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 05/11/2023

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

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F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00179663, KS00178763, and KS00178583. The 2567 was sent electronically on 05/24/23.	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 27 residents with three reviewed for accidents and hazards. Based on record review, observation, and interview, the facility failed to provide Resident (R)1 with a safe environment free of accidents and hazards and appropriate supervision when on 03/08/23 at 09:35 AM, Certified Nurse's Aide (CNA) M and CNA N placed R1 in bed utilizing a full lift to provide him cares, and raised the bed up, CNA N then left R1's room to answer a call light; CNA M left R1's side to help his roommate from the bathroom, and R1 fell to the floor from the bed. This deficient practice placed R1 at risk for injury, pain, and altered psychosocial well-being. Findings included: - The Electronic Medical Record (EMR)	F 689		

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

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documented R1 had diagnoses of Alzheimer's disease with early onset (progressive mental deterioration characterized by confusion and memory failure), dementia with agitation (progressive mental disorder characterized by failing memory, confusion), and major depressive disorder (major mood disorder).

The "Quarterly Minimum Data Set (MDS)," dated 03/15/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R1 was unable to complete the interview. The MDS documented R1 had short- and long-term memory problems, did not know the current season, did not know the location of his room, did not know staff names or faces, and did not know he was in a nursing facility. The MDS documented R1 required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. R1 was totally dependent on one staff for locomotion on and off the unit and eating.

The "Cognitive Loss Dementia Care Area Assessment (CAA)," dated 01/03/23, documented R1 had early onset Alzheimer's disease that was progressing. The CAA documented R1did not speak or respond often and rarely opened his eyes. The CAA documented R1would grab at staff and kick out his legs.

The "Activities of Daily Living/Rehabilitation Potential CAA," dated 01/03/23, documented R1 required extensive assistance of two staff for completion of all activities of daily living and was dependent on staff for eating and locomotion. The CAA documented R1 was non-ambulatory and was transferred with a full lift with maximum

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assistance of two staff.

The "Fall CAA," dated 01/03/23, documented R1 had a history of frequent falls and was a riwsk for falls per the fall risk assessment. The CAA documented R1 had difficulty maintaining his balance and had decreased safety awareness.

The " Fall Care Plan," revised 03/08/23, directed staff to ensure that a fall matt was at R1's bedside, to use a body pillow for positioning while in bed, ensure R1 used a concave mattress, to move R1 to the nurse's station when he was restless in bed, to not leave R1 alone when he is restless, and to keep R1's bed in the lowest position when he was at rest in bed.

The "Hospital Emergency Room Report," documented due to the patient's inability to participate in the unwitnessed fall screen, a CT (computerized tomography) scan was completed of R1's brain which was negative for traumatic intracranial abnormalities. R1's lacerations were cleaned and closed with Dermabond (medical glue) and steri-strips which are to remain in place until they fall off.

The "Witness Statement," dated 03/09/23, documented CNA M was in R1's room with CNA N. The two staff placed R2 on the toilet and R1 in bed to do cares. CNA N was then called out of the room. When CNA N left, R2 was getting up from the toilet so CNA M left R1 to go help R2. While CNA M was helping R2, CNA M noticed R1 rolling out of bed.

The "Facility Incident Report," dated 03/15/23, documented on 03/08/23 at 09:35 AM, Licensed Nurse (LN) G was called to R1's room by CNA N.

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LN G saw R1 laying on the floor after rolling out of bed and hitting his head on the night stand. CNA M and CNA N were in the process of putting R1 to bed after breakfast and were going to provide R1 with personal cares. CNA M and CNA N placed R1's bed in a higher position and removed the fall mat for the transfer. CNA M and CNA N transferred R1 using a gait belt to the bed. CNA N left R1's room to tend to another resident while CNA M stayed with R1 to wait for CNA N's return. R2, R1's roommate, was on the commode and was trying to stand up on his own without assistance. CNA M quickly attended to R2 and helped him sit down as CNA M was concerned R2 would fall. At that time, CNA M witnessed R1 begin to roll out of his bed. CNA M attempted to catch R1, but R1 rolled out of his bed and hit his head on the night stand. CNA N returned to the room within minutes of leaving and saw R1 on the floor and left to get LN G. LN G assessed R1 and noted that he had a laceration to the upper right side of his head with a hematoma surrounding it, and a laceration above his right eye. LN G applied pressure to the head wounds until the emergency medical service arrived and was transferred to the local area hospital. The night stand was removed from R1's room, staff involved were educated on the importance on not having two residents in a room needing assistance with cares at the same time with only one CNA. All staff were educated on this protocol at the in-service training on 03/16/23.

On 05/11/23 at 09:30 AM, observation revealed R1 sitting up in a Broda (high backed specialty chair) at the nurse's station with his eyes closed. R1 did not respond to any interaction.

On 05/11/23 at 10:30 AM, observation revealed

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R1 was laying in bed on a concave mattress with the bed lowered to the floor and a fall mattress at the bedside.

On 05/11/23 at 09:45 AM, CNA O stated R1 had a lot of falls and was not to be left alone when he was restless. CNA O stated R1 would kick his legs a lot and try and roll out of his chair and his bed.

On 05/11/23 at 10:45 AM, CNA N stated that had left CNA M alone in R1's room when they had R1 and R2 needing assistance with cares because a call light was going off. CNA N stated she and CNA M shouldn't have had two residents needing assistance in the same room.

On 05/11/23 at 11:30 AM, Administrative Staff A stated that CNA M and CNA N should not have been providing cares for two residents in the same room at the same time and CNA N should not have left the room.

The facility's "Fall Preventions and Management Protocol," revised 09/17/19, documented all team members will practice basic universal fall precautions for all residents in addition to specific precautions for residents who have been identified as low and high risk. The interdisciplinary team will develop a plan for services to improve or maintain the resident's standing and sitting balance and other interventions to reduce the resident's risk for falls. This plan will include specific information about the resident's routine and personal habits that may place the resident at risk for falls and address plans for reducing that risk.

The facility failed to provide R1 with a safe

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F 689	Continued From page 5 environment free of accidents and hazards and appropriate supervision to prevent accidents which placed R1 at risk for injury, pain, and altered psychosocial well-being.	F 689		