

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/31/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE SHAWNEE		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 W 65TH STREET SHAWNEE, KS 66203		
(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints 199494, 199427, 199428, 199201, 198717, 198279, 198244, and 197470 at the above named assisted living conducted on 08/26/26 and 08/31/26. The facility reported a census of 50 residents. The sample included five residents.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) Based on observation, interview, and record review, the facility failed to protect Resident (R) 5 from neglect by the failure to ensure facility staff provided R5 adequate supervision when she was able to wander away from an outside activity without staff knowledge on 07/04/26. She was found in a nearby hospital by police. This placed R5 in Immediate Jeopardy. Findings included:	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 - Record review for R5 revealed an admission date of 10/14/25 with a diagnosis of dementia. The 05/22/26 (most recent) "Functional Capacity Screen" (FCS) documented R5 was independent with transfers and walking/mobility. She had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 05/21/26 (before incident) "Negotiated Service Agreement" (NSA) identified R5 ambulated independently without a device and received staff attention and/or verbal prompts to and from the dining room and community activities as needed due to memory impairment. The 07/23/26 (after incident) "NSA" identified R5 received outdoor activities within the secured courtyard so she could re-enter the building as she desired. The 07/04/26 at 03:00 PM "Alert Charting Note" by Licensed Practical Nurse (LPN) D documented a Certified Nurse Aide (CNA) reported around 12:15 PM staff were unable to locate R5. R5 remained missing at 01:14 PM when facility staff notified emergency services. Police found R5 at a nearby hospital. The facility's undated investigation of the incident documented on 07/04/26, R5 participated in an activity on the front, unsecured porch of the facility with a group of residents and two staff members. At approximately 12:45 PM, facility staff realized R5 was missing. Police officers arrived to the facility and went to the hospital with a facility staff member. Hospital staff reported a concerned stranger found R5 near a busy intersection, picked her up, and took her to the	S3026		

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S3026	Continued From page 2 hospital. The 07/10/26 notarized "Witness Statement" by support staff F reported she saw residents going outside between 10:45 AM and 11:00 AM. She helped hold the door and stayed outside with the residents while activities staff G went back inside to assist other residents to attend the outdoor activity. The 07/10/26 notarized "Witness Statement" by CNA E reported he saw R5 around 11:15 AM sitting outside in a chair by a table by the facility's front door. Review of notarized witness statements by staff present during the incident revealed 11:15 AM was the last time R5 was visualized by facility staff before she went missing. On 08/26/26 at 09:43 AM, Administrative Staff A stated R5 left while she sat outside on the facility's front porch with other residents participating in an activity on 07/04/26. There were two staff with residents going in and out the front door with a potential of 10-12 residents present on the front porch at a time. R5 was able to walk away from the activity without staff noticing. R5's family reported R5 was viewed on local businesses' security cameras near a busy street north of the facility. The hospital logged R5 left the waiting room and went to an exam room at 12:32 PM, which was one hour and 17 minutes from the time staff last saw R5. Observation on 08/26/26 at 11:54 AM revealed R5 ambulated independently without any assistive devices in the common area and sat down in a chair at a dining table. She stated her name clearly when asked by the state surveyor. She	S3026		

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S3026	Continued From page 3 smiled, nodded her head, and chatted with unintelligible speech. Observation on 08/26/26 at 03:16 PM revealed the front door of the facility was on the northeast end of the porch with railing along the southeast side with tables and chairs on the porch. Opposite the front door was the southwest end of the porch that opened to the right, straight ahead, or to the left. To the right was 90-degree turn around an outside corner wall obstructing the view to another section of the porch that had outdoor sofas and chairs. Straight ahead led to a sidewalk edging the parking lot with a small yard that had flower beds and tall trees. The left end of the porch opened to the parking lot on the south side of the building. On 08/26/26 at approximately 03:16 PM Administrative Staff A stated during the outdoor activity on 07/04/26 the front door to the facility was propped open so residents could enter or exit as they desired. The front desk concierge sat near the door outside. The inner door between the foyer and the main part of the facility remained closed and secured. If residents wanted to go through the secured door from the foyer into the main part of the facility, the front desk concierge got up from where she sat outside, went inside the foyer, and opened the door. The weather on 07/04/26 according to Wunderground.com was 74 degrees Fahrenheit (F) with a wind speed of six miles per hour (mph) at 11:54 AM near the time R5 wandered away from an activity. According to the Google.com/maps website accessed on 09/01/26, a possible route taken by	S3026		

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S3026	Continued From page 4 R5 revealed it was approximately 0.5 miles from the front porch of the facility to where R5 was possibly picked up by a concerned stranger. The area had an intersection controlled by traffic lights. The north/south street had four lanes with a speed limit of 35 mph. The east/west street had six lanes with a center median and turning lanes with a speed limit of 45 mph. There was a frontage road on the north and south sides of the street with an additional 2 lanes each. The surrounding area had a shopping center, car dealership, fast food restaurants, a multi-building apartment complex, and large parking lots. The facility's 03/2026 "Missing Resident Policy" documented a missing resident required immediate attention by facility staff. A visual observation of the missing resident confirmed the resident had been found. The Immediate Jeopardy was removed on 07/06/26 when the following actions documented by the facility in their Removal Plan were implemented and accepted by the department on 08/27/26 at 12:42 PM. 1) The facility immediately ceased activities outside of secured areas. 2) Outside activities would be held in secured courtyards. 3) Upon request, small groups of residents (no larger than 3 residents at a time) could participate in outdoor activities outside of the secured courtyard accompanied by one staff and following the "Resident Outings Policy." 4) On 07/06/26 staff received training in conducting outdoor activities in the secured courtyards and unsecured areas. 5) On 07/06/26 staff received elopement drill and missing resident process training. 6) The administrator was responsible for	S3026		

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S3026	Continued From page 5 follow-up monitoring and would review the "Resident Outings Form" after outside activities were held in unsecured areas for a period of three months to verify compliance.	S3026		
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)(2) Based on interview and record review the facility failed to complete a "Functional Capacity Screen" (FCS) for Resident (R) 5 following a significant change when she wandered away from an outside activity without staff knowledge on 07/04/26. Findings included: - Record review for R5 revealed an admission date of 10/14/25 with a diagnosis of dementia. The 05/22/26 (most recent) "FCS" documented R5 was independent with transfers and walking/mobility. She had short-term and	S3081		

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S3081	Continued From page 6 long-term memory, memory/recall, and decision-making cognitive difficulties. The 05/21/26 (before incident) "Negotiated Service Agreement" (NSA) identified R5 ambulated independently without a device and received staff attention and/or verbal prompts to and from the dining room and community activities as needed due to memory impairment. The 07/23/26 (after incident) "NSA" identified R5 received outdoor activities within the secured courtyard so she could re-enter the building as she desired. The 07/04/26 at 03:00 PM "Alert Charting Note" by Licensed Practical Nurse (LPN) D documented a Certified Nurse Aide (CNA) reported around 12:15 PM staff were unable to locate R5. R5 remained missing at 01:14 PM when facility staff notified emergency services. Police found R5 at a nearby hospital. Review of R5's record lacked of evidence of documentation of an "FCS" following a significant change. On 08/31/26 at 05:23 PM Administrative Staff A confirmed R5's record lacked evidence of documentation of an "FCS" completed after a significant change when she wandered away from an outside activity without staff knowledge on 07/04/26. The facility's 11/2022 "Resident Functional Capacity Screen" policy documented a functional capacity screen would be conducted following a significant change in a resident's physical, mental, or psychosocial functioning.	S3081		

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S3081	Continued From page 7 The facility failed to complete an "FCS" for R5 following a significant change when she wandered away from an outside activity without staff knowledge on 07/04/26.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(2) Based on observation, interview, and record review the facility failed to complete a "Negotiated Service Agreement" (NSA) for Resident (R) 5 following a significant change. Findings included: - Record review for R5 revealed an admission date of 10/14/25 with a diagnosis of dementia.	S3092		

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S3092	Continued From page 8 The 05/22/26 (most recent) "FCS" documented R5 was independent with transfers and walking/mobility. She had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 05/21/26 (before incident) "Negotiated Service Agreement" (NSA) identified R5 ambulated independently without a device and received staff attention and/or verbal prompts to and from the dining room and community activities as needed due to memory impairment. The 07/23/26 (19 days after incident) "NSA" identified R5 received outdoor activities within the secured courtyard so she could re-enter the building as she desired. The 07/04/26 at 03:00 PM "Alert Charting Note" by Licensed Practical Nurse (LPN) D documented a Certified Nurse Aide (CNA) reported around 12:15 PM staff were unable to locate R5. R5 remained missing at 01:14 PM when facility staff notified emergency services. Police found R5 at a nearby hospital. Review of R5's record lacked evidence of documentation of an "NSA" following a significant change until 19 days after the change. On 08/26/26 at 10:06 AM Administrative Nurse C stated the "NSA" and "Healthcare Service Plan" were combined into one document. On 08/31/26 at approximately 04:50 PM Administrative Staff A stated the facility's document named "Personal Service Plan" was also the facility's "NSA." On 08/31/26 at 05:23 PM Administrative Staff A	S3092		

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S3092	Continued From page 9 confirmed R5's record lacked evidence of documentation of an "NSA" completed after a significant change until 19 days after the change when she wandered away from an outside activity without staff knowledge on 07/04/26. The 03/2026 "Service Plan Process Policy" documented the service plan would be reviewed and updated following a change in condition. The facility failed to complete a "NSA" for R5 following a significant change.	S3092		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident 's negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202(i) Based on interview and record review the facility failed to Resident (R) 1 received the services described in his "Negotiated Service Agreement" (NSA) for cognitive difficulties. Findings included: - Record review for R1 revealed an admission date of 09/25/25 with diagnoses of dementia and history of falling. The 10/10/25 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with toileting, transfers, and walking/mobility. He had	S3102		

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S3102	Continued From page 10 short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. R1 was marked at risk for falls. The 10/06/25 "NSA" identified R1 received assistance from one staff to assist with clothing, perineal hygiene and transferring on and off the toilet. He took himself to the bathroom at times without assistance. He received reminders throughout the day for cognitive difficulties. He had a history of falling at home, was non-compliant with using an assistive device, and had a history of hypotension. He received encouragement and reminders to use an assistive device. The "NSA" failed to describe the services R1 received for transfers and walking/mobility. The 10/06/25 "NSA" documented the following interventions under the sections titled "Cognitive/Psychosocial" and "Reluctance to Accept Care:" - Use the Positive Physical Approach (go slow, make eye contact, get down low). - Use preferred name, calm and gentle voice and yes/no questions. - Respect and acknowledge the resident's reality and avoid attempts to argue or reason. - Avoid statements and/or interactions that may embarrass or shame the resident (reacting with shock, scolding, parental tone). The 10/12/25 at approximately 01:57 PM video footage provided by an unidentified family member revealed R1 was alone in his apartment and attempted to ambulate from his bathroom. R1 held onto the doorknob of the bathroom door with his left hand and his right hand was against the door frame when he fell backwards and	S3102			

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S3102	Continued From page 11 landed on the floor with his upper body in the bathroom and his feet near the bathroom door. R1 called out for help. At 02:07 PM (10 minutes after falling) Certified Medication Aide (CMA) I and Certified Nurse Aide (CNA) K entered R1's apartment and approached R1. CMA I stood near R1's feet and said "Are you freaking kidding me?" R1 continued to call out "Help, somebody help. Pull me up" and reached his hand out toward CMA I. CMA I said loudly "[R1] what are you doing" while she continued to stand. CNA K asked "Does he do this often?" CMA I replied "yes, every day. Twice a day. Everyday." R1 kicked his feet against the bathroom door. CMA I said loudly "Hey [R1] stop! [R1] stop! Stop, stop! You're not dying. We're going to call 911. Is your hip hurting? Do you need to go to the hospital?" At 02:10 PM CNA J entered into view of the video camera. CMA I said "Twice a day, three times a day, every day." CMA I and CNA J assisted R1 off the floor into a wheelchair. CMA I reacted with shock, scolded, and spoke in a parental tone to R1 while he lay on the floor asking for help. At no time during the video did staff get down low near R1, speak slowly in a calm, gentle voice, treat R1 with respect, or avoid embarrassing or shameful interactions with him per his "NSA." On 08/31/26 at approximately 04:50 PM Administrative Staff A confirmed R1 did not receive the services described in his "NSA" by direct-care staff. The 03/2026 facility's "Service Plan Process Policy" did not address residents receiving the services described in their "NSA's." The facility failed to Resident (R) 1 received the	S3102		

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S3102	Continued From page 12 services described in his "Negotiated Service Agreement" (NSA) for cognitive difficulties.	S3102			
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) Based on observation and interview the facility failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of five over-the-counter (OTC) medications. Findings included: - Observation on 08/26/26 at 10:42 AM revealed Certified Medication Aide (CMA) H unlocked and opened the A-hall medication cart. The following OTC medications lacked residents' full names:	S3211			

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S3211	Continued From page 13 One bottle of acetaminophen 500 milligrams (mg), 225 gelcaps One bottle of Bayer aspirin 81 mg, 300 tablets One bottle of vitamin C 1000 mg, 500 tablets One bottle of eye health complex , 140 softgels One bottle of vitamin B-12 1000 micrograms (mcg) 90 softgels On 08/26/26 at approximately 10:42 AM CMA H confirmed five medications lacked residents' full names. The 05/2025 facility's "Medication Administration" policy did not address labeling OTC medications with residents' full names. The facility failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of OTC medications.	S3211		