

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

PRINTED: 02/09/2024
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 C 01/30/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
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F 000	INITIAL COMMENTS	F 000			
F 684 SS=D	The following citations represent the findings of complaint investigation #KS00185035. The 2567 was sent electronically on 02/09/24. 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 three residents reviewed for medications. Based on record review and interviews, the facility failed to ensure staff accurately transcribed orders from the hospital on admission and failed to follow the physician's orders for Resident (R) 1. This deficient practice placed R1 at risk for unwarranted physical complications and less-than-therapeutic effects related to medication use. Findings included: - R1 admitted to the facility on 12/27/23, discharged to the hospital on 01/04/24, readmitted to the facility on 01/09/24, and discharged home 01/24/24. R1's Electronic Medical Record (EMR)	F 684			

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

TITLE

(X6) DATE

02/09/2024

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

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F 684	Continued From page 1 documented diagnoses of generalized muscle weakness and Hashimoto's encephalopathy (a rare disease that involves impaired brain function and is a steroid-responsive acute or subacute encephalopathy characterized by autoimmune thyroiditis [autoimmune disorder where the immune system attacks the thyroid gland] associated with elevated levels of antithyroid antibodies). The "Admission Minimum Data Set (MDS)" dated 01/15/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The "Functional Abilities Care Area Assessment (CAA)" dated 01/23/24, documented R1 had a decline in activities of daily living (ADLs) from her previous level of functioning related to multiple hospitalizations with the most recent due to head pressure, slurred speech, vision changes, confusion, hallucinations, and urinary tract infection. R1's "Care Plan" last revised 01/23/24, documented R1 had a cerebral vascular accident (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) and Hashimoto's encephalopathy. The care plan documented an intervention, dated 01/10/24, that directed staff to give medications as ordered by the physician and monitored/documentated side effects and effectiveness. R1's EMR revealed a "Discharge Order Report" dated 12/27/23, that documented an order for prednisone 10 milligrams (mg) in the morning.	F 684			

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F 684	Continued From page 2 R1's EMR lacked evidence the prednisone order from 12/27/23 was entered and administered. R1's EMR revealed a "Consultation Report" on 12/28/23 that documented R1 recently admitted to the facility and the medication review process revealed the following discrepancies on the admission orders: there was an order for prednisone, but there was no current order in THE EMR. Recommendation to consider clarifying the medication orders and communicate with the prescriber and pharmacy as appropriate. The "Notes" tab of R1's EMR revealed the following: A "Physician Progress Note" on 12/28/23 at 11:08 AM, documented R1 had chronic steroid use and Hashimoto's encephalopathy with a plan to continue prednisone 10 mg. A "Physician Progress Note" on 01/02/24 at 04:30 PM, documented R1 had chronic steroid use and Hashimoto's encephalopathy with a plan to continue prednisone 10 mg. R1's EMR revealed "Consult Notes" on 01/05/24 at 01:06 PM that documented R1 had not been receiving her daily prednisone that past week and there was a concern that given her recurrent hospitalization, it was related to a relapse of Hashimoto's encephalopathy. The note documented that it was not unheard of as there were case reports with relapsing symptoms, however, it was presumed to be only present in about 10 to 15 percent of cases. The note documented R1 had poor sleep over the past several days which was also an area of concern in previous hospitalizations leading to ongoing	F 684			

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F 684	Continued From page 3 confusion. That could have been a stronger contributor to her current presentation. The note documented from an encephalopathy picture, R1 did not have true confusion at that time, provided a good history, and performed extremely well on bedside cognitive testing. The facility's investigative report, dated 01/08/24, documented R1 was admitted to the facility on 12/27/23 and had a BIMS score of 14. R1 had a history of Hashimoto's encephalopathy. The nurse practitioner (NP) noted a change in condition and spoke to R1 and her representative about possible options to evaluate symptoms. The NP, R1, and her representative agreed to further evaluation at the emergency department (ED) to rule out infection or worsening Hashimoto's encephalopathy. The NP reviewed R1's chart and repeated a medication reconciliation on 01/04/24 at approximately 04:05 PM and it was noted that prednisone was not currently on the Medication Administration Record (MAR). Upon investigation, it was discovered that prednisone was missed on the admission orders by the admitting nurse, the second nurse, and the interdisciplinary team (IDT). A pharmacy recommendation was received on 12/28/23 stating that there were discrepancies on the admission orders which involved an order for prednisone but no current order in the chart. According to the hospital physician's note on 01/04/24, the probability of R1's Hashimoto's encephalopathy relapsing was only 10 to 15 percent. It was also noted that R1 had poor sleep over the last several days which had been an area of concern in previous hospitalizations leading to ongoing confusion. From an encephalopathy picture, she did not have true confusion at that time, provided a good history,	F 684			

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F 684	Continued From page 4 and performed extremely well on bedside cognitive testing. On 01/30/24 at 01:23 PM, Administrative Nurse E stated when a resident is admitted to the facility, the nurse and aide help the resident settle. She stated the floor nurse put in the admission orders and the nurse manager helped. Every morning, the nurse managers reviewed the orders when they did chart review. Administrative Nurse E stated when the provider visits, the nurse on duty reviews the notes for new orders, and any new orders the provider puts in, show up in red in the chart. She stated the night nurses double-check the new orders. On 01/30/24 at 01:31 PM, Licensed Nurse (LN) G stated admission orders were done by the nurse or nurse managers. She stated the nurses double-checked the admission orders and the managers checked after that. LN G stated the providers put orders in and the nurse confirmed any pending orders. On 01/30/24 at 01:42 PM, Administrative Nurse D stated when a resident was admitted, the nurse received orders from the hospital and verified them with the provider. The admitting nurse transcribed the orders into the system, a second nurse reviewed them, and IDT reviewed them after that. Administrative Nurse D stated when a provider visited, some of them put their own orders in and some gave verbal orders. She stated the nurse reviewed the orders but not the provider's progress notes because they visited so often. Administrative Nurse D stated the pharmacy sent recommendations to the nurse managers, herself, and the administrator. Between those people, the recommendations	F 684			

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F 684	Continued From page 5 were reviewed and sent to the physician. She stated staff saw what the recommendation was and if it was something they could address, they updated it, initialed, dated it, and uploaded the recommendation into the miscellaneous tab of the EMR. On 01/30/24 at 01:54 PM, Administrative Nurse F stated when she received a pharmacy recommendation, she did not sign her name until it was completed in the EMR. She stated she wanted to say that was what she did with R1's recommendation from 12/28/23 but it did not get put in. Administrative Nurse F stated when she received an admission pharmacy recommendation, she printed it off, verified the order with the hospital discharge orders, and made sure the provider did not put a note in not wanting the medication. Once she did that, she put the order in the EMR per the discharge orders, confirmed it in the EMR, signed the recommendation, and put a nurse's note in that it was completed. The facility's "Reconciliation of Medications on Admission/Re-Admission and Monthly Orders" policy, last revised in March 2019, directed medication reconciliation reduced medication errors and enhanced resident safety during the admission/transfer process by identifying the medications the resident needed and administering without interruption, the correct dosages and routes. The policy directed the facility used an approved medication reconciliation form or other record to list all medications from the medication history, the discharge summary, the previous MAR, and the admitting orders. The facility reviewed the list carefully to determine if there were any	F 684			

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F 684	Continued From page 6 discrepancies, conflicts, or severe drug-to-drug interactions. The facility's "Physician Visits" policy, last revised in April 2013, directed the attending physician performed relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. The facility's "Medication Regimen Review (MRR) Policy," dated July 2018, directed medication regimen reviews were completed upon admission, and completed MRR reports were sent to the medical director, director of clinical services, and healthcare provider to review the recommendations. The facility failed to ensure staff accurately transcribed orders from the hospital on admission and failed to follow the physician's orders for R1. This deficient practice placed R1 at risk for unwarranted physical complications and less-than-therapeutic effects related to medication use.	F 684			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756			

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F 756	Continued From page 7 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 three residents reviewed for medications. Based on record review and interviews, the facility failed to address the admission medication regimen review for Resident (R) 1 when the Consultant Pharmacist (CP) found irregularities with her admission orders. This deficient practice had the risk for unwarranted physical complications and unnecessary medication use for R1.	F 756			

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F 756	Continued From page 8 Findings included: R1 admitted to the facility on 12/27/23, discharged to the hospital on 01/04/24, readmitted to the facility on 01/09/24, and discharged home 01/24/24. R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness and Hashimoto's encephalopathy (a rare disease that involves impaired brain function and is a steroid-responsive acute or subacute encephalopathy characterized by autoimmune thyroiditis [autoimmune disorder where the immune system attacks the thyroid gland] associated with elevated levels of antithyroid antibodies). The "Admission Minimum Data Set (MDS)" dated 01/15/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The "Functional Abilities Care Area Assessment (CAA)" dated 01/23/24, documented R1 had a decline in activities of daily living (ADLs) from her previous level of functioning related to multiple hospitalizations with the most recent due to head pressure, slurred speech, vision changes, confusion, hallucinations, and urinary tract infection. R1's "Care Plan" last revised 01/23/24, documented R1 had a cerebral vascular accident (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) and Hashimoto's encephalopathy. The care plan documented an intervention, dated	F 756			

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F 756	Continued From page 9 01/10/24, that directed staff to give medications as ordered by the physician and monitored/documented side effects and effectiveness. R1's EMR revealed a "Discharge Order Report" dated 12/27/23, that documented an order for prednisone 10 milligrams (mg) in the morning. R1's EMR lacked evidence the prednisone order from 12/27/23 was entered and administered. R1's EMR revealed a "Consultation Report" on 12/28/23 that documented R1 recently admitted to the facility and the medication review process revealed the following discrepancies on the admission orders: there was an order for prednisone, but there was no current order in THE EMR. Recommendation to consider clarifying the medication orders and communicate with the prescriber and pharmacy as appropriate. The "Notes" tab of R1's EMR revealed the following: A "Physician Progress Note" on 12/28/23 at 11:08 AM, documented R1 had chronic steroid use and Hashimoto's encephalopathy with a plan to continue prednisone 10 mg. A "Physician Progress Note" on 01/02/24 at 04:30 PM, documented R1 had chronic steroid use and Hashimoto's encephalopathy with a plan to continue prednisone 10 mg. R1's EMR revealed "Consult Notes" on 01/05/24 at 01:06 PM that documented R1 had not been receiving her daily prednisone that past week and there was a concern that given her recurrent hospitalization, it was related to a relapse of	F 756			

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F 756	Continued From page 10 Hashimoto's encephalopathy. The note documented that it was not unheard of as there were case reports with relapsing symptoms, however, it was presumed to be only present in about 10 to 15 percent of cases. The note documented R1 had poor sleep over the past several days which was also an area of concern in previous hospitalizations leading to ongoing confusion. That could have been a stronger contributor to her current presentation. The note documented from an encephalopathy picture, R1 did not have true confusion at that time, provided a good history, and performed extremely well on bedside cognitive testing. The facility's investigative report, dated 01/08/24, documented R1 was admitted to the facility on 12/27/23 and had a BIMS score of 14. R1 had a history of Hashimoto's encephalopathy. The nurse practitioner (NP) noted a change in condition and spoke to R1 and her representative about possible options to evaluate symptoms. The NP, R1, and her representative agreed to further evaluation at the emergency department (ED) to rule out infection or worsening Hashimoto's encephalopathy. The NP reviewed R1's chart and repeated a medication reconciliation on 01/04/24 at approximately 04:05 PM and it was noted that prednisone was not currently on the Medication Administration Record (MAR). Upon investigation, it was discovered that prednisone was missed on the admission orders by the admitting nurse, the second nurse, and the interdisciplinary team (IDT). A pharmacy recommendation was received on 12/28/23 stating that there were discrepancies on the admission orders which involved an order for prednisone but no current order in the chart. According to the hospital physician's note on	F 756			

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F 756	Continued From page 11 01/04/24, the probability of R1's Hashimoto's encephalopathy relapsing was only 10 to 15 percent. It was also noted that R1 had poor sleep over the last several days which had been an area of concern in previous hospitalizations leading to ongoing confusion. From an encephalopathy picture, she did not have true confusion at that time, provided a good history, and performed extremely well on bedside cognitive testing. On 01/30/24 at 01:23 PM, Administrative Nurse E stated when a resident is admitted to the facility, the nurse and aide help the resident settle. She stated the floor nurse put in the admission orders and the nurse manager helped. Every morning, the nurse managers reviewed the orders when they did chart review. Administrative Nurse E stated when the provider visits, the nurse on duty reviews the notes for new orders, and any new orders the provider puts in, show up in red in the chart. She stated the night nurses double-check the new orders. On 01/30/24 at 01:31 PM, Licensed Nurse (LN) G stated admission orders were done by the nurse or nurse managers. She stated the nurses double-checked the admission orders and the managers checked after that. LN G stated the providers put orders in and the nurse confirmed any pending orders. On 01/30/24 at 01:42 PM, Administrative Nurse D stated when a resident was admitted, the nurse received orders from the hospital and verified them with the provider. The admitting nurse transcribed the orders into the system, a second nurse reviewed them, and IDT reviewed them after that. Administrative Nurse D stated when a	F 756			

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F 756	Continued From page 12 provider visited, some of them put their own orders in and some gave verbal orders. She stated the nurse reviewed the orders but not the provider's progress notes because they visited so often. Administrative Nurse D stated the pharmacy sent recommendations to the nurse managers, herself, and the administrator. Between those people, the recommendations were reviewed and sent to the physician. She stated staff saw what the recommendation was and if it was something they could address, they updated it, initialed, dated it, and uploaded the recommendation into the miscellaneous tab of the EMR. On 01/30/24 at 01:54 PM, Administrative Nurse F stated when she received a pharmacy recommendation, she did not sign her name until it was completed in the EMR. She stated she wanted to say that was what she did with R1's recommendation from 12/28/23 but it did not get put in. Administrative Nurse F stated when she received an admission pharmacy recommendation, she printed it off, verified the order with the hospital discharge orders, and made sure the provider did not put a note in not wanting the medication. Once she did that, she put the order in the EMR per the discharge orders, confirmed it in the EMR, signed the recommendation, and put a nurse's note in that it was completed. The facility's "Reconciliation of Medications on Admission/Re-Admission and Monthly Orders" policy, last revised in March 2019, directed medication reconciliation reduced medication errors and enhanced resident safety during the admission/transfer process by identifying the medications the resident needed and	F 756			

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

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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 C 01/30/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
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F 756	Continued From page 13 administering without interruption, the correct dosages and routes. The policy directed the facility used an approved medication reconciliation form or other record to list all medications from the medication history, the discharge summary, the previous MAR, and the admitting orders. The facility reviewed the list carefully to determine if there were any discrepancies, conflicts, or severe drug-to-drug interactions. The facility's "Physician Visits" policy, last revised in April 2013, directed the attending physician performed relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. The facility's "Medication Regimen Review (MRR) Policy," dated July 2018, directed medication regimen reviews were completed upon admission, and completed MRR reports were sent to the medical director, director of clinical services, and healthcare provider to review the recommendations. The facility failed to address the admission medication regimen review for R1 when the CP found irregularities with her admission orders. This deficient practice had the risk for unwarranted physical complications and unnecessary medication use for R1.	F 756			