STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E197	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOKS CO SENIOR SERVICES INC DBA REDBUD VILLAGE	1000 S WASHINGTON STREET PLAINVILLE, KS 67663

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations are the result of abbreviated complaint investigation KS00178020 and KS00177440. The 2567 was sent electronically on 03/09/23.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents with three reviewed for accidents. Based on record review, observation, and interview the facility failed to ensure Resident (R) 1 and R2's care plans were followed regarding safe transfers. On the morning of 02/06/23, Certified Nurse's Aide (CNA) M bear hugged R1 without a gait belt to transfer R1 from her bed to the wheelchair for R1's bath. CNA M then bear hugged R1 without a gait belt to transfer R1 from her wheelchair to the whirlpool chair. CNA M placed R1 in the whirlpool bath and lowered R1into the water and proceeded to bath R1. CNA M noticed a dark purple bruise across R1's right nipple and across her right breast from one side to the other. On 01/11/23 at approximately 11:00 AM, R2 placed his call light on as he had to go to the bathroom. CNA N answered R2's call light and chose to transfer R2 to the bathroom by	F 689		

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

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F 689	Continued From page 1	F 689		

herself without R2 having non-skid socks or shoes on. R2 lost his footing when standing up from the toilet and had to be lowered to the ground. This deficient practice placed R1 and R2 at risk for avoidable falls and injury.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (high blood pressure), and chronic embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream) and thrombosis (clot that developed within a blood vessel) of left femoral (thigh) vein.

The "Quarterly Minimum Data Set (MDS)," dated 02/14/23 documented R1 had a Brief Interview for Mental Status score of 99 and indicated she had short- and long-term memory loss. The MDS documented R1 required extensive assistance of two staff for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 10/10/22, documented R1 was unable to complete the BIMS assessment and had difficulty with memory recall. R1's speech was hard to understand. R1 required staff assistance to complete all her activities of daily living due to her cognitive status.

The "Activities of Daily Living Care Plan," dated 07/27/22, instructed staff R1 required two staff assistance with toileting, transfer with a gait belt, and ambulating short distances.

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F 689	Continued From page 2	F 689		

The "Facility Investigation Report," dated 02/07/23, documented on 02/06/23, CNA M transferred R1 by bear hugging her and did not use a gait belt. CNA M then took R1 to the bath house and transferred R1 from her wheelchair to the whirlpool chair by bear hugging R1 and did not use a gait belt. CNA M then undressed R1 and placed R1 into the whirlpool and washed R1's bottom half before lowering the whirlpool chair into the water. CNA M then washed R1's back and then moved to R1's breasts and CNA M noticed a dark purple bruise across R1's right nipple and across her right breast from one side to the other. CNA M notified LN G about R1's bruise.

The "Facility Investigation Report," dated 02/07/23, documented LN G had been on duty 02/05/23 at 06:00 PM through 02/06/23 at 06:00 AM. LN G provided cares throughout the night and did not note any bruising to R1 during cares. On the morning of 02/06/23, LN G was called to the bath house by CNA M and noted a purple straight-line bruise to the right breast across the nipple line possibly from a gait belt. LN G did not take actual measurements but stated the bruising measured approximately 0.5 centimeters (cm) by 7 to 8 cm in length across the breast. LN G did not call Administrative Nurse D about the bruising, but rather e-mailed Administrative Nurse D and Administrative Staff A.

The "Facility Incident Report," dated 02/07/23, documented on 02/07/23 at 09:45 AM the wound nurse was performing a skin assessment on R1 and noted bruising to R1's right chest/breast that measure 20 cm by 2 cm across the lower right chest area under R1's breast, the whole right breast/nipple was bruised measuring 16 cm by 2

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cm, and the right breast up to R1's neck that measured 16 cm by 4 cm, and an 18 cm lump on the right side from R1's arm pit to the right nipple.

On 02/23/23, at 11:30 AM, observation revealed R1 sat up in her wheelchair and was assisted with eating. R1 sat upright in her wheelchair, was dressed and well-kempt.

On 02/23/23 at 10:00 AM, CNA O stated R1 required two assist with all over activities of daily living. CNA O stated R1 required two staff assist and a gait belt with any transfer.

On 02/23/23 at 01:30 PM, Administrative Staff A stated that all the staff working at the facility should be following the resident's plan of care to ensure the safety of the residents during cares.

The facility's "Care Plans, Comprehensive Person-Centered Policy," revised March 2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the needs of the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, builds on the resident's strengths, and reflects currently recognized standards of practice for problem areas and conditions.

The facility failed to ensure R1's care plan was

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followed regarding safe transfers placing R1 at risk for avoidable injury.

- R2's Electronic Medical Record (EMR) documented R2 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral vascular accident (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) effecting the right dominant side, osteoarthritis (chronic arthritis without inflammation), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set (MDS)," dated 01/04/23, documented R2 had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognitive status. The MDS further documented R2 required extensive assistance of two staff for bed mobility, transfer, dressing, toileting, personal hygiene, and bathing. R2 was documented as having one non-injury fall during the look back period.

The "Fall Care Are Assessment (CAA)," dated 05/22/22, documented R2 had balance problems during transitions and not steady and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet, and surface-to-surface transfers.

The "Activities of Daily Living Care Plan," dated 07/27/22, documented R2 was able to transfer with his walker, gait belt and assistance of two to three staff.

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The "Fall Care Plan," dated 07/27/22, directed staff to ensure R2 wore shoes for transfers at all times and ensure R2 was wearing appropriate footwear (shoes or gripper socks) when he is out of bed.

The "Facility Incident Report," dated 01/12/23, documented on 01/12/23 at approximately 11:00 AM, R2 used his call light to request to go to the bathroom. Certified Nurse's Aide (CNA) N answered R2's call light and attempted to get help from another CNA. The other CNA stated she was busy doing something else, so CNA N chose transfer R2 from his chair by herself, ambulate R2 by herself, and toilet R2 by herself. When R2 attempted to stand from the toilet, R2's feet slipped out from underneath him and R2 was lowered to the floor by CNA N. R2 stated, "I should have had my shoes on." R2 had no apparent injury.

On 02/23/23 at 11:15 AM, observation revealed R2 sat in his wheelchair in his room watching TV. R2 was dressed for the day and had socks and shoes on his feet.

On 02/23/23 at 01:00 PM CNA P stated that R2 was a two staff assistance with all of his activities of daily living, and he needed to have his shoes on for all transfers and ambulation.

On 02/23/23 at 01:30 PM, Administrative Staff A stated that all of the staff working at the facility should be following the resident's plan of care to ensure the safety of the residents during cares.

The facility's "Care Plans, Comprehensive Person-Centered Policy," revised March 2022, documented a comprehensive, person-centered

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F 689	Continued From page 6 care plan that includes measurable objectives and timetables to meet the needs of the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, builds on the resident's strengths, and reflects currently recognized standards of practice for problem areas and conditions. The facility failed to ensure R2's care plan was followed regarding safe transfers placing R2 at risk for avoidable falls and injury.	F 689		