STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175571	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbud Village	1000 S Washington Street Plainville, KS 67663

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 33 residents, with three residents reviewed for falls and supervision. Based on record review and interview, the facility failed to provide the care planned supervision for cognitively impaired Resident (R) 1 (who had a history of falls, dizziness, and weakness) to prevent a fall with major injury. On 01/08/26 at 08:57 PM, Licensed Nurse (LN) G assisted R1 to the north patio smoking area, placed a smoking apron on R1, and lit R1's cigarette. LN G left R1 outside on the patio and went back inside the facility, which left R1 without direct supervision. While inside, LN G stepped away for a moment and heard R1 yell for help at 09:05 PM. LN G went outside and discovered R1 on the ground on his left side. R1 required emergency medical transport to a local hospital and surgery to repair his broken left hip. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of paroxysmal (a sudden, intense, recurring onset of symptoms) atrial fibrillation (rapid, irregular heartbeat), orthostatic hypotension (blood pressure dropping with change of position), dizziness (lightheadedness, spinning, or imbalance), and tobacco use. The Significant Change Minimum Data Set (MDS) dated 12/03/25 documented R1's Brief Interview for Mental Status (BIMS) score was four, which indicated severely impaired cognition. The MDS documented R1 required moderate staff assistance for sit-to-stand and transfer, required maximum staff assistance with toileting, dressing, and personal hygiene, and was dependent on staff for bathing. The MDS documented R1 had two or more injury falls (not major) since 10/08/25. The Care Area Assessment (CAAs) dated 12/03/25 documented R1 was a fall risk and had two or more falls with minor injury since the last assessment. R1's Care Plan, initiated 08/09/22, documented R1 had a history of syncopal episodes (a temporary loss of consciousness caused by a sudden drop in blood flow to the brain) and was at risk for falls. The care plan directed staff to encourage R1 to call for staff assist if he felt weak, dizzy, or unsteady before attempting to transfer or ambulate. The care plan directed staff to observe/monitor R1 for changes in gait or balance when/after R1 smoked, as R1 had been noted to become dizzy at times after he smoked (08/10/22). The care plan directed staff to provide R1 with a safe environment (08/09/22). The care plan directed staff to monitor R1 while smoking and light R1's cigarette (11/25/25). The Smoking Safety Evaluation dated 11/17/25 documented R1 had problems with balance while sitting or standing, had previously burned his skin, clothing, furniture, or other items, and dropped ashes on himself. The evaluation indicated the staff were to light R1's cigarette and monitor R1 while the resident smoked. The Morse Fall Scale dated 12/08/25 documented a fall risk score of 70, which indicated R1 was a high risk for falls. The Communication with Physician Note dated 11/20/25 documented at 06:35 AM, staff were called to R1's room. R1 lay on the floor on his back with his knees bent. R1 verbalized he was going out of his room to get coffee and then felt weak and dizzy. R1 verbalized he hit his head and had pain in his neck. The Communication with Physician Note dated 11/21/25 documented the staff notified R1's primary care physician (PCP) regarding R1's increasing weakness and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	received an order for physical therapy. The Incident Note dated 11/23/25 documented a Certified Nurse Aide (CNA) found R1 on the floor. R1 reported he was dizzy, he hit his head, he felt weak and confused to his surroundings. The note documented orders received to send R1 to the emergency room (ER) for increased weakness and confusion. The Nurses Note dated 11/25/25 documented R1 was weak, displayed difficulty getting up off his bed and into his wheelchair, and displayed difficulty moving his feet at times. The Plan of Care Note dated 11/26/25 documented R1's health status had declined, and R1 required more assistance with activities of daily living (ADL). R1 required one to two staff members' assistance as needed. The Communication with Physician Note dated 12/23/25 documented R1 was found on the ground outside. The nurse observed R1 sitting outside on the concrete, on his buttocks, with bilateral legs outstretched in front of him. R1 attempted to transfer himself from his wheelchair into the lawn furniture and slipped from the cushion of the lawn chair and onto the ground. R1 educated on requesting assistance when transferring self. The Health Status Note dated 12/28/25 documented R1 was not eating, was drinking very little, and getting weaker as the day went on. The ER was called, and a new order was given to obtain a urine specimen. The Health Status Note dated 01/02/26 documented R1's health status had declined recently from independent to requiring one to two staff members for ADLs. R1's appetite decreased, and R1 did not want to eat or drink despite education on the importance of nutrition and hydration. R1 was more fatigued throughout the day, his overall health status declined the past several months, and worsened over the past week. The Nurse's Note dated 01/02/26 documented R1 was weak that evening and R1 displayed difficulty ambulating. The Incident Note dated 01/08/26 documented R1 went outside to the smoke patio about 08:57 PM, noting staff let him out as R1 had missed the original smoke time. R1 sat in a chair, and staff (LN G) went inside for a few minutes. At 09:05 PM, staff (LN G) heard R1 yell and went to check on R1. LN G found R1 on the ground, lying on his left side. R1 denied hitting his head. R1's right slipper was noted to be off. R1 was alert and oriented and moved his legs. LN G asked R1 if he was in pain, and R1 stated no more than usual. R1 recently started on round-the-clock tramadol (pain medication) due to severe pain. Staff assisted R1 to try to push off the ground to sit up, and R1 moved about five degrees, but immediately grabbed his right hip and said it hurt badly. Staff assisted R1 back to the ground and called the ambulance to transfer R1 to the ER for severe hip pain. R1 told the paramedics his left hip also hurt, and the left hip was noted to have some rotation. It was noted R1 had a skin tear to the top of his left hand and blood on his shirt to the left elbow. The paramedics and LN assisted R1 in removing his coat, as it was soaked in water, and R1 was very cold. R1 stated his left shoulder hurt. The Radiology Report dated 01/08/26 documented R1 had sustained a non-displaced subcapital hip fracture at the junction where the femoral (thigh bone) head meets the femoral neck and a mid-left femoral neck fracture. The Incident Note dated 01/09/26 documented R1 left via ambulance at 09:15 PM for the local hospital. LN G called the local hospital and was informed R1 broke his left hip. The Plan of Care Note dated 01/13/26 documented R1 had returned from the hospital and was non-weight-bearing due to his hip fracture. The facility's Incident Report dated 01/14/26 documented on 01/08/26 at 08:57 PM, R1 went outside to smoke a cigarette. R1 walked outside wearing a coat and using his walker, and then sat in his favorite chair on the smoking patio. LN G placed a smoking apron on R1 and lit R1's cigarette. LN G went inside the door to monitor through the windows while at the nurses' cart, until R1 finished smoking. At 09:05 PM, R1 yelled for help. LN G went outside and found R1 lying on the ground on his left side. R1 denied hitting his head. It was noted R1's right slipper was off his foot on the ground next to him. R1 reported he lost his balance as he stood up, and his slipper came off, which then caused him to fall onto the ground. R1 was alert and oriented times two and staff (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	performed a full body assessment in the same place to avoid injuries, with no major injuries or concerns at that time. The staff obtained R1's vital signs: temperature 97.8 degrees Fahrenheit (F), blood pressure 150/87 millimeters of Mercury (mmHg), heart rate 87 beats per minute, respiration 16 per minute, and oxygen saturation 93% on room air. LN G asked R1 if he had any pain, and he replied no more than usual. R1 recently started on tramadol to help with pain. Additional staff arrived and assisted LN G with getting R1 up from the ground. LN G instructed R1 to push off the ground to sit up. R1 moved about five degrees when he immediately grabbed his right hip and said it hurt badly. Staff assisted R1 back to a lying position, where it was not painful. The staff immediately called for an ambulance to transfer R1 to the local hospital ER. Once EMS arrived, the paramedics talked more with R1, and he stated his left hip also hurt. LN G noted minimal right hip rotation when R1 moved inside with light. It was also noted R1 had a skin tear to the top of his left hand, and when his coat was taken off, staff noted blood coming through his shirt by his left elbow. While the paramedics and LN G assisted R1 with removing his coat, R1 complained of left shoulder pain, but continued to move his arm freely to finish taking off his coat. Blankets were placed over R1 while on the gurney, and R1 was transferred to the local hospital ER for further evaluation. While in the ER, R1 stated he had left hip pain and wounds and that he had hit his head when he fell. Lab work and imaging obtained. Computed tomography (CT scan- a test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) of the head was negative for abnormalities. CT of the cervical spine showed no abnormalities. Left hip x-ray showed a non-displaced subcapital hip fracture that occurs at the junction where the femoral (thigh bone) head meets the femoral neck and mid left femoral neck fracture. R1 transferred to a higher level of care orthopedic unit. R1 received surgery to repair his hip fracture on the morning of 01/09/26. While in the hospital, R1 let occupational therapy work with him, but would not allow physical therapy to work with him. R1 returned to the facility on [DATE], and was non-weight bearing on his left leg, requiring a pivot transfer or Hoyer (total body mechanical lift) lift transfer. Education provided to R1 on the importance of wearing proper footwear when walking outside to smoke. R1 knew he needed to wear tennis shoes or other appropriate footwear rather than slippers when he ambulated outside to smoke. R1 was unavailable for observation or interview. On 01/26/26 at 11:30 AM, Administrative Nurse D stated LN G stated she had monitored R1 out the windows by the patio when another staff member had come up to her informing her of another resident having pain. LN G stated she stepped away from the window to go to the nurse's office to look at the resident's medication administration record to see if they could have pain medication when she heard R1 yell. Administrative Nurse D stated LN G told her she was gone from the window for no more than ten seconds when she heard R1 yell. Administrative Nurse D stated she considered watching R1 from the window to be direct supervision, and LN G could not stay outside with R1 because it was cold, the smoke bothered LN G, and LN G had precancer. Administrative Nurse D stated lack of supervision did not contribute to R1's fall with injury, but allowing R1 to walk outside on the concrete to smoke in his slippers had been the cause of R1's fall. Administrative Nurse D stated R1's slippers were at least two sizes too big, but he preferred the slippers. Administrative Nurse D stated staff should have had R1 wear tennis shoes to go out to smoke. Administrative Nurse D stated R1's BIMS score was low, but he was actually a good historian with short-term items, and she believed R1 when he said he tripped over his slipper. Administrative Nurse D stated LN G was unavailable for the interview, as she was a nursing instructor and was in class. Administrative Nurse D stated she would have LN G call this surveyor for an interview. LN G did not call the surveyor for an interview. The facility's Smoking Policy, revised July 2017, documented the policy establishes safe and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	consistent guidelines for smoking within the facility to protect the health and safety of all residents while maintaining a smoke-free environment for staff, visitors, and residents. The staff shall consult with the physician and/or director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Smoking and Safety Evaluation. Any smoking-related privileges, restrictions, and concerns would be noted on the care plan, and all personnel caring for the resident would be alerted to these issues. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor, or volunteer at all times while smoking. The facility's Fall Risk Assessment, revised March 2018, documented the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, would seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on assessment information. Assessment data would be used to identify underlying medical conditions that may increase the risk of injury from falls. The staff would evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, ADL capabilities, and cognition. Staff would collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.