MAR/TAR. CNA Q stated R164 was a daily	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 46 weight. On 12/19/23 at 10:13 AM Licensed Nurse (LN) H stated the unit nurse made out a list of who was a daily weight and gave the list to the CNAs to obtain the weights. LN H stated the CNAs would then give the list of weights to the nurse to input into the MAR/TAR and the nurse should notify the physician of weight changes as needed. On 12/19/23 at 03:16 PM Administrative Nurse D stated she expected that a resident who was a daily weight would be weighed daily. Administrative Nurse D stated that the aides should be reporting the weights to the unit nurse for the nurse to chart and notify the physician as needed. The facility policy "Weight and Height Policy" last revised February 2018 documented: resident should be weighed upon admission/re-admission, weekly for three weeks, and as needed. Daily/weekly weight monitors - residents identified at risk should be weighed daily/weekly based on recommendations by the Interdisciplinary Team (IDT) or health care provider. Notify the health care provider and the resident and/or legal representative of any significant weight changes as indicated. The facility failed to ensure staff obtained a physician ordered daily weight for R164 who had CHF. This deficient practice placed R164 at risk for fluid overload and other possible complications. - R52's Electronic Medical Record (EMR) from	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 47 the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and osteomyelitis (local or generalized infection of the bone and bone marrow). The "Admission Minimum Data Set" (MDS) dated 10/28/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R52 required partial/moderate assistance with moving from a sitting position to standing. The MDS documented R52 had an infection of her foot. The MDS documented R52 had a pressure reducing device on her bed and in her chair. The MDS documented R52 had received a diuretic (medication to promote the formation and excretion of urine) during the observation period. R52's "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/01/23 documented R52 was able to make her needs know to the staff. R52 required extensive assistance of one staff member for most of her ADLs. R52's "Care Plan" dated 10/20/23 documented staff would obtain R52's weight prior to breakfast daily and report results to the nurse. R52's EMR under "Orders" tab revealed physician orders: Furosemide (diuretic) oral Tablet 40 milligrams (mg) give 60mg by mouth two times a day related to CHF dated 10/20/23.	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 48 R52's EMR revealed a physician "Progress Note" dated 10/23/23 with an order for daily weights for monitoring for heart failure. R97's EMR under "Documentation Survey Report" for daily weights reviewed from 10/20/23 to 12/17/23 (59 days) lacked evidence staff measured and recorded R52's weight on following dates 10/20/23, 10/25/23, 10/31/23, 11/03/23, 11/10/23, 11/11/23, 11/12/23, 11/17/23, 11/25/23, 11/26/23, 12/1/23, 12/2/23, 12/3/23, 12/06/23, 12/09/23, 12/10/23, 12/12/23, 12/13/23, 12/14/23, 12/15/23, 12/16/23, and 12/17/23. The clinical record lacked documentation of physician notification of daily weight was not obtained. Observation on 12/18/23 at 12:12 PM R52 wheeled herself in a wheelchair to the dining room. On 12/19/23 at 11:39 AM Certified Nurse Aide (CNA) P stated the nurse assigned the daily weights, CNA P stated the CNAs usually obtain the weights and report the weight to the nurse. On 12/19/23 at 11:52 AM Licensed Nurse (LN) J stated the CNAs obtain the daily weights and report the weights to the charge nurse. LN J stated R52 was on a daily weight related to taking a diuretic medication daily. LN J stated the physician would be notified if the daily weight was not obtained and documented in the resident's EMR under the progress notes. On 12/19/23 at 03:15 PM Administrative Nurse D stated the CNAs obtain the weights and report the results to the charge nurse would document the weight in the resident's EMR. Administrative Nurse D stated the physician would be notified if	F 684			

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

PRINTED: 01/01/2024
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 12/19/2023
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 684	Continued From page 49 a daily weight was not obtained and document the notification in the residents' EMR. The facility's "Weight and Height Policy" last revised 02/2018 documented daily/weekly weight monitors residents identified at risk would be weighed daily/weekly based on recommendations by the interdisciplinary team (IDT) or health care provider. The facility would notify the health care provider and the resident and/or legal representative of any significant weight changes as indicated. The facility failed to follow a physician order for daily weights to monitor weight gain for fluid overload for R52, who had CHF. This deficient practice placed R52 at risk of adverse side effects for unnecessary medication or complications related to fluid overload.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 50 The facility identified a census of 76 residents. The sample included 18 residents with five residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure staff implemented appropriate infection control practices during wound care for Resident (R) 52, who had a history of a wound infection. The facility also failed to ensure pressure reducing measures were in place for R34. This deficient practice placed these residents at risk of development of pressure ulcers, of wound worsening and complications related to infections. Findings included: - R52's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and osteomyelitis (local or generalized infection of the bone and bone marrow). The "Admission Minimum Data Set" (MDS) dated 10/28/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R52 required partial/moderate assistance with moving from a sitting position to standing. The MDS documented R52 had an infection of her foot. The MDS documented R52 had a pressure reducing device on her bed and in her chair.	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 51 R52's "Pressure Ulcer Care Area Assessment" (CAA) dated 11/01/23 documented R52 was monitored regularly by the physician for current wound. R52's "Care Plan" dated 10/21/23 documented staff would cleanse R52's wound on her right foot with wound cleanser, apply Skin-prep (liquid skin protectant) to peri-wound, apply drape to peri-wound. Cut black foam to fit wound and secure with drape. Change every Monday, Wednesday, Friday and as needed for wound care. R52's EMR under "Orders" tab revealed physician orders: Right foot wound: cleanse with wound cleanser, apply Skin-prep to peri-wound, apply drape to peri-wound. Cut black foam to fit wound and secure with drape. Change every Monday, Wednesday, Friday, and as needed for wound care and osteomyelitis dated 10/20/23. Cefazolin sodium (antibiotic) injection solution reconstituted two grams give two grams intravenously (directly into the blood stream via a vein) every morning and at bedtime for infection dated 12/16/23. Observation on 12/18/23 at 01:01 PM R52 sat in a recliner next to the bed with bilateral lower extremities elevated. Administrative Nurse E washed her hands in the bathroom, donned clean gloves, then unplugged the wound vac from the wound on R52's right foot, allowed the tubing from the wound-vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) drop onto the floor next to the recliner. Administrative Nurse E removed the	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 52 dressing from R52's right foot, doffed her gloves then donned a clean pair of gloves and cleansed the wound without performing hand hygiene. Administrative Nurse E doffed gloves and with no hand hygiene performed donned a clean pair of gloves and obtained photos of R52's wound on R52's phone. Administrative Nurse E doffed gloves again and donned a clean pair of gloves, without performing hand hygiene, and applied a dressing to R52's right foot wound. Administrative Nurse E cut the foam with scissors, then applied outer dressing. Administrative Nurse E removed the collection canister and tubing that rested on the floor and disposed of the items in the trash can. Administrative Nurse E connected a new collection canister to the wound vac and tubing to R52's right foot wound. On 12/19/23 at 11:52 AM Licensed Nurse (LN) J stated staff should always do hand hygiene during wound care and between gloves changes. On 12/19/23 at 02:30 PM Administrative Nurse E stated hand hygiene should be performed between glove changes, after providing care, and when hands were soiled. Administrative Nurse E stated the facility had an in-service over hand hygiene two weeks ago. The facility's "Handwashing/Hand Hygiene" policy last revised 11/2021 documented the facility considered hand hygiene the primary means to prevent the spread of infections. All associates would be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All associates would follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 53 associates, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for associates use to encourage compliance with hand hygiene policies. Center for Disease Control and Prevention (CDC) recommends using Alcohol Based Hand Sanitizer with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care. Before and after coming on duty; Before and after direct contact with residents; Before preparing or handling medications; Before performing any non-surgical invasive procedures; Before and after handling an invasive device (e.g., urinary catheters, IV access sites); Before donning sterile gloves; Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings; Before and after assisting a resident with meals; and Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. The facility failed to ensure R52 was provided	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 54 wound care following professional standards of infection control. This deficient practice placed R52 at risk of further infection and worsening of wounds. - The "Diagnoses" tab of R34's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), injury of lumbar spinal cord, and difficulty in walking. The "Quarterly Minimum Data Set (MDS)" dated 11/14/23, documented R34 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The MDS documented R34 used a wheelchair and required substantial assistance from staff for bathing and toileting. The MDS further documented R34 was dependent on staff to transition from seated to lying or lying to seated position and for chair to bed transfers. The "Pressure Ulcer/Injury Potential Care Area Assessment (CAA)" dated 10/28/23, documented R34 was at risk for skin breakdown due to weakness, decreased mobility, and incontinence. R34's "Care Plan" with an initiated date of 11/23/23, documented R34 had potential for impairment to skin integrity due to weakness, decreased mobility, pain, and incontinence. An intervention initiated on 10/23/23 directed staff to assist R34 with turning and repositioning as needed. A "Physicians Order" with a start date of 12/11/23, documented R34 was to have on pressure relief ankle foot orthotic boots (PRAFO-special boot	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 55 which keeps the ankle and foot aligned to treat muscle weakness, imbalance and removes pressure from the back of the heel) while in bed, every shift. R34's EMR from 12/12/23 to 12/16/23 lacked documentation of refusal to wear the PRAFO boots. On 12/14/23 at 10:13 AM R34 slept in her room, in bed, without the PRAFO boots on. R34's PRAFO boots were on a chair across from her bed. On 12/19/23 at 12:05 PM Certified Nurse Aide (CNA) N stated if R34 had an order for the PRAFO boots to be on while bed, then R34 should have had them on even while she rested in bed during the day. On 12/19/23 at 12:25 PM Licensed Nurse (LN) H stated R34 should have had the PRAFO boots on while in bed. LN further stated in R34's case the PRAFO boots should probably have been on most of the time; however, when R34 was in bed the PRAFO boots should have been on her. On 12/19/23 at 03:17 PM Administrative Nurse D stated if R34 had an order for PRAFO boots to be on while in bed, then staff were expected to have placed them on R34 while she was in bed. The facility provided "Skin Observation and Wound Prevention Protocol" dated 03/2009 documented Charge nurses should observe the condition of the resident's skin on admission and on a routine basis. This system also provides a communication process for the nursing assistant to report residents with skin changes to the	F 686			

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

PRINTED: 01/01/2024
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 12/19/2023
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 686	Continued From page 56 charge nurse.	F 686			
F 690 SS=D	The facility failed to implement/ensure pressure reducing measures were in place for R34, who was at risk for pressure injuries. This placed R34 at increased risk for pressure/skin injuries. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 57 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with five reviewed for bowel and bladder management and/or urinary catheter (tube inserted into the bladder to drain urine). Based on interviews, observations, and record review, the facility failed to identify changes in Resident (R) 47's bowel and bladder incontinence patterns and implement individualized toileting interventions. The facility additionally failed to ensure R115's indwelling catheter had an appropriate indication and physician's order to provide catheter and related care. This deficient practice placed both residents at risk for complications related to bladder management and incontinence. Findings included: - The electronic medical record (EMR) for R47 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), major depressive disorder (major mood disorder), and chronic kidney disease. R47 "Significant Change Minimum Data Set	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 58 (MDS)" completed 11/27/23 noted a Brief Interview for Mental Status (BIMS) score of 14 indicating mild cognitive impairment. The MDS indicated she required supervision or touch assistance for toileting, and lower body dressing. The MDS indicated she was occasionally incontinent of urine and frequently incontinent of bowel with no toileting program. R47's "Cognitive Loss Care Area Assessment (CAA)" completed 08/18/23 indicated she had dementia with cognitive communication deficits. The CAA indicated she was independent of all self-care activities prior to her hospitalization for her cerebral infarction. R47's "Functional Abilities CAA" completed 08/18/23 indicated she was at risk for a decline in her activities of daily living (ADLs) related to her medical diagnoses, weakness, and reduced mobility. The CAA noted she required limited staff assistance with her ADLs and personal care. R47's "Urinary Incontinence CAA" completed 08/18/23 indicated she was incontinent. The CAA instructed staff to provide toileting assistance related to her incontinence and monitor her for skin impairment. R47's "Care Plan" initiated 08/21/23 indicated she had a self-care performance deficit and required limited staff assistance for bed mobility, transfers, toileting, and hygiene. The care plan indicated she required assistance from one staff for transfers and ambulation to the bathroom. The plan indicated she had bowel and bladder incontinence and instructed staff to provide check/change assistance every three hours and directed staff to establish R47's voiding patterns.	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 59 R47's EMR revealed a "72 Hour Toileting Log" report completed 11/20/23 which noted no issues or analysis and provided no recommendations or possible interventions. A review of R47's "Documentation Survey Report" indicated she had multiple episodes of bowel and bladder incontinence noted on 11/24/23. A "Nursing Quarterly Data Collection" report completed 11/25/23 indicated R47 was continent of both bowel and bladder. The assessment was not completed due to her status being documented as continent. No recommendations were listed on the report. On 12/14/23 at 12:45 PM R47's resident representative stated R47 was recovering from a stroke that left her with difficulties communicating and remembering. She stated R47 was independent with her ADL, but her abilities had declined since her stroke. On 12/14/23 at 02:05 PM an inspection of R47's room revealed a heavy urine smell. R47's room floor had a wet substance leading around the room and into the restroom. Parts of R47's floor had a dried / sticky substance covering it. On 12/18/23 at 12:34 PM R47 was in her room standing next to the closet in her room. R47 had a pair of white pants on the floor next to her recliner. R47 stated she just changed her pants and was going to lunch. R47 had a pile of clothing in her laundry basket. She reported she could do most things for herself but needed staff assistance from time to time. Staff were not in the room to assist her changing. R47 smelled of urine	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 60 as she went to the dining room. On 12/19/23 at 12:31PM Certified Nurse Aid (CNA) stated she was not sure if R47 was incontinent, but all residents were checked on every three hours. She stated if staff noticed changes in a resident's bathroom usage or increased episodes of incontinence, the nurse was notified. She stated R47 was more independent than other residents, but staff should notice if her clothing or room smelled like urine. At 12/19/23 at 12:55PM Licensed Nurse (LN) stated staff should be checking on R47 frequently and providing her with restroom breaks. She's stated R47 had issue with memory and may not know she was incontinent or not approach staff. She stated residents with sing of increased incontinence should be reassessed and provided interventions. At 12/19/23 at 01:08PM Administrative Nurse D stated all residents were screened upon admission for incontinence and given a 72-hour toileting trail. She stated the trail would show the patterns and help determine needed interventions. She stated a reassessment should be completed if signs of increased incontinence or changes occur with toileting. A review of the facility's "Bowel and Bladder Management" policy revised 08/2023 indicated the facility would complete a bowel and bladder assessment on each resident upon admission and provide individualized toileting programs for appropriate residents. The facility failed to identify changes in R47's increased incontinence patterns and implement	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 61 individualized toileting interventions. This deficient practice placed R47 at risk for complications related to incontinence. - R115's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, disorder of kidney and ureter (duct that urine passes from the kidney to the bladder), femur (thigh bone) fracture (broken bone) of left leg, and encounter for fitting and adjustment of urinary device. The "Admission Minimum Data Set" (MDS) was in progress. R115's "Care Area Assessment" (CAA) was in progress. R115's "Baseline Care Plan" dated 12/10/23 documented staff would provide catheter care per facility policy. R115's "Care Plan" dated 12/13/23 documented staff would place catheter drainage bag below the level of R115's bladder every shift related left femur fracture. The plan of care for R115 lacked reason for the indwelling catheter. R115's EMR under the "Orders" tab lacked a physician order for a foley catheter placement and the medical indication and catheter related care. R115's clinical record lacked evidence of catheter cares provided for the indwelling catheter. Observation on 12/19/23 at 09:34 AM R115 laid on the bed. Certified Nurse Aide (CNA) P entered R115's room, washed her hands, donned gloves, and explained the procedure to R115 for catheter	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 62 care. CNA P removed two wipes from the package and placed the wipes on R115's right thigh. CNA P used one wipe to clean R115's foreskin and around the base of the penis. CNA P placed the soiled wipe on the bed between R115's legs. CNA P used the second wipe to clean the tip of R115's penis and wiped away from the tip of the penis down the tubing with the wipe. CNA P removed the soiled wipes and placed items into the trash can next to the bed. With the same gloves, CNA P assisted R115 onto his left side, provided peri-care, and placed a clean incontinent brief under R115. CNA P doffed her right-hand glove only, donned a clean glove without performing hand hygiene, then adjusted R115's clothes, and bedding. Wearing the same gloves, CNA P touched the bedside table, adjusted the abed height with a remote control and assisted R115 with repositioning on the bed. CNA P removed the soiled trash from R115's room. On 12/19/23 at 11:39 AM CNA P stated hand hygiene should be performed between glove changes. CNA P stated staff should change gloves after catheter care was completed. On 12/19/23 at 11:52 AM Licensed Nurse (LN) J stated staff should always do hand hygiene after peri-care or catheter care and between gloves changes. LN J stated there should always be a physician order for a resident to have an indwelling catheter and a diagnosis for that catheter. On 12/19/23 at 02:30 PM Administrative Nurse E stated hand hygiene should be performed between glove changes, after providing care, and when hands were soiled. Administrative Nurse E	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 63 stated the facility had an in-service over hand hygiene two weeks ago. On 12/19/23 at 03:15 PM Administrative Nurse D stated the resident would need an order for indwelling catheter and diagnosis for the catheter. Administrative Nurse D stated catheter care was to be provided every shift. Administrative Nurse D stated the care plan should include the diagnosis and direction for care related to the indwelling catheter. Administrative Nurse D stated the care provided should be documented on the "Treatment Administration Record" (TAR). The facility's "Urinary Catheter Care" policy last revised 08/2023 documented staff would verify that there is a healthcare provider's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. Use a washcloth with warm water and soap, or a disposable moist cloth to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth or disposable moist cloth with each cleansing stroke. With a clean washcloth, rinse with warm water or use a clean disposable moist cloth, using the above technique. Return foreskin to normal position. Dispose of used cloth(s) in designated container. Use a clean washcloth with warm water and soap, or a disposable moist cloth to cleanse and rinse the catheter from insertion site to approximately four inches outward. Dispose of used cloth(s) in designated container. Secure catheter utilizing a leg band. Check drainage tubing and bag to ensure that the catheter is draining properly. Discard disposable items into designated containers. Remove gloves and	F 690			

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

PRINTED: 01/01/2024
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 12/19/2023
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 690	Continued From page 64 discard into designated container. Wash and dry hands thoroughly. Reposition the bed covers. Make the resident comfortable. Place the call light within easy reach of the resident. Clean wash basin and return to designated storage area. Clean the bedside stand and/or overbed table. Return the overbed table to its proper position. Wash and dry hands thoroughly. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room. The facility failed to ensure R115 had an appropriate indication for the ongoing use of an indwelling catheter. The facility further failed to ensure appropriate foley care orders were in place to direct nursing staff on foley catheter care for R115. This placed R115 at increased risk for catheter related complications.	F 690			
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725			

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

PRINTED: 01/01/2024
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 12/19/2023
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 725	Continued From page 65 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 18 residents. Based on record review, interviews, and observations, the facility failed to ensure sufficient staffing was provided to maintain the residents' physical and psychosocial wellbeing. This placed the residents at risk for impaired quality of life. Findings Included: - The Payroll Based Journaling (PBJ) report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2023 Quarter 1 and 3 indicated the facility had excessively low weekend staffing. Review of the facility's "Resident Council Minutes" from 12/2022 through 11/2023 indicated the council had recurring concerns with call light response times. (The complaint of slow call lights was not on the 01/23, 03/23, and 08/2023 council minutes). (Refer to F565) On 12/18/23 at 12:43PM R43 sat in her bed with her bedside table pulled overlap. Staff delivered and prepped her meal. Staff then left the room	F 725			

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

PRINTED: 01/01/2024
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 12/19/2023
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 725	Continued From page 66 with the door slightly propped open. R43 had bit sized meat and cut potatoes on her tray. R43 began eating her meal. From 12:45PM to 01:20PM no supervision or check-in was provided to R43 during her meal. On 12/19/23 at 07:20AM R43 ate her breakfast without staff supervision in her room with her door barely open. Observation on 12/19/23 at 01:06 PM R37 laid on her right side on the bed. R37's was uncombed and matted upward. On 12/14/23 at 01:10PM Resident (R)19 reported the facility was slow to get her up and had not given her a bath in weeks. She stated the only one who bathed her was hospice services because the facility staff repeatedly told her they didn't have enough staff. She stated since starting hospice services, the visiting nurse ensured she was bathed and provided hygiene care. R19 reported she preferred to be bathed more than twice weekly and did not understand why the facility could not do it. (Refer to F677) On 12/18/23 at 02:00PM, the Resident Council reported ongoing concerns with staffing, call light response times, and activities of daily living not being completed. The council reported it took sometimes over 30 to 45 minutes for staff to respond to call lights. The council reported the facility staffing was lower on weekends and the wait times could go up to an hour. The council reported the facility was working on finding permanent staff and getting rid of agency staff. The council reported the staffing concerns were affecting bathing, toileting, weekend activities, and meals.	F 725			

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

PRINTED: 01/01/2024
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 12/19/2023
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 725	Continued From page 67 On 12/18/23 at 03:30PM Administrative Staff A stated the facility was currently attempting to improve staffing by hiring more permanent staff and getting rid of agency staff. He said the facility currently had a performance improvement plan to address the low staffing and issues related to care concerns affected by staffing. On 12/19/23 at 12:34 Certified Nurse Aid (CNA) O stated weekend staffing was a struggle. She stated the weekend didn't have enough help to complete the assist the resident's need. She stated the residents usually must wait for staff from other units to come over to complete lifts and transfers that require more than one staff. She stated resident's baths get delay or pushed off to the next shift. On 12/19/23 at 01:04 Licensed Nurse I stated the facility has been low on staffing the units. She stated the facility was not looking at patient acuity and the needs of the residents when making assignment for the staff. She stated the lack of assistance made it hard to complete Hoyer (full body mechanical lift) lifts, transfers, bathing, toileting, and individualized care needs outside of the times when the nurse managers worked. She stated the lack of assistance caused residents to have to reschedule or wait long times for toileting and bathing. On 12/19/23 at 02:34 Activities Staff Z reported stated weekend activities were mainly one-one with the residents and completing activities assessment. She stated the facility was often staffed less on the weekends and residents were frequently provided solitary activities such as coloring, puzzle, and electronic tablets to play	F 725			

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

PRINTED: 01/01/2024
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 12/19/2023
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 725	Continued From page 68 games. She was not sure why, but weekends have always been lightly staff compared to weekdays. She stated instead of having an activities staff for each unit (three units), one staff would work the weekend to cover all the units. (Refer to F679) On 12/19/23 at 02::45 Social Services X reported she had received a lot of grievances related to weekend staffing and reported them to the nursing department and administrator. She stated much of the focus was on slow call light times and staff response. She stated a social service staff is always working in the building seven days a week to meet with the residents and address their needs. On 12/19/23 at 03:16 Administrative Nurse D stated the facility was currently working to replace agency staff with more permanent staffing to improve resident care and response times. She reported call light response times was an ongoing issue and she felt it had improved recently. The facility failed to ensure sufficient staffing was provided to maintain the resident's physical and psychosocial wellbeing. This placed the residents at risk for impaired quality of life.	F 725			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756			

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

PRINTED: 01/01/2024
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 12/19/2023
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 756	Continued From page 69 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) recommendations for physician documented rationale for the	F 756			

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

PRINTED: 01/01/2024
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 12/19/2023
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 756	Continued From page 70 continued use of the antipsychotic medication (class of medications used to treat major mental conditions which cause a break from reality testing) for Resident (R) 37 were addressed by the physician. This deficient practice placed R37 at risk for unnecessary psychotropic medication and related complications. Findings included: - R37's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set" (MDS) dated 01/11/23 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented bathing activity itself did not occur during the observation period. The MDS documented R37 received antipsychotic medication and antidepressant (class of medications used to treat mood disorders) medication for seven days during the observation period. The "Quarterly MDS" dated 10/14/23 documented a BIMS score of six which indicated severely impaired cognition. The MDS documented that R37 required set up or clean up assistance for bathing activity during the observation period.	F 756			

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

PRINTED: 01/01/2024
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 12/19/2023
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 756	Continued From page 71 The MDS documented R37 received antipsychotic medication and antidepressant medication during the observation period. R37's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/17/23 documented R37 was at risk for adverse side effects from psychotropic medication ordered related to her diagnosis of dementia. R37's "Care Plan" dated 01/05/23 documented staff would consult with the physician to consider dose reduction at least every three months for psychotropic medications. Review of the EMR under "Orders" tab revealed physician orders: Olanzapine (antipsychotic) tablet five mg give one tablet by mouth at bedtime for dementia dated 07/25/23. R37's EMR under the "Misc." tab the "Monthly Medication Review" (MMR) reviewed from January 2023 to October 2023 revealed recommendations for gradual reduction and physician documentation for risk versus benefits for the continued use of the antipsychotic medication for R37 with a diagnosis of dementia and Alzheimer's disease. R37's clinical record lacked a physician documented response to the MMR which included a rationale and risk versus benefits for the continued use of the antipsychotic medication with a diagnosis of dementia and Alzheimer's disease. Observation on 12/19/23 at 01:06 PM R37 laid on	F 756			

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

PRINTED: 01/01/2024
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 12/19/2023
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 756	Continued From page 72 her right side on the bed. R37's hair was uncombed and matted upward. On 12/19/23 at 11:52 PM Licensed Nurse (LN) J stated the resident, or their representative would sign a consent for the use of psychotropic medications. LN J stated staff administered the medication as ordered by the physician for the diagnosis given by the physician. LN J stated the nurse managers, or the director of nurse would review pharmacy monthly recommendations. On 12/19/23 at 03:15 PM Administrative Nurse D stated for any psychotropic medication the physician was involved in the monitoring of the medication. Administrative Nurse D stated physician reviewed the diagnosis for each medication administered. Administrative Nurse D stated the monthly pharmacy recommendations were emailed to her and the nurse managers would make the changes. The facility's "Medical regimen Review) MRR) Policy" dated 07/2018 documented a drug regimen review was performed for each resident at the time admission, monthly thereafter and as indicated, based upon a resident's condition. This Medication Regimen Review (MRR) included, but was not limited to, time frames for different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. The facility failed to ensure the CP recommendations for physician documented rationale for the continued use of the antipsychotic medication for R37 were addressed by the physician. This deficient practice placed R37 at risk for unnecessary psychotropic	F 756			

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

PRINTED: 01/01/2024
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 12/19/2023
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 756	Continued From page 73	F 756			
F 757 SS=D	medication and related complications. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to ensure dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 52. This deficient practice R52 at risk for unnecessary medication use and physical complications for the affected resident.	F 757			

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

PRINTED: 01/01/2024
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 12/19/2023	
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 74 Findings included: - R52's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and osteomyelitis (local or generalized infection of the bone and bone marrow). The "Admission Minimum Data Set" (MDS) dated 10/28/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R52 required partial/moderate assistance with moving from a sitting position to standing. The MDS documented R52 had an infection of her foot. The MDS documented R52 had a pressure reducing device on her bed and in her chair. R52's "Pressure Ulcer Care Area Assessment" (CAA) dated 11/01/23 documented R52 was monitored regularly by the physician for current wound. R52's "Care Plan" dated 10/20/23 documented staff would evaluate the effectiveness of R52's pain interventions and review for compliance, alleviating of symptoms, dosing schedules and her satisfaction with results, impact on functional ability and impact on cognition. Review of the EMR under "Orders" tab revealed physician orders: Voltaren external gel (anti-inflammatory class of medication used to reduce inflammation) one			F 757			

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

PRINTED: 01/01/2024
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 12/19/2023
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 75 percent (%) (diclofenac sodium) (topical), apply to affected area every four hours as needed dated 11/21/23. The order lacked a dose. Observation on 12/18/23 at 12:12 PM R52 wheeled herself in a wheelchair to the dining room. On 12/19/23 at 11:39 AM Licensed Nurse (LN) J stated every medication should have a dosage to be administered as ordered by the physician. LN J stated if a medication lacked a dose to be administered, she would clarify the order with physician. LN J stated R52's Voltaren order lacked have a dose ordered for administration after she reviewed R52's "Medication Administration Record" (MAR). On 12/19/23 at 11:52 AM Administrative Nurse D stated she would except all medication orders would have a dose to be administered as ordered by the physician. Administrative Nurse D stated she would except the nurse would clarify the medication order with physician. The facility's "Physician Medication Orders" policy lasted revised 04/2021 documented medications would be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Orders for medications must include Name and strength of the drug; Quantity or specific duration of therapy; Dosage and frequency of administration; Route of administration if other than oral; and Reason or problem for which given. The facility failed to ensure dosing instructions for Voltaren gel for R52. This deficient practice placed R52 at risk for unnecessary medication	F 757			

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

PRINTED: 01/01/2024
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 12/19/2023
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 76	F 757			
F 758 SS=D	use, side effects and physical complications. Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 77 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure an appropriate indication or documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the continued use of antipsychotic (class of medications used to treat major mental conditions which cause a break from reality testing) for Resident (R)115 and R37. This deficient practice placed these residents at risk for unnecessary psychotropic medication and related complications. Findings included: - R115's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, disorder of kidney and ureter (duct that urine passes from the kidney to the bladder), femur (thigh bone) fracture (broken bone) of left leg, and encounter for fitting and adjustment of	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 78 urinary device. The "Admission Minimum Data Set" (MDS) was in progress. R115's "Care Area Assessment" (CAA) was in progress. R115's "Care Plan" dated 12/11/23 documented staff would administer medication as ordered and monitor/document side effects and effectiveness. R115's "Care Plan" also documented the facility would consult with the pharmacy and physician to consider dose reduction, if clinically appropriate, and ongoing need for use. Review of the EMR under "Orders" tab revealed physician orders: Quetiapine fumarate (antipsychotic) oral tablet 25 milligrams (mg) give one tablet by mouth at bedtime for insomnia (inability to sleep) dated 12/09/23. R115's clinical record lacked a physician documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication. Observation on 12/19/23 at 09:34 AM R115 laid on his back on the bed with the head of bed elevated. R115's catheter drainage bag was attached to the bed frame covered with a dignity bag. On 12/19/23 at 11:52 PM Licensed Nurse (LN) J stated the resident, or their representative would sign a consent for the use of psychotropic (alters mood or thought) medications. LN J stated staff	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 79 administered the medication as ordered by the physician for the diagnosis given by the physician. On 12/19/23 at 03:15 PM Administrative Nurse D stated for any psychotropic medication the physician was involved in the monitoring of the medication. Administrative Nurse D stated physician reviewed the diagnosis for each medication administered. The facility's "psychotropic Drug Management Policy" policy last revised 10/2022 documented non-drug interventions would be implemented to the extent possible to assist the resident attain a satisfactory quality of life. To provide a therapeutic environment, use only those medications with a therapeutic benefit to the individual resident. Unnecessary drugs would be avoided. An unnecessary drug was any drug when used in excessive dose (including duplicate drug therapy, for excessive duration, without adequate monitoring, without adequate indications for its use, and/or in the presence of adverse consequences which indicate the dose would be reduced or discontinued. This can be one or in combination together. To avoid the use of unnecessary drugs and their associated adverse drug effects (ADEs), psychotropic medications would be used only after non-drug interventions alone have failed to manage behavioral symptoms associated with dementia and a medication was used to treat a specific condition as diagnosed and documented in the clinical record. This facility would monitor residents using psychotropic medications for efficacy and adverse reactions. Psychotropic is defined as any drug that affects brain activities associated with mental processes and behaviors.	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 80 The facility failed to provide a physician documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication for R115 for insomnia. This deficient practice placed him at risk for unnecessary psychotropic medication and related complications. - R37's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set" (MDS) dated 01/11/23 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented bathing activity itself did not occur during the observation period. The MDS documented R37 received antipsychotic medication and antidepressant (class of medications used to treat mood disorders) medication for seven days during the observation period. The "Quarterly MDS" dated 10/14/23 documented a BIMS score of six which indicated severely impaired cognition. The MDS documented that R37 required set up or clean up assistance for bathing activity during the observation period. The MDS documented R37 received	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 81 antipsychotic medication and antidepressant medication during the observation period. R37's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 01/17/23 documented R37 was at risk for adverse side effects from psychotropic (alters mood or thought) medication ordered related to her diagnosis of dementia. R37's "Care Plan" dated 01/05/23 documented staff would consult with the physician to consider dose reduction at least every three months for psychotropic medications. Review of the EMR under "Orders" tab revealed physician orders: Sertraline hci (antidepressant) tablet 100 milligrams (mg) give one tablet by mouth at bedtime related to depression dated 01/04/23. Mirtazapine tablet (antidepressant) 7.5mg give one tablet by mouth at bedtime for dementia dated 01/04/23. Olanzapine (antipsychotic) tablet five mg give one tablet by mouth at bedtime for dementia dated 07/25/23. R37's clinical record lacked a physician documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication. Observation on 12/19/23 at 01:06 PM R37 laid on her right side on the bed. R37's hair was uncombed and matted upward. On 12/19/23 at 11:52 PM Licensed Nurse (LN) J	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 82 stated the resident, or their representative would sign a consent for the use of psychotropic medications. LN J stated staff administered the medication as ordered by the physician for the diagnosis given by the physician. On 12/19/23 at 03:15 PM Administrative Nurse D stated for any psychotropic medication the physician was involved in the monitoring of the medication. Administrative Nurse D stated physician reviewed the diagnosis for each medication administered. The facility's "psychotropic Drug Management Policy" policy last revised 10/2022 documented non-drug interventions would be implemented to the extent possible to assist the resident attain a satisfactory quality of life. To provide a therapeutic environment, use only those medications with a therapeutic benefit to the individual resident. Unnecessary drugs would be avoided. An unnecessary drug was any drug when used in excessive dose (including duplicate drug therapy, for excessive duration, without adequate monitoring, without adequate indications for its use, and/or in the presence of adverse consequences which indicate the dose would be reduced or discontinued. This can be one or in combination together. To avoid the use of unnecessary drugs and their associated adverse drug effects (ADEs), psychotropic medications would be used only after non-drug interventions alone have failed to manage behavioral symptoms associated with dementia and a medication was used to treat a specific condition as diagnosed and documented in the clinical record. This facility would monitor residents using psychotropic medications for efficacy and adverse reactions. Psychotropic is defined as any	F 758			

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

PRINTED: 01/01/2024
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 12/19/2023
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 758	Continued From page 83 drug that affects brain activities associated with mental processes and behaviors. The facility failed to provide a physician documented rationale which included the multiple unsuccessful attempts for nonpharmacological interventions and risk versus benefits for the continued use of the antipsychotic medication for R37 who has diagnosis of dementia and Alzheimer's disease. This deficient practice placed her at risk for unnecessary psychotropic medication and related complications.	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761			

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

PRINTED: 01/01/2024
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 12/19/2023
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 761	Continued From page 84 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 resident. The facility had three medication storage rooms and five medication carts. Based on observation, record review and interview, the facility failed to ensure safe and secure storage of medications and biologicals. This deficient practice created a risk for adverse side effects and ineffective medication administration. Findings included: - On 12/14/23 at 09:25 AM the medication cart on the 300 hallway was left unsecured and unlocked in an area where residents were present. Licensed Nurse (LN) J came running out of a resident's room in the 300 hall when she realized she left the medication cart unlocked. On 12/14/23 at 09:45 AM the treatment cart in the 400 hall was left unsecured and unlocked. On 12/14/23 at 09:25 AM LN J stated the medication and treatment carts should be secured when not in use. On 12/19/23 at 03:16 PM Administrative Nurse D stated that the medication cart, medication room, and treatment carts should all be securely locked when staff was not using them. The facility policy "Storage and Expiration of Medications, Biologicals, Syringes and Needles" revised 01/01/13 documented the facility should ensure that all medications and biologicals, including treatment items, were securely stored in	F 761			

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

PRINTED: 01/01/2024
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 12/19/2023
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 761	Continued From page 85 a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors. The facility failed to ensure safe and secure storage of medications and biologicals. This deficient practice created a risk for adverse side effects and ineffective medication administration.	F 761			
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to ensure physician ordered laboratory test results for Resident (R) 37 were included the clinical record. This deficient practice could result in unnecessary tests and delayed treatment. Findings included: - R37's Electronic Medical Record (EMR) under the "Orders" tab revealed physician order: Complete Blood Count (CBC) laboratory test to be obtained monthly per physician order. Notify the physician of results dated 04/27/23. R37's EMR lacked laboratory tests obtained on 08/25/23, 09/25/23 and 10/25/23. On 12/19/23 at 03:15 PM Administrative Nurse D stated outside laboratory obtained the lab tests	F 775			

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

PRINTED: 01/01/2024
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 12/19/2023
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 775	Continued From page 86 ordered by the physician. Administrative Nurse D stated the results were faxed to the facility and the physician was notified of the results, then the nurse would initial and dated the results. Administrative Nurse D stated the laboratory results were then sent to medical records, and scanned into the results are then scanned into the resident's EMR under the "Misc." tab. Administrative Nurse D stated she was not sure what the time frame before the results were scanned into the resident's EMR, but she expected the results to scanned quickly to be reviewed by the physician and nurses. The facility's "Electronic Medical Records" policy last revised 06/2020 documented Electronic Medical Records may be used in lieu of paper records. The facility failed to ensure physician ordered laboratory test results for R37 were signed and included in the clinical record. This deficient practice could result in unnecessary tests and delayed treatment.	F 775			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812			

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

PRINTED: 01/01/2024
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 12/19/2023
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 812	Continued From page 87 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The facility identified one main kitchen and five satellite kitchenette areas. Based on observation, record review and interview, the facility failed to ensure kitchen staff appropriately sanitized a probe-type thermometer used to check food temperatures prior to meal service. The facility failed to ensure staff cleaned and maintained a satellite kitchen ice machine. This deficient practice left residents at risk for food borne illnesses and cross-contamination. Findings included: - During the initial tour of the facility on 12/14/23 shortly after 07:00 AM, the ice machine on the 400 hall had a brown gooeey substance on the inside drain. The outside of the ice machine was visibly soiled. On 12/18/23 at 12:01 PM Dietary Staff DD prepared to check the temperature of the hot foods she placed on the steam table for meal service on the long-term care unit of the facility. Dietary Staff DD put on gloves without performing hand hygiene and grabbed a probe-type thermometer. Dietary Staff DD removed the cover of the probe and placed the probe end of thermometer into the metal container with the	F 812			

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

PRINTED: 01/01/2024
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 12/19/2023
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 812	Continued From page 88 Salisbury steaks without sanitizing it first. Dietary Staff DD removed the probe from the steaks and then inserted the probe into the metal container that contained chicken breasts. Dietary Staff DD then removed the probe from the chicken breasts. Dietary Staff DD continued to check the temperature of each food item on the steam table (corn, Brussel sprouts, macaroni and cheese, mashed potatoes, and brown gravy) without sanitizing the probe of the thermometer after insertion into each food. On 12/18/23 at 12:05 PM Dietary Staff DD stated she did not have any of the sanitizing wipes to sanitize the thermometer probe and was not sure where to find them. On 12/19/23 at 08:51 AM Dietary Staff BB stated that the servers were expected to sanitize the thermometer after temperatures were obtained of each food item. Dietary Staff BB stated she would do some more education with her staff on proper procedure when checking the temperatures of the foods. Dietary Staff BB stated she expected the ice machines to be wiped down daily and cleaned weakly. Dietary Staff BB stated she would go over the policies and procedures again to re-educate her staff on the cleaning of the ice machines. The undated facility policy "Food Temperatures" documented: Foods should be served at proper temperatures to ensure food safety and palatability. Wash, rinse and sanitize a dial face, metal probe-type thermometer with an alcohol wipe. Re-sanitize the thermometer after each use. The undated facility policy "Ice Machine" documented: Sanitation of equipment- daily-wash the exterior of machine with hot water and	F 812			

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

PRINTED: 01/01/2024
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 12/19/2023
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 812	Continued From page 89 detergent. Rinse with clean water and cloth. Use sanitizing solution and clean cloth to sanitize. Remove the drainage grate and tray and send through dishwasher. Allow drainage grate and tray to air dry and replace the drainage grate and tray. Store the ice scoop free from ice in a sanitary enclosed container. Document cleaning on the cleaning schedule. The facility failed to ensure kitchen staff appropriately sanitized the probe-type thermometer before and after obtaining each food temperature prior to service. The facility failed to ensure kitchen staff properly maintained and cleaned an ice machine used by staff for resident's drinks. This deficient practice had the potential for food borne illnesses and cross-contamination of food for the residents.	F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 90 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 91 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents. The facility identified two COVID-19 (highly contagious, potentially life-threatening respiratory virus) positive residents. Based on record review, observations, and interviews, the facility failed to ensure infection control standards were followed related to COVID-19 isolation precautions, clean supply/equipment storage, and hand hygiene during cares. This deficient practice placed the residents at risk for infectious diseases. Findings included: - On 12/14/23 at 07:05AM an unidentified staff member at the front desk wore her face mask around her chin while seated at the desk. The facility identified Residents (R)52 and R116 as positive for Covid-19. On 12/14/23 at 07:20AM an inspection of the clean linen rooms on the 300 and 400 halls revealed dirty vacuums stored next to the uncovered linen. Green lift slings sat directly on the floor in both rooms. On 12/14/23 at 08:22AM R119's supplemental oxygen nasal cannula (oxygen mask supplying air to both nostrils) and oxygen tubing rested directly	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 92 on the seat of her recliner. No storage bag was present for the cannula or tubing. On 12/14/23 at 09:18AM an inspection of R114 room revealed no signage indicating her droplet precautions or required personal protective equipment (PPE). An isolation cart was placed outside her room. On 12/14/23 at 12:22PM R114's nasal cannula and oxygen tubing laid directly on her unmade bed. On 12/14/23 at 12:38PM Certified Nurse Aide (CNA) M entered R116's room without wearing PPE. CNA M reported R116 was not on isolation and staff did not need to wear PPE. Licensed Nurse (LN) G came and stated R116 was on isolation precautions, and everyone was required to wear PPE upon entry to the room. On 12/14/23 at 03:44PM R215's unbagged nasal cannula and oxygen tubing rested on the floor next to her bed despite the storage bag was present. On 12/18/23 at 01:01PM Administrative Nurse E completed hand hygiene before providing wound care to R52. Administrative Nurse E unplugged the wound-vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) and removed R52's dressing. She changed her gloves but failed to complete hand hygiene in between glove change. Administrative Nurse E cleansed the wound and touched her personal phone during the cleansing. She again changed her gloves but failed to complete hand hygiene in between glove change. A new dressing was then applied to complete the wound care.	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 93 On 12/18/23 at 01:14PM LN H prepared R1's medication administration through her feeding tube (tube for introducing high calorie fluids into the stomach). LN H failed to complete hand hygiene before preparing the medication, upon entering the room, or upon administering the medication using the feeding tube. She completed hand hygiene upon exiting the room after the administration was completed. On 12/19/23 at 09:34 AM R115 laid on the bed. CNA P entered R115's room, washed her hands, donned gloves, and explained the procedure to R115 for catheter care. CNA P removed two wipes from the package and placed the wipes on R115's right thigh. CNA P used one wipe to clean R115's foreskin and around the base of the penis. CNA P placed the soiled wipe on the bed between R115's legs. CNA P used the second wipe to clean the tip of R115's penis and wiped away from the tip of the penis down the tubing with the wipe. CNA P removed the soiled wipes and placed items into the trash can next to the bed. With the same gloves, CNA P assisted R115 onto his left side, provided peri-care, and placed a clean incontinent brief under R115. CNA P doffed her right-hand glove only, donned a clean glove without performing hand hygiene, then adjusted R115's clothes, and bedding. Wearing the same gloves, CNA P touched the bedside table, adjusted the bed height with a remote control and assisted R115 with repositioning on the bed. CNA P removed the soiled trash from R115's room. At 12/19/23 at 12:35PM CNA O stated staff were expected to complete hand hygiene before providing cares to residents and when visibly	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 94 soiled. She stated oxygen tubing should be stored in a clean bag next to the machine or tank. She stated staff received training monthly on the online training service and in meetings about how to apply PPE and remove it. She stated only clean linen should be stored in the closet and slings should never be placed on the floor. At 12/19/23 at 01:05PM LN I stated hand hygiene should be completed before passing meals, medications, providing cares, and when soiled. She stated residents in isolation should have signage posted outside their rooms showing what PPE was required before entering. On 12/19/23 at 02:29PM Administrative Nurse F stated the facility routinely held in-service training related hand hygiene related to basic cares for residents. She stated hand hygiene should always be completed before providing direct contact care for the residents that included wound care, catheter care, medication administration, activities of daily living, and when assisting residents. Administrative Nurse E stated isolations signs and PPE carts should be posted outside the resident's door for isolation residents. She stated R116 was on isolation precautions and signs should have been posted outside her door. She stated posted signs identifying Covid-19 exposure were at the front door and main desk. She stated oxygen tubing and cannulas should be stored in their provided clean storage bag to prevent contamination or infections. A review of the facility's "Standard Precautions" policy revised 09/2022 indicated hand hygiene and prevention practices should be used regardless of a resident's diagnoses. The policy	F 880			

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

PRINTED: 01/01/2024
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 12/19/2023
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 880	Continued From page 95 indicated hand hygiene should be performed before, during, and after direct contact with residents. The policy noted hand hygiene was to be completed after removal of PPE. The policy indicated soiled facility equipment should not be stored around or in the same area as clean equipment, clothing, linen, hygiene products, food, or furniture to prevent contamination. A review of the facility's "Isolation" policy revised 09/2022 indicated staff were follow were the appropriately indicated personal protective equipment outlined for residents in isolation precautions. The policy noted the facility will communicate and ensure staff are informed of the appropriate levels of precautions to prevent further spread infection. The policy indicated signs will be placed in visible areas to describe to level of precautions and PPE required. The facility failed to ensure infection control standards were followed related to COVID-19 and isolation precautions, clean supply/equipment storage, and hand hygiene during cares. This deficient practice placed the residents at risk for infectious diseases.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883			

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

PRINTED: 01/01/2024
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 12/19/2023
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 883	Continued From page 96 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883			

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

PRINTED: 01/01/2024
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 12/19/2023
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 883	Continued From page 97 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included 18 residents with five reviewed for influenza (highly contagious viral infection) and pneumococcal (type of bacterial infection) immunizations. Based on record review and interviews, the facility failed to provide pneumococcal vaccinations or informed refusals for Residents (R)13 and provide influenza vaccinations or informed refusals for R53. This deficient practice placed the residents at risk for complication related to infectious diseases. Findings included: - R13's clinical record lacked evidence indicating she or her representative was offered, consented, refused, or had received the pneumonia vaccination since her admission in 2019. - R53's clinical record lacked evidence indicating she or her representative was offered, consented, refused, or had received the Influenza vaccination since her admission on 05/25/23. On 12/19/23 at 02:23PM Administrative Nurse F stated she recently took over from the previous infection preventionist and the facility was catching up with all the infection control tasks. She stated each resident's immunizations should be reviewed upon admission and offered either at admission or during the next administration cycle. She stated the missing immunization consents	F 883			

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

PRINTED: 01/01/2024
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 12/19/2023
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 883	Continued From page 98 would be completed and offered. A review of the facility's "Influenza Immunization" policy indicated all residents will be screened and offered immunizations. The policy noted resident and representative will be provided education related to the vaccinations and provided consent/declination opportunities. The policy indicated the documentation will be placed in the residents medical record for review. A review of the facility's "Pneumococcal Immunization" policy revised 05/2023 indicated the pneumococcal vaccination will be provided to residents over 65 years old or with medical indications. The policy noted the vaccination consent or declination will be completed and maintained in the medical records. The facility failed to provide pneumococcal vaccinations or informed refusals for R13 and provide influenza vaccinations or informed refusals for R53. This deficient practice placed the residents at risk for complication related to infectious diseases.	F 883			