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 11/07/2023

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 KS00183791 and KS00183645. The 2567 was sent electronically on 11/13/23.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents with three residents reviewed for misappropriation of property. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 remained free from misappropriation when former staff, Licensed Nurse (LN) G, diverted ten oxycodone (opioid pain medication) which were prescribed and dispensed for Resident (R) 1. This deficient practice placed R1 at risk for ongoing misappropriation and untreated pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnose of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), anxiety (mental or emotional reaction characterized by	F 602		

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

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apprehension, uncertainty and irrational fear), and hypertension (high blood pressure).

The "Annual Minimum Data Set (MDS)," dated 09/27/23, documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS further documented R1 required extensive assistance of two staff for bed mobility, transfer, dressing, personal hygiene, and bathing. R1 was totally dependent on staff for toileting. The MDS documented R1 received no opioid medication during the review period.

The "Pain Care Area Assessment (CAA)," dated 09/27/23, documented R1 had chronic pain syndrome and continued to voice discomfort. R1 was seen by the pain clinic and voiced that did not help her pain.

R1's "Care Plan," revised 09/12/23, directed staff to administer R1 analgesia per orders and to give pain medication half an hour before treatments or care. The care plan documented R1 took acetaminophen (over the counter [OTC] pain medication) and Excedrin Migraine (OTC pain medication). The care plan directed staff to anticipate R1's need for pain relief and respond immediately to any complaint of pain.

The "Doctor's Order," dated 10/18/23, prescribed R1 oxycodone 5 milligrams (mg) 1 tablet every four to six hours as needed with a quantity of 10 pills ordered, and no refills.

The "Police Narrative Report," dated 10/26/23, documented the law enforcement officer (LEO) was called to the facility at approximately 10:30 AM regarding theft of oxycodone pills from the facility. The LEO was shown the video footage of

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LN G opening a drawer in a rolling cart that contained prescription drugs. The video showed LN G popping pills out of a foil container and placing them in another drawer then taking them out again and placing the pills in her pocket then walking into the restroom and coming out again seconds later. The video then showed LN G place something into her bag that was on the rolling cart. Later that day, the LEO was called back to the facility for interrogation of LN G. LN G at first denied having stolen the pills and then admitted to stealing the pills and ingesting them. The LEO wrote LN G a "Notice To Appear" in court for theft on November 28, 2023 at 05:00 PM.

The "Facility Incident Report," dated 10/30/23, documented on 10/18/23 LN G was working at the facility as medication aide and received a prescription from the pharmacy for R1 for oxycodone 5 mg with ten pills noted to be in the blister pack. LN G placed the medication in the medication cart and made out a card count sheet for the oxycodone. On 10/22/23, LN H notified the facility administration that he thought there were less cards in the medication cart then there should have been, and he specifically remembered there being a card for R1 in the medication cart that was no longer there along with any documentation for the narcotic. An investigation was started immediately, and it was discovered the narcotic count sheets had been altered and that the individual count sheet for R1's oxycodone was missing. All staff were urine drug tested and all staff came back negative for opioids. LN G was the main staff that was working on the medication cart during the time the oxycodone came up missing. LN G was placed on suspension pending investigation. The

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facility administration reviewed camera footage and determine on 10/22/23 LN G had popped several pills from one medication card into a medication cup and placed the med cup into the top drawer of the med cart. LN G then opened the top drawer of the med cart, took the med cup and her drink into the bathroom and then came out of the bathroom quickly. Later footage showed LN G prepared to move her medication cart, unplugged the cart from the wall, and then reached into her pocket and took something out of her pocket and placed it into her personal bag that was on the side of the medication cart. Further footage showed LN G pop several more pills out of a medication card and take her drink into the spa/bath house along with her drink. LN G then returned to the med cart, opened the narcotic lock box and popped several more pills out of a medication card and then placed those pills into the top drawer of the medication cart. LN G then went into a resident's room to give two residents their medications. Neither resident in the room took narcotic medication. Later, LN G was seen reaching into her pocket and taking some type of medication. On 10/26/23 LN G was called to the facility for interview with administration and the police. At first, she denied any knowledge and then admitted that she had taken ten oxycodone of R1's for herself but not for distribution and that she had shredded the empty pill card and the paperwork associated with it. LN G was terminated immediately.

On 11/07/23 at 10:00 AM, observation revealed R1 laid on her side in bed watching television.

On 11/07/23 at 10:00 AM, R1 stated that she had never taken any narcotic pain medication for her pain and did not feel like she needed narcotics.

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R1 stated Tylenol and Excedrin helped with her pain and if she could ever get her pressure injury healed on her buttocks, she could get an injection that would help with her pain.

On 11/07/23 at 10:30 AM, Administrative Nurse D stated that during the investigation it was determined that only the ten pills from R1 were taken and that all other narcotics were accounted for. Administrative Nurse D stated that the facility offered LN G mental health interventions which she refused. Administrative Nurse D stated LN G had committed theft of R1's narcotic medication.

The facility's "Identifying Exploitation, Theft and Misappropriation of Resident Property Policy," dated April 2021, documented exploitation, theft and misappropriation of resident property are strictly prohibited. It is understood by leadership in the facility that preventing these occurrences requires staff education and training. Examples of misappropriation of resident property are drug diversion (taking the resident's medications), identity theft, theft of money from bank accounts, and unauthorized or coerced purchases on a resident's credit card.

The facility failed to ensure R1 remained free from misappropriation when former staff, LN G, diverted ten which were prescribed and dispensed for R1. This deficient practice placed R1 at risk for misappropriation or untreated pain.