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 07/19/2023

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 survey and complaint investigation KS00181508. The 2567 was sent electronically on 08/01/23.	F 000		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: The facility identified a census of 26 residents with three reviewed for food allergies. Based on record review, observation and interview, the facility failed to accommodate Resident (R) 1's food allergy to fish which placed R1 at risk for an allergic reaction when R1 was served fish which she had a known allergy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following and cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by	F 806		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/01/2023

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blockage or rupture of an artery to the brain), atrial fibrillation (rapid, irregular heartbeat), and hypertension (high blood pressure).

The "Admission Minimum Data Set," dated 07/11/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R1 required extensive assistance of two staff for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. R1 was independent with eating with set up help assistance.

The "Nutritional Care Plan," dated 07/10/23, documented R1 was allergic to fish and directed staff to serve and provide diet as ordered.

The "Facility Admission Order Set," faxed 07/05/23, documented R1 was allergic to morphine (pain medication), sulfa, ACE Inhibitors (type of blood pressure medications), and fish.

The facility's "Allergy Tab" in the EMR documented R1 was allergic to morphine, sulfa, ACE Inhibitors, and fish.

The "Incident Note," dated 07/14/23, documented R1 called the nurse into her room due to dietary staff gave R1 fish tacos. R1 was allergic to fish. The note recorded R1 spit it out and stated she did not think that she had swallowed any but she was not sure. The nurse asked R1 what kind of reaction she had to fish and R1 stated her lips and eyes swelled. The nurse assessed R1's vital signs; R1's blood pressure was 122/64 milligrams of Mercury (mm/Hg), temperature was 97.6 degrees Fahrenheit (F), pulse was 70 beats per minute, respirations were 18 breaths per minute,

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F 806	Continued From page 2	F 806		

and oxygen percentage was 97 percent. The nurse was directed to given Benadryl (antihistamine) per standard protocol to R1 as a precaution to her exposure to fish. Staff administered Benadryl 25 milligrams (mg) to R1 by mouth. R1 was in good spirits, sitting in her chair, and watching TV. R1 was not in any distress and stated she was doing ok.

The "Incident Note," dated 07/15/23, documented R1 stated the evening before she alerted staff that she had taken a bite of fish taco but spit it into the trash can when she discovered it was fish. R1 stated she was allergic to fish. The nurse assessed R1's vital signs and found them to be within normal limits. R1 denied any pain or abnormal swelling; nohives were present. R1 sat in her room in good spirits watching TV.

The "Facility Incident Report" dated 07/17/23, documented on the evening of 07/14/23, around 06:00 PM, R1 received supper in her room. After R1 took her first bite of the taco, R1 immediately noticed there was fish on the taco. R1 had an allergy of unknown severity to fish. R1 was able to call the nurse to notify the nurse of the situation. R1 was thoroughly assessed by the charge nurse for any anaphylactic (an acute allergic reaction) signs of reaction. R1 was showing mild symptoms of a reaction when the nurse assessed R1. R1 had an order on her "Medication Administration Record" (MAR) to receive an epinephrine (medication sued to treat severe allergic reactions) injection if needed for any anaphylaxis reactions. R1 was given Benadryl (antihistamine medication) from the physician standing order list. All other resident meal cards were checked to verify resident's allergies, diet, and texture. .

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On 07/19/23 at 10:30 AM, observation revealed R1 sat up in her chair watching TV. R1 reached over to her table and was able to take a drink with her left hand.

On 07/19/23 at 10:30 AM, R1 stated that she had been allergic to fish for as long as she can remember and normally, if she ate fish her eyes and her lips swelled shut. R1 stated that she did not have any kind of reaction to the fish that she spat out.

On 07/19/23 at 10:45 AM, Social Services X stated R1 had told her on admission that she was very allergic to fish and Social Services X ensured that nursing was aware of the information.

On 07/19/23 at 11:00 AM, Dietary Manager (DM) BB stated the facility had a process problem with the meal cards for each resident not coming back to the kitchen as the meal cards were sometimes thrown away or sent to the laundry and washed. DM BB stated that sometimes missing meal cards were not noticed for several shifts and then dietary staff told him and he made out a new dietary card. R1 did not have a meal card that day which stated that she was allergic to fish and so R1 was served fish. DM BB stated R1's dietary order stated that R1 was allergic to fish on her admission to the facility.

On 07/19/23 at 11:15 AM, Administrative Nurse D stated the facility had a system problem related to ensuring that all of the dietary cards for all of the residents were accounted for every meal. Administrative Nurse D proposed that the facility count the meal cards after each meal, whether it

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would be housekeeping or dietary staff, to ensure that all meal cards were returned to the kitchen for the next meal; if a meal card was missing then an an audit would be performed on the meal cards to find out which meal cards were missing and a new meal card made to ensure allergies, diet, texture etcetera.

The facility's "Food Allergies and Intolerances Policy," revised August 2017, documented residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergen(s).

The facility failed to accommodate R1's food allergy to fish which placed R1 at risk for an allergic reaction.