

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE ROSEHILL		STREET ADDRESS, CITY, STATE, ZIP CODE 12802 JOHNSON DRIVE SHAWNEE, KS 66216		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 184289, 186905, 186985, 189374, 191441 at the above named assisted living facility conducted on 11/18/24 and 11/19/24.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of 36 residents with three residents included in the sample and two closed record reviews. Based on observation, interview, and record review the administrator failed to ensure designated staff completed a Functional Capacity Screen (FCS) for Resident (R) 2 after a significant change of condition. Findings included: - Record review for R2 revealed admission date of 07/16/24 with diagnoses of anxiety, transient cerebral ischemic attack, and atrial fibrillation.	S3081		

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

TITLE

(X6) DATE

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S3081	Continued From page 1 The 07/16/24 (most recent) FCS identified R2 was independent with dressing, toileting, transferring, walking, and eating; supervision was needed with bathing; physical assistance was needed for management of medications and treatments; and had no cognitive or communication difficulties. The 10/15/24 "Personal Service Plan" [the facility's combined Negotiated Service Agreement and Healthcare Service Plan (NSA/HSP)] identified facility clinical staff would order, administer and store all R2's medications; provide physical assistance with washing upper and lower body and shampooing hair; provide physical assistance with putting on and taking off clothing; assistance with toileting tasks; physical assistance with mobility; and encouragement in program participation to increase observation. The NSA/HSP identified that R2 had fallen with fall management plan in place. R2's record lacked evidence of an FCS completed upon readmission from a hospital stay and a significant change in condition. Observation of R2 on 11/19/24 at 12:58 PM revealed facility staff provided physical assistance and cues to reposition resident in recliner and then further assisted resident to eat lunch meal. Interview on 11/19/24 at 11:36 AM of Administrative Nurse B revealed R2 was admitted to the hospital and returned on 10/15/24. Administrative Nurse B confirmed an FCS was not completed upon a significant change in condition when the resident was readmitted from the hospital and hospice services commenced. Interview on 11/19/24 at approximately 01:05 PM	S3081		

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S3081	Continued From page 2 of Certified Medication Aide (CMA) G revealed R2 had to "be fed more times than not since hospitalization." CMA G stated that staff now has to dress and bathe R2. The administrator failed to ensure designated staff completed an FCS for R2 after a significant change in condition.	S3081		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 36 residents with three residents included in the sample and two closed record reviews. Based on observation, interview, and record review the administrator failed to ensure designated facility staff ensured the "Functional Capacity Screen" (FCS) for Resident (R) 3 accurately reflected her functional capacity for impaired hearing, bladder incontinence, management of medications, and falls or unsteadiness. Findings included: - Record review for R3 revealed an admission date of 08/19/24 with diagnoses of cerebral infarction, muscle weakness, dysphagia, heart failure and acute respiratory failure with hypoxia.	S3082		

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S3082	Continued From page 3 The 08/19/24 FCS failed to identify R3 was at risk of falls or had impaired hearing. The FCS stated she was independent with management of medications and identified her as continent of bladder. The 09/23/24 "Personal Service Plan" (the facility's combined Negotiated Service Agreement and Healthcare Service Plan) identified R3 as heightened fall risk with fall precautions; was incontinent of bladder; facility's clinical staff ordered, stored and administered medications; and failed to provide services for impaired hearing. Review of October 2024 and November 2024 medication administration records revealed facility staff documented administration of all ordered medications. Review of progress notes revealed a "General Progress Note" by Licensed Nurse (LN) H on 09/21/24 at 12:22 PM that stated R3's ears were both flushed and R3 stated "seems better" but that the LN noted R3 was hard of hearing at baseline. On 11/19/24 at 02:45 PM R3 stated she had difficulty with hearing. She stated that without wax build-up she has difficulty hearing people, and it was more difficult to hear when in a group. On 11/19/24 at approximately 11:39 AM Administrative Nurse B confirmed R3's FCS failed to identify R3 needed physical assistance with management of medications and that she was occasionally incontinent of bladder. The administrator failed to ensure designated	S3082		

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S3082	Continued From page 4 facility staff ensured the FCS for R3 accurately reflected her functional capacity for impaired hearing, bladder incontinence, management of medications, and falls or unsteadiness.	S3082		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 36 residents with three residents included in the sample and two closed chart reviews. Based on record review and interview the administrator failed to ensure the Negotiated Service Agreement (NSA) for all residents listed the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSP). Findings included: - Record review for Resident (R)1, R2, and R3 revealed the NSAs failed to name the licensed nurse responsible for implementing and supervising the HSPs. Review of personnel hired since last survey provided by facility reveals Administrative Staff B was hired 04/09/23 as "Health and Wellness Director."	S3165		

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S3165	Continued From page 5 On 11/18/24 at 11:01 AM Administrative Nurse B confirmed she had not seen or documented anywhere within the NSAs that she was the licensed nurse responsible for the HSPs since her hire date. On 11/18/24 at 11:03 AM Administrative Staff B confirmed R1, R2 and R3's NSAs did not list the licensed nurse responsible for the HSPs, stating that all residents' NSAs do not identify licensed nurse responsible for the HSPs. The administrator failed to ensure all residents' NSAs named the licensed nurse responsible for implementing and supervising their HSPs.	S3165		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3)	S3211		

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S3211	Continued From page 6 The facility reported a census of 36 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of nine over-the-counter (OTC) medications in the medication carts. Findings included: - Observation on 11/18/24 at 12:50 PM revealed the cabinets in the pharmacy room contained the following OTC medications were not labeled with residents' full names: One tube Voltaren gel, 5.29 ounces One bottle miconazole powder 2%, 65 grams One tube vitamin A&D ointment, 4 ounces On 11/18/24 at approximately 12:54 PM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names. - Observation on 11/18/24 at 01:02 PM revealed the second floor medication cart contained the following OTC medications were not labeled with resident's full names: One bottle aspirin 81 milligram (mg), 120 tablets Two boxes omeprazole 20mg, 14 tablets One bottle dimenhydrinate 50mg, 100 tablets On 11/18/24 at approximately 01:06 PM Administrative Nurse B confirmed the OTC medications were not labeled with resident's full names. - Observation on 11/18/24 at 01:15 PM revealed	S3211		

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S3211	Continued From page 7 the first floor medication cart contained the following OTC medications were not labeled with residents' full names: One bottle acetaminophen 325mg, 100 tablets One container Blue-emu super strength topical cream, 12 ounces On 11/18/24 at approximately 03:07 PM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names. A policy regarding labeling of medications was requested on 11/18/24 at 04:34 PM which the facility failed to provide. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of nine OTC medications.	S3211		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart.	S3215		

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S3215	Continued From page 8 Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 36 residents. Based on observation and interview the administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations. Findings included: - Observation on 11/18/24 at 01:24 PM revealed the pharmacy had a refrigerator with an opened box that contained an unsealed vial of tuberculin. The vial was dated as opened 08/03/24. The box and the vial of Tuberculin contained instructions that a vial of tuberculin which had been opened for 30 days should be discarded.	S3215		

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S3215	Continued From page 9 On 11/18/24 at approximately 01:24 PM Certified Medication Aide E confirmed the tuberculin vial was opened and dated 08/03/24. The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 36 residents. Based on interview and record review the administrator failed to provide evidence of documentation quarterly reviews of the facility's	S3280		

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S3280	Continued From page 10 emergency management plan were completed with all residents and staff. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with all residents and staff since the last survey. On 11/19/24 at approximately 04:39 PM Staff D confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with all residents. On 11/19/24 at approximately 04:41 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff. The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and	S3310		

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S3310	Continued From page 11 (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 36 residents with three residents included in the sample and two closed record reviews. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for six residents and one staff. Findings included: - Review of resident census revealed Resident (R) 6 was admitted 10/04/24, R7 on 08/30/24, R8 on 10/22/24, R9 on 10/26/24, and R10 on 10/08/24. Records were requested 11/19/24 at 11:17 AM for TB two-step tests (TST) for residents admitted since 08/04/24 due to tuberculin opened on that date. On 11/19/24 at approximately 03:49 PM Administrative Staff A confirmed R6, R7, R8, R9, and R10's TST were not completed. - Record review for R2 revealed admission date of 07/16/24 with diagnoses of anxiety, transient cerebral ischemic attack, and atrial fibrillation.	S3310		

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S3310	Continued From page 12 The 08/21/24 (36 days after admission) first step of the two-step TB skin test for R2 was negative. R2's record lacked evidence of documentation an initial TB skin test was administered within seven days of residency. On 11/19/24 at approximately 11:35 AM Administrative Staff B confirmed R2's initial TB skin test was not administered within seven days of residency. - Review of Licensed Nurse (LN) F's employee record revealed a hire date of 05/15/24. The first Mantoux skin test was "Date Given" on 05/18/24 and read 05/20/24. The second TST was administered on 05/21/24 (next day after first step read). On 11/18/24 at approximately 03:58 PM Administrative Staff B confirmed LN F's second step of TST was not completed one to three weeks after first step. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test within seven days of employment or admission and after a negative first step, the second TST shall be administered with one to three weeks. The facility's "Tuberculosis Screening/Testing Policy - Residents" policy last revised 10/2024 stated testing should be performed within one week of admission or per state regulation. The administrator failed to ensure the facility	S3310		

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S3310	Continued From page 13 remained in compliance with the state department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 36 residents. Based on observation and interview the administrator failed to ensure the facility was	S3320		

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S3320	Continued From page 14 maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 11/18/24 at 01:28 PM of the basement revealed a propped open door to storage room that contained seven bottles of 32 fluid ounce lemon-ese cleaner with labels that said "Keep out of reach of children." On 11/18/24 at approximately 01:33 PM Maintenance Staff E confirmed chemicals were not stored in a locked area. - Observation on 11/18/24 at 01:58 PM of the unlocked spa room revealed a housekeeping cart which was stored unlocked with the following chemicals located inside: Two spray bottles Ecolab peroxide multi surface cleaner and disinfectant One aerosol can Ecolab Radiance furniture polish, 17 ounce One bottle lemon-eze bathroom crème cleaner, 32 fluid ounces One aerosol can stainless steel cleaner and polish, 17 ounces One aerosol can boardwalk stainless steel cleaner, 18 ounces One spray bottle Ecolab ZephAir citrus cucumber odor remover, 32 fluid ounces On 11/18/24 at approximately 02:08 PM Administrative Nurse B confirmed chemicals were not stored in a locked area. - Observation on 11/19/24 at 10:18 AM of the front desk area revealed an unlocked cabinet with	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/19/2024
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S3320	Continued From page 15 one aerosol can of Endust, 15.5 ounces with label that said, "Keep out of reach of children." On 11/19/24 at approximately 05:05 PM Administrative Nurse B confirmed chemical was not stored in a locked area. The facility's "Operations/Environmental Services" manual dated December 2023 documented all housekeeping carts should always be locked when unattended and all supply closets that store chemicals should be locked when not in use. The administrator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		