STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175478	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 75 residents. The sample included 18 residents, with two residents sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2's plate guard was applied to his breakfast plate.Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), 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), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of ten, which indicated moderately impaired cognition. The MDS documented R2 had an impairment on one side of his upper body. The MDS documented R2 needed supervision or touching assistance with eating.The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 09/04/25 documented R2 had a decline with activities of daily living (ADL) due to a significant change due to falls with injury. R2's CAA documented due to the progression of R2 disease therapy was to start training on wheelchair therapy. The CAA documented R2 received speech therapy for oropharyngeal dysphagia (difficulty starting a swallow, involving problems moving food/liquid from the mouth to the esophagus), where the long-term goal was to improve swallow abilities to independence, modified independence.R2's Care Plan documented the following interventions:07/14/25 - Encourage swallow strategies/ positions, small bites, small sips, and slow rate of oral intake.10/30/25 - Encourage R2 to use and set up the plate guard at meals.12/01/25 - Diet as ordered.On 12/08/25 at 08:37 AM, R2 sat at the dining room table. R2 had his breakfast tray with a fried egg. R2 was cutting up the egg. R2's egg was sliding on his plate. R2 did not have a plate guard. On 12/10/25 at 10:04 AM, Licensed Nurse (LN) I stated the plate guard was something new for R2. The LN I stated there was a process to ensure R2 had his plate guard. She stated the dietary ticket should state plate guard, the staff member taking R2's tray should do a second check, and nursing staff should be monitoring to ensure the plate guard was in place. On 12/10/25 at 10:37 AM, Administrative Nurse D stated R2's plate guard should be on his meal ticket. She stated nursing staff would ensure the plate guard was in place. The facility did not provide a policy for adaptive equipment, as requested on 12/10/25.

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. The facility identified a census of 75 residents. The sample included 18 residents, with five residents reviewed for medication administration. Based on observation, record review, and interviews, the facility failed to meet professional standards when staff failed to administer Resident (R) 21's medication.Findings included:- R21's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- elevated blood pressure), falls, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (a progressive mental disorder characterized by failing memory and confusion).R21's Quarterly Minimum Data Set (MDS) dated 11/05/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severely impaired cognition. The MDS documented R21 was dependent on staff assistance for all activities of daily living (ADL) except eating, which R21 needed supervision of touching assistance from staff.R21's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 12/23/24 documented R21 received therapy service and had opted for hospice services due to his comorbidities. R21 had dementia and other debilities that impaired his ability to perform ADLs. R21 had a history of falls, and the nursing staff were to monitor him and initiate interventions as needed.R21's Care Plan documented the following interventions:10/21/24 - Nursing staff to give R21's medications as ordered by the physician and monitor side effects and effectiveness.12/18/24 - Staff to observe R21 closely for signs of pain and administer pain medications as ordered.R21's EMR under physicians' Orders lacked an order related to self-administration medication.On 12/08/25 at 07:22 AM, mediation in a clear cup sat on R21's overhead table in his doorway. There was no nursing staff in the area to monitor R21's medication.On 12/08/25 at 07:26 AM, Licensed Nurse (LN) H stated she had stepped away to look at another resident's skin. She stated the process was to ensure medications meant for a resident were given to the resident and not sat down out of her view.On 12/10/25 at 10:04 AM, LN I stated R21 did not have a self-administration assessment and was unable to give himself his medications. LN I stated medication that was not in the nurse's view should be wasted. She stated medication meant for a specific resident should be given to the resident after they are popped.On 12/10/25 at 10:36 AM, Administrative Nurse D stated medication should never be out of the view of the nurse.The facility's Resident Self-Administration of Medication revised 03/2019 documented it was the policy of the facility that those residents who desired to self-administer medication could do so if the review determined the resident was capable.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. The facility identified a census of 75 residents. The sample included 18 residents, with one resident reviewed for tube feeding complications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 8's tube feeding bags were marked with the date, time, and contents in the feeding bag. Findings included:- R8's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of myasthenia gravis (an abnormal condition that causes muscles to tire and weaken easily), muscle weakness, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and need for assistance with personal care.The admission Minimum Data Set (MDS) for R8 dated 11/20/25 recorded a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented supervision or touching assistance from staff for eating. R8's Feeding Tube Care Area Assessment (CAA) dated 11/20/25 documented R8 was admitted to the facility with multiple nutrition related comorbidities. The CAA documented R8 received tube feeding (tube for introducing high-calorie fluids into the stomach) three times a day after his meals, due to R8's consuming less than 25 percent of his meals.R8's Care Plan documented the following feeding tube interventions: 11/15/25 - Enteral tube feeding order every shift, staff to monitor for adverse effects. 11/15/25 - Enteral tube feeding site care, clean area with soap and water, observe for skin breakdown.11/15/25 - Staff to check tube feeding placement before beginning feeding and administration of medication. R8's EMR under the Orders tab documented the following physicians' orders:Give every night shift, tube feeding, and change the enteral feeding bag and tubing, dated 11/14/25.Replace syringe for Flushes, dated 11/14/25.Enteral Feed Order one time a day for nutritional maintenance, continuous feed from 6 PM to 7 AM 40 milliliters (ml)/ hour (hr.) increasing by 20 ml/hr. every 4 hours until the goal of 80 ml/hr. for 12 hours was reached, dated 12/05/25.On 12/09/25 at 09:33 AM, R8's enteral feeding bags were hung on the pole next to R8. R8's bag had water in one bag, and the line to R8's feeding bag had brown colored substance in the feeding tube. R8's bags were not dated with the content, date, time, or the staff initials.On 12/10/25 at 10:04 AM, Licensed Nurse (LN) I stated feeding tube bags should be labeled with content, date, and time. She stated when the feeding bags were hung, the bags should be labeled.On 12/10/25 at 10:37 AM, Administrative Nurse D stated the enteral feeding tube bags should be labeled with the date, time, contents, and the nurse's initials. She stated education would be given to nursing. The facility's Enteral Nutrition revised 09/2025 documented adequate nutritional support enteral nutrition would be provided to residents as ordered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. The facility identified a census of 75 residents. The sample included 18 residents, with six residents reviewed for unnecessary medications. Based on interviews, observation, and record review, the facility failed to ensure dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 10. Findings included:- R10's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of osteoarthrosis (chronic arthritis without inflammation), atrial fibrillation (rapid, irregular heartbeat), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Quarterly Minimum Data Set (MDS) dated 11/13/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R10 had occasional pain during the observation period. R10's Pain Care Area Assessment (CAA) dated 05/14/25 documented after a recent hospitalization R10 required more assistance with the activities of daily living. R10's Care Plan dated 11/05/25 documented:11/05/25 - Staff would administer R10's pain medication as ordered. R10's EMR under the Orders tab revealed the following physician orders: Voltaren external gel (an anti-inflammatory class of medication used to reduce inflammation), one percent (%) (diclofenac sodium) (topical), apply to lower to mid buttocks topically two times a day for pain, dated 2/07/25. The order lacked a dose for administration. On 12/09/25 at 7:52 AM, R10 sat in his wheelchair with his urinary leg strapped to his left leg. R10 propelled his wheelchair from his room and into the hallway. On 12/10/25 at 10:04 AM, Licensed Nurse (LN) I stated every medication required a dosage for administration. LN I stated Voltaren gel needed a dose for administration. LN I stated she would notify the physician to clarify an order that lacked a dose. On 12/10/25 at 10:38 AM, Administrative Nurse D stated she would expect all medication orders would have a dose to be administered as ordered by the physician. Administrative Nurse D stated she would expect the nurse to clarify the medication order with the physician. The facility was unable to provide a policy, as requested on 10/10/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 75 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure linens were stored in a sanitary manner, the facility further failed to ensure Bilevel Positive Airway Pressure (BIPAP- a device that helps with breathing), nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs), and an oxygen cannula were stored in a sanitary container when not in use. The facility further failed to ensure the blood pressure cuff, pulse monitor, and temporal thermometer on a monitoring machine were sanitized after each resident's use. Findings included:- On 12/08/25 at 07:24 AM, an inspection the 400-hallway revealed clean towels placed on a portable toilet outside of empty room [ROOM NUMBER].On 12/08/25 at 07:45 AM, a walkthrough of the secured Long-term Care unit was completed.An inspection of R69's room revealed three bags of soiled linen sat directly on the floor. Two soiled hospital gowns lay directly on the floor next to the bags.An inspection of R22's room revealed clean towels placed directly on the personal protective equipment (PPE) cart outside his room.An inspection of R71's room revealed two clean towels placed on the handrails next to her room's entry door.An inspection of R42's room revealed a clean hospital gown placed on the handrail next to her room's entry door.An inspection of R24's room revealed clean towels placed directly on the counter outside her room. - On 12/08/25 at 09:53 AM, R95's BIPAP, nebulizer, and an oxygen cannula laid unbagged and directly on the bottom of her bedside cabinet. No storage device was noted.On 12/09/25 at 07:27 AM, License Nurse (LN) K obtained R2's blood pressure, temporal temperature, and pulse in the main dining room. LN K did not sanitize the pulse monitor, temporal temperature monitor, or blood pressure cuff before and after R2's use.On 12/10/25 at 10:37 AM, Administrative Nurse D stated all respiratory equipment not in use should be placed in a sanitary bag. She stated she was unsure if the blood pressure cuff, pulse monitor, and temporal temperature monitor should be sanitized between each resident's use. Administrative Nurse D stated she would have to look at the facility's policy. She stated clean linen should not be placed on a Personal Protective Equipment (PPE) cart or on the resident's hall rails. She stated linen should be stored in a sanitary manner. The facility's Laundry and Bedding policy, revised 09/2019, documented laundry and bedding should be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen.The facility's Standard Precautions policy, revised 10/2025, documented standard precautions should be used in the care of residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all bodily fluids except sweat contain transmissible infectious agents. The facility did not provide a policy pertaining to the storage of respiratory equipment when not in use, as requested on 12/10/25.