STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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 citations are the result of a licensure re-survey with attached complaints at the above named assisted living facility in Shawnee, Kansas on 6/6/17, 6/7/17, 6/8/17 and 6/12/17.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (3) The facility reported a census of 50 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1sampled resident (#507) the operator failed to ensure that for allegations of abuse and neglect were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report. Findings included: - Record review for resident #507 recorded admission date of 2/24/16 with diagnoses of: dementia, diabetes mellitus type I, hypertension and constipation. Functional Capacity Screen (FCS) dated 3/1/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and unable to perform management of medications and treatments. Resident has problems with long term memory, short term memory, memory recall and decision making. Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3/1/17 recorded resident to receive staff assistance with bathing dressing, toileting, transfers walk/mobility and management of medications and treatments. Resident log (nurse's notes) dated 5/22/17 at 6:07am recorded the following: "Resident	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3028	Continued From page 2	S3028		

reportedly found on floor at 3:50 this morning laying on side/arms. Resident denied pain, good usual ROM (range of motion) with no c/o (complaint) or signs/symptoms of pain. Ice pack applied to zygomatic (cheek) bone." signed by licensed nurse #D.

Interview on 6/6/17 at 2:10pm with resident noted resident unable to focus and began telling a jumbled story unrelated to the current topic of conversation.

Interview on 6/7/17 with operator #A confirmed resident fall on 5/22/17 at 6:07am was not reported to the department and stated he/she was unable to find an investigation on the incident.

Interview on 6/6/17 at 11:50am with operator #A confirmed a resident to resident incident involving another resident #609, in this resident's room 3 weeks ago. He/she stated a report had been filed with the department. Incident involved the other resident standing by this resident's bed.

Review of investigation by facility recorded the incident occurred on 5/5/17 at 10:45pm.

Confidential interview on 6/7/17 at 7:00pm with certified staff #E reported he/she recorded a written statement and submitted it to the facility regarding the incident. Facility later called him/her back to the facility, licensed nurse #G said to "show me" "and facility typed it up and told me to sign it". "I was busy so I signed it and did not read it."

Notarized statement from operator #A recorded: "I had written statements from a couple of associates and I had a note from (certified staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3028	Continued From page 3 #E), but not a formal statement" "The file was on my desk when I left on 5/12/17 and it was gone when I returned on 5/16/17." Further review of the facility investigation included typed written statements with attached signature pages that lacked the date prepared or signed. Notarized statement from licensed nurse #B recorded "On 5/16/17 certified staff E and #F and licensed nurse #C were interviewed by myself, operator #A and licensed nurse #G relating to incident between resident (#607) and resident (#609). Each interview was done separately, as was re-enactment with each associate, myself and licensed nurse #G. Certified staff #E and #F and licensed nurse #C were invited into office separately to give statements. I typed statement for certified staff #E due to communication. It was printed out, he/she was asked if it was right or needed any correction. He/she stated no and signed it." For resident #507, the operator failed to ensure that for allegations of abuse and neglect were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report. The operator also failed to safely secure and maintain investigation records of a reported incident.	S3028		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3085	Continued From page 4 the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) The facility census recorded 50, the sample included 3 residents. Based on record review and interview for 3 sampled residents (#606, #607 and #608) the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, is done in collaboration with the resident or the resident's legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service. Findings included:	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3085	Continued From page 5 - Record review for resident #607 recorded admission date of 2/24/16 with diagnoses of: dementia, diabetes mellitus type I, hypertension and constipation. Functional Capacity Screen (FCS) dated 3/1/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and unable to perform management of medications and treatments. Resident has problems with long term memory, short term memory, memory recall and decision making. Negotiated Service agreement/ Health care service plan (NSA/HCSP) dated 3/1/17 recorded resident to receive staff assistance with bathing dressing, toileting, transfers walk/mobility and management of medications and treatments. Interview on 6/7/17 at 11:25am with confidential source, stated a "sitter" was hired recently to sit with resident at night for safety. Interview on 6/7/17 at 4:30pm with licensed nurse #B confirmed resident had a sitter come in for about a week after an incident on 5/5/17 with another resident. He/she confirmed NSA lacked entry for this outside provider. Record review for resident #608 recorded admission date of 5/27/17 with diagnosis of Alzheimer's. FCS dated 5/28/17 recorded resident required assistance with bathing and toileting and was unable to perform management of medications and treatments.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3085	Continued From page 6 NSA/HCSP dated 5/28/17 recorded resident to receive staff assistance with bathing and toileting and medication management as needed. Physician's telephone order dated 6/2/17 recorded PT/OT (physical therapy/ occupational therapy) evaluation and treatment. Interview on 6/7/17 at 3:53pm with licensed nurse #B, confirmed resident had an evaluation and is receiving treatment by PT/OT since 6/5/17. Confirmed NSA lacked entry for use of this outside provider. For residents #607 and#608 who required outside services, the operator failed to ensure the Negotiated Service Agreement (NSA) was done in collaboration with the resident or the resident's legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service.	S3085		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by:	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3171	Continued From page 7 KAR 26-41-204 (i) The facility reported a census of 50 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 sampled resident (#606) the operator failed to ensure all health care services were provided to the resident in accordance with acceptable standards of practice. Findings included: - Record review for resident #606 recorded admission date of 8/30/16 with diagnoses of: dementia, atrial fibrillation, diabetes mellitus II, hypertension, pacemaker, edema and deep vein thrombosis. Functional Capacity Screen (FCS) dated 3/1/17 recorded resident unable to perform management of medications and treatments. Negotiated service agreement/ health care service plan (NSA/HCSP) dated 3/8/17 recorded staff to provide assistance with administration of medications as needed and blood sugar monitoring 3 or more times a week. Physician's orders dated 5/18/2017 recorded resident to receive the following: Insulin lispro 13 units, subcutaneous (SQ) breakfast only, ok to give at end of the meal, only give 6 units if he/she eats less than 50% (percent). Hold if he/she eats less than 10 % Insulin lispro 6 units SQ lunch only, ok to give at end of the meal, only give 3 units if he/she eats less than 50%. Hold if he/she eats less than 10 %	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3171	Continued From page 8 Insulin lispro 10 units SQ dinner only, ok to give at end of the meal; only give 5 units if he/she eats less than 50%. Hold if he/she eats less than 10 % Interview on 6/8/17 at 10:26am with licensed nurse #B confirmed facility did not have a record of staff training for % of resident meal intake. Interview on 6/8/17 at 10:30am with licensed nurse #B confirmed staff does not record % of meal eaten for resident "It's just spoken. The nurse won't give the insulin until he/she talks to the CNA (certified nursing assistant)." Record lacked documentation of percent of meal eaten prior to administration of insulin. For resident #606, the operator failed to ensure all health care services were provided to the resident in accordance with acceptable standards of practice.	S3171		
S3201 SS=F	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3201	Continued From page 9 before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(D) The facility reported a census of 50 residents. The sample included 3 residents and one focus review resident. Based on record review and interview for all residents with facility managed medications, the operator failed to ensure the licensed nurse or medication aide documented actual clock times medications were administered, when the medication administration record identified only time intervals. Findings included: - Review of facility's resident roster revealed all 50 residents received complete facility medication management. Review of residents' medication administration records for residents #606, #607 and #608 recorded AM, PM, Noon, HS or PRN for	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3201	Continued From page 10 medication administration times. Interview on 6/7/17 with licensed nurse #B confirmed all facility residents receive medication administration assistance, facility uses liberalized time parameters on MAR/TARs (medication administration and treatment administration records) and that no record of specific medication administration times are recorded for the liberalized time entries. For all residents of the facility the operator failed to ensure the licensed nurse or medication aide documented actual clock times medications were administered, when the medication administration record identified only time intervals.	S3201		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 50 residents. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 sampled resident (#607) the operator failed to ensure documentation of all	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3261	Continued From page 11	S3261		

incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.

Findings included:

Record review for resident #607 recorded admission date of 2/24/16 with diagnoses of: dementia, diabetes mellitus type I, hypertension and constipation.

FCS dated 3/1/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and unable to perform management of medications and treatments. Resident has problems with long term memory, short term memory, memory recall and decision making.

NSA/HCSP dated 3/1/17 recorded resident to receive staff assistance with bathing dressing, toileting, transfers walk/mobility and management of medications and treatments.

Interview on 6/6/17 at 11:50am with operator #A confirmed a resident to resident incident involving another resident in this resident's room 3 weeks ago. He/she stated a report had been filed with the department. Incident involved the other resident standing by this resident's bed.

Review of investigation by facility recorded the incident occurred on 5/5/17 at 10:45pm.

Resident log (nurse's notes) records the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3261	Continued From page 12 following: 4/8/17 at 12:45pm "This nurse called to neighborhood where resident had right hand stuck in wheel of wheelchair ...." Next note recorded on 5/6 17 at 8:00pm "resident up per meals and activities .... " Record lacked documentation of incident, notification of family, notification of physician and assessment of resident at the time of the incident. Interview on 6/7/17 at 4:15pm with licensed nurse #C confirmed he/she did not write a nurse's note in resident's chart regarding the incident, but did write a note in the other resident's chart. He/she stated "I didn't write a note because he/she was just doing his/her normal routine. He/she (other resident) was just looking for a place to sleep." For resident #607 the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		
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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3280	Continued From page 13 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 26-4-104(d)(3) The census equaled 50 residents; the sample included 3 residents and one focus review resident. Based on interviews and review of records, for all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility's emergency management plan with employees and residents. Findings included: - On 6/7/17 at 1:35pm during review of the facility's disaster/emergency preparedness plan with operator #A, the following disaster topics were reviewed: 2/16/17 tornado and severe weather and July 2016 entire emergency plan was reviewed.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046053	A. BUILDING: _____ B. WING _____	C 06/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHAWNEE	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
S3280	Continued From page 14 Quarterly reviews of the facility's disaster/emergency preparedness plan with residents were conducted on the following dates: 6/1/17, 3/2/17 and 12/1/16. The last emergency full evacuation of residents was conducted on 7/27/16. The operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility's emergency management plan with employees and residents.	S3280		