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

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE ROSEHILL	12802 JOHNSON DRIVE SHAWNEE, KS 66216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72. The sample included 21 residents. Based on observation, record reviews, and interviews, the facility failed to ensure Resident (R) 101 received the necessary care and services to maintain his highest practicable level of health and hygiene Findings included: - The [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R101's Brief Interview for Mental Status (BIMS) score was six. R101 required extensive one-person physical assistance with personal hygiene, toileting, and dressing. R101 required total assistance of one-person with bathing. R101 required supervision with one-person physical assistance with eating. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 03/23/2020 revealed resident required total assistance of up to two staff for bathing. R101 needed supervision and occasionally more assistance with eating during the assessment period related to eating not initiated. The Nutritional Status CAA dated 03/23/2020 revealed R101 had an increased risk for malnutrition and dehydration. R101 was on a puree diet due to swallow safety and coughed at meals which increased his risk of poor intake. The Care Plan initiated 03/17/2020 revealed R101 had a decline in his ADLs from his previous level of function due to recent hospitalization , after a fall with left [MEDICAL CONDITION]. The care plan directed staff to offer bathing assistance Wednesday and Friday evenings and as needed. The Care Plan initiated 03/18/2020 revealed R101 had a potential for aspiration and dysphagia (difficulty swallowing) and directed staff to supervise or assist R101 with oral intake as needed and needed help feeding. The Task tab of the EMR revealed a task for bathing on Wednesday and Friday. The documentation survey report documented a bed bath was given on 03/18/2020 then no bathing charted for 03/20/2020, 03/25/2020, 03/27/2020, and 04/01/2020. The bathing was charted as activity did not occur on 04/03/2020. The EMR lacked documentation for 23 out of 61 meals during R101's stay at the facility. The Weights/Vitals tab of the EMR revealed a 8.6 pound weight loss during R101's stay at the facility. In an interview on 08/06/2020 at 03:21 PM, Certified Nurse Aide (CNA) N stated tasks are done and documented prior to the end of the shift. If there was a blank on the task report the task was not done. She stated at 04:25 PM the CNAs assigned to that hall charted meal percentages and if they weren't charted then it wasn't done. In an interview on 08/06/2020 at 04:23 PM, Licensed Nurse (LN) I stated the CNAs knew the bathing schedule, if the resident refused then the nurse tried to see why the resident refused and tried to get resident to take a bath. CNAs charted the bathing. In an interview on 08/06/2020 at 02:54 PM, Administrative Nurse D stated she was not sure what a blank on the tasks meant. She stated bathing, eating, pain, skin issues showed up on the nurse's dashboard so if something was not charted then the nurse had to chart on it. She stated she reviewed the dashboard every morning to see what showed up and addressed it with the nurse managers. The Activities of Daily Living Care Documentation Policy last revised November 2018 directed ADL care not performed during a shift was reported to the manager on duty and to the incoming associates of the next shift. The facility failed to provide the necessary care and services related to bathing and eating per the care plan to R101. This placed the resident at risk for a decline in health status, hygiene and function.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72 residents. The sample included 21 residents. Based on interviews, observations, and record reviews the facility failed to record the percentages of meals eaten for one of four Residents, (R)44. The facility also failed to record the amount of fluid consumed by one resident (R99) on a fluid restriction for R101 who was to be monitored closely for fluid intake due to dehydration. Findings included: - R44's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The 07/27/20 Admission Minimum Data Set documented a Brief Interview for Mental Status core of 15, which indicated intact cognition. She required limited to extensive staff assistance with her Activities of Daily Living. She had sustained a weight loss of five percent or more in the last month or more than 10 percent in the last six months and was not on a physician prescribed weight loss program. She held food in her mouth at times. The 07/29/20 Nutritional Status Care Area Assessment documented R44 had a weight loss of 8.9 percent since her admission on 07/21/20. She was on a modified textured diet to ensure safe swallowing. The Care Plan revised on 07/31/20 documented R44 was on a modified textured diet and had a weight loss of 8.9% since admission. The staff assisted in meeting her extensive food preferences. Nutritional supplements had been added to her medications. The Nutrition Risk Review on 07/27/20 documented R44 was very particular on the food she liked, and the staff worked with her to get as many types of food as she wanted. The EMR documented R44 weighed 127.8 pounds on 07/21/20 and 112.6 pounds on 08/05/20 The EMR lacked documentation for the percentages of meals eaten for: Two of three meals on 07/23/20 and 07/24/20, 07/27/20, 07/29/20, 07/30/20, 08/01/20 and 08/04/20. One of three meals on 07/25/20. Three of three meals on 07/26/20, 08/02/20, and 08/03/20. On 08/05/20 at 07:30 AM R44 sat in her room as she watched television. She stated she had little appetite in the last few months but, thought it was improving. She used to like cheese but had lost her taste for it. She didn't like meat unless it was in goulash. She never liked eggs before but, she did like the facility's poached eggs. On 08/05/20 at 12:30 PM R44 ate lunch in the dining room. She was not noted to have trouble chewing or swallowing. She asked for several extra food items which the staff brought to her. On 08/06/20 at 01:45 PM Certified Nurse Aide (CNA) M stated the CNAs documented the percentages of meals eaten on everyone. On 08/06/20 at 02:00 PM Licensed Nurse H stated the CNAs documented the percentages of meals eaten by the residents. On 08/06/20 at 02:31 PM Administrative Nurse D stated meal percentages eaten are documented by the CNAs and are cross checked by the nurses. The facility's Routine Clinical Documentation policy dated January 2018 documented all services routinely provided to the resident are documented in the resident's record The CNAs documented the amount eaten by the residents. The facility failed to ensure the percentages of meals eaten by R44. This failure had the potential for the inability of the facility staff to properly evaluate the reason for her substantial weight loss. - R99's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The EMR documented an admission date of [DATE]. The Care Plan dated 08/04/20 documented R99 was on a 2,000 milliliter per day fluid restriction. The EMR documented an order for [REDACTED]. On 08/05/20 at 09:42 AM R99 sat upright in his bed. He became short of air with his speech. He stated he felt short of air when he did anything. On 08/06/20 at 01:45 PM Certified Nurse Aide M stated fluid restrictions are broken down to the amount given for each meal in the Tasks function of the EMRs. There is also a chart which indicated the amount of fluid in each type of glass provided by the facility. Each staff member was responsible for the documentation of the amount of fluid they noted the resident drank. On 08/05/20 at 02:00 Licensed Nurse H stated fluid restrictions were noted on the residents' Medication/Treatment Administration Record (MAR/TAR). She asked the CNAs how much fluid the resident received which she added to the amount she gave the resident, prior to the daily prior to the daily total documented. On 08/06/20 at 02:31 PM Administrative Nurse D stated the dietician broke down the amount of fluid a resident, on a fluid restriction, received throughout the day. On 08/06/20 at 03:39 PM Administrative Nurse E stated she placed the fluid restrictions in a resident's

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

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

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) care plan and on the MAR/TAR when an order was received. The facility's Fluid Restriction Policy dated October 2015 documented fluid intake was documented in the EMR. The facility failed to document the fluids R99 consumed. This had the potential for unwarranted side effects from possible fluid overload or dehydration. - The [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE] revealed R101's Brief Interview for Mental Status (BIMS) score was six, which indicated severely impaired cognition. R101 required supervision with one-person physical assist with eating. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 03/23/2020 revealed R101 required supervision and occasionally more assistance with eating. The Nutritional Status CAA dated 03/23/2020 revealed R101 had an increased risk for malnutrition and dehydration. The Care Plan initiated 03/18/20 directed staff to encourage good nutrition and hydration in order to promote healthier skin. The Task tab of the EMR directed staff to offer fluids three times a day. The documentation survey report revealed 28 scheduled fluid times were not documented and there were 12 fluid times documented as not offered. In an interview on 08/06/2020 at 09:41 PM, Anonymous reporter TT stated a family member of R101 reported to her that when resident discharged from facility, he smelled, was dirty, had food in his beard, wasn't shaved, hair was greasy, and had significant weight loss. Upon review of lab results from hospital admission on 04/08/2020 provided by Anonymous reporter TT, R101 had BUN 31, creatinine 1.3, lactic acid 6.2. Anonymous reporter TT reported R101 was admitted to hospital on [DATE] with urinary tract infection (infection in any part of your urinary system including kidneys, ureters, bladder, and urethra) and pneumonia (inflammation of the lungs). In an interview on 08/06/2020 at 02:54 PM, Administrative Nurse D stated she expected staff to chart fluids weren't offered if they weren't. She stated she expected staff to offer fluids during usual cares and if the resident that normally accepts fluids, declines then she expected staff to assess why they refused for possible change. In an interview on 08/06/2020 at 04:23 PM, Licensed Nurse (LN) I stated residents were given fresh ice water every shift. He stated the CNAs have a report sheet that showed resident's fluid preferences and if they were thickened liquids. In an interview on 08/06/2020 at 04:25 PM, Certified Nurse Aide (CNA) N stated residents are offered fluids a few times throughout the shift unless on a fluid restriction. She stated she took cups of water to the resident's room to offer fluids. The Hydration Program Policy last revised October 2019 documented residents should drink at least eight to ten eight-ounce glasses of total fluids each day, at least four of the total eight to ten glasses should be water. The facility failed to offer fluids and document fluid intake for R101 which had the potential for unwarranted physical complications due to decreased fluid intake.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 72 residents. The sample included 21 residents. Based on record reviews and interviews, the facility failed to prevent a significant medication error when they failed to transcribe and administer [MEDICATION NAME] (a medication used to treat a rapid, irregular heartbeat) for Resident (R) 100. Findings included: - R100's signed physician's orders [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented R100 required extensive assistance of one to two staff for all activities of daily living. The MDS documented R100 had a Brief Interview for Mental Status (BIMS) score of six, indicating moderately impaired cognition. The [MEDICATION NAME] Care Plan, dated 04/13/20, documented R100 would be free from signs/symptoms or complications of cardiac problems and instructed staff to administer medications as ordered. Review of R100's Electronic Health Record, dated 04/11/20 at 04:30 PM, documented R100 returned from the hospital. The POS, dated 04/11/20, instructed staff to administer [MEDICATION NAME] 0.125 micrograms (mcgs,) one tablet, by mouth, one time daily, for [MEDICAL CONDITION]. The POS instructed staff to hold the medication for a heart rate below 60 beats per minute (BPM). Review of R100's Medication Administration Record [REDACTED]. On 04/20/20 at 03:28 PM, the MAR indicated [REDACTED]. The Physician's Progress Note dated 04/22/20 at 05:00 PM, documented R100 reported he did not feel well. On 08/05/20 at 09:30 AM, LN J stated each charge nurse was responsible for transcribing admission or readmission orders [REDACTED]. Administrative Nurse D stated staff education was completed and a nurse manager was responsible for the safety measures currently in place. On 08/05/20 at 04:48 PM, Consultant GG stated R100's cause of death, listed on the death certificate, was [MEDICAL CONDITION]. The facility's Medical Management Overview - Med One policy, dated 03/2019, documented the facility would administer medications as prescribed by the health care provider. The facility failed to administer [MEDICATION NAME] as prescribed by the health care provider placing R100 at risk for adverse reactions related to medication omission.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 72. The sample included 21 residents. Based on observation and interview the facility failed to ensure insulin pens (medication that regulated the amount of sugar in the blood) were properly dated in two of five medication carts. Findings included: - On 08/04/20 at 09:19 AM, on initial tour, observation of 100 Hall medication cart revealed two [MEDICATION NAME] pens (long acting insulin), one [MEDICATION NAME]pen (long acting insulin that worked several hours after administration) undated when opened and two [MEDICATION NAME] (insulin that worked 15 minutes after injection) with no resident name or opened date. On 08/04/20 at 09:19 AM, observation of 200 Hall medication cart revealed one [MEDICATION NAME] pen and one [MEDICATION NAME] pen not dated when opened. A review of the manufacturer's instructions for [MEDICATION NAME]at https://fda.gov documented [MEDICATION NAME]should be discarded 28 days after opening, [MEDICATION NAME] discarded 28 days after opening, and [MEDICATION NAME]discarded 42 days after opening. On 08/04/20 at 09:20 AM, Licensed Nurse (LN) G stated nursing staff would normally date insulin pens when opened and the two [MEDICATION NAME] pens contained no resident names or opened dates. On 08/06/20 at 02:43 PM, Administrative Nurse D stated she would expect insulin pens to be labeled with the resident's name and dated upon opening. The facility's Medication and Treatment - Storage policy, dated 10/2018, documented medications would be stored in accordance with the manufacturers' and states' regulations. The facility failed to properly label and store insulin pens. This deficient practice placed residents at risk for decreased medication effectiveness.