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	03/23/2026

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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. The facility identified a census of 33 residents, with 15 residents reviewed for misappropriation of property through diversion. Based on record review, observation, and interview, the facility failed to prevent misappropriation of medications for 15 cognitively impaired residents including some controlled substances, which resulted in missed medications for the affected residents. Findings included: The Facility Incident Report, dated 02/13/26, documented on 02/08/26 at 06:30 AM, Laundry Staff U went into the soiled utility room to pick up dirty laundry. When Laundry Staff U was transferring the dirty laundry to the laundry bin, she came across a black trash bag that made a noise when she picked it up. Laundry Staff U opened the bag and saw a bunch of pills. She took the pills to the LN G. LN G notified the facility's administrative staff. Upon investigation by Administrative Nurse D and Administrative Staff A, camera footage revealed, the laundry bin was last emptied at 08:03 PM on 02/07/26. At 08:10 PM Certified Medication Aide (CMA) R removed a black trash bag from the medication cart, carried it down the north hall to the soiled utility room, then left the soiled utility room without the black trash sack. During review of the camera footage, CMA R took out a resident's bubble packed (individually dosed cards of medications) medications, placed the medications into a medication cup, and put some of the medications into the trash bag. Other medications popped from the bubble packs were placed in a medication cup and put in the top left-hand drawer of the medication cart. The controlled substance drawer was unlocked, and pills were placed into the medication cups in the top left drawer. Forty-three pills were identified in the black trash sack belonging to 15 different residents, who were all cognitively impaired. It was determined nine controlled substances or muscle relaxers were popped from the residents' medication cards but were not accounted for. Laundry Staff U's Notarized Witness Statement, dated 02/08/26, documented at 06:30 AM, Laundry Staff U emptied the soiled laundry barrel. When she got to the bottom of the barrel, there was a black trash bag. Laundry Staff U picked up the black trash bag and noticed it made a noise. She looked inside the bag, and noted there were a whole bunch of pills in the bag. Laundry Staff U went and asked the medication aide what to do with them. Laundry Staff U then found Licensed Nurse (LN) G and asked her what to do with the pills. Laundry Staff U showed LN G where she found the pills. Review of Resident (R)1, R3, and R4's records revealed the following outcomes related to misappropriation of their medications: Resident (R) 1's Electronic Medical Record (EMR) documented diagnoses of pain, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). R1's Quarterly Minimum Data Set (MDS), dated 12/12/25, documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS documented R1 had a PHQ-9 (a tool assessing depression severity) of 9, which indicated mild depression. The MDS documented R1 took antipsychotics (a class of medications used to treat major mental conditions, which cause a break from reality), anticonvulsants (a class of medications used to treat seizures and manage epilepsy by regulating abnormal electrical activity in the brain), and opioid (continued on next page)

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

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F 0602 Level of Harm - Actual harm Residents Affected - Few	(a class of medications used to treat moderate to severe pain) medications. The Care Area Assessment (CAA), dated 09/10/25, documented R1 had a diagnosis of Alzheimer's disease and took psychotropic medications. R1's Care Plan dated 09/02/25, documented R1 had pain and directed staff to administer pain medications as ordered (01/22/26). The plan documented R1 took antipsychotic medications and directed staff to administer the medications as ordered (09/03/25). R1's EMR documented R1 did not receive the following medications the night of 02/07/26: cyclobenzaprine (muscle relaxer), divalproex sodium (anticonvulsant), donepezil (antidementia), Eliquis (anticoagulant), risperidone (antipsychotic), and zaleplon (a hypnotic). The Nurse's Note, dated 02/09/26 at 12:09 PM, documented R1 stated she wanted to leave the facility because she felt disrespected and felt ugly. R1 stated her back hurt too much for her to move. R1 would get up into her chair for short period of time but did not wish to leave her room. On 03/23/26 at 10:00 AM, observation revealed R1 sat in her recliner staring out the window in her room. R3's EMR documented R3 had diagnoses of Alzheimer's Disease, dementia, and anxiety. R3's Significant Change MDS, dated 02/02/26, documented a BIMS of 0, which indicated severely impaired cognition. The MDS documented R3 took antianxiety medications and opioid medications. CAA's, dated 02/02/26, documented R3 had diagnoses of Alzheimer's disease and dementia. R3 had a BIMS of 0. R3 took psychotropic medications. R3's Care Plan, dated 01/22/26, documented R3 took psychotropic medications, antianxiety medications, antidepressant medications, and pain medications and directed staff to administer the medications as ordered (01/22/26). R3's EMR indicated R3 did not receive the following medications on the night of 02/07/26: tramadol (opioid pain medication), lorazepam (antianxiety medication), melatonin (medication to help regulate sleep), and gabapentin. The Nurse's Note, dated 02/08/26 at 02:30 AM, documented R3 was very restless through the night and up to the bathroom multiple times. R3 was unavailable for observation. R4's EMR documented R4 had diagnoses of major depressive disorder (major mood disorder which causes persistent feelings of sadness), psychosis (any major mental disorder characterized by a gross impairment and perception), and anxiety. The Quarterly MDS, dated 01/08/26, documented R4 had a BIMS score of four, which indicated severe cognitive impairment. The MDS documented R4 took antipsychotic medications, antidepressant medications, and anticonvulsant medications. CAA's, dated 07/16/25, documented R4 had impaired cognitive abilities with a BIMS score of six. R4 displayed disorganized thinking and inattention. The CAA documented R4 took psychotropic medications. R4's Care Plan, dated 11/25/25, documented R4 had agitated behaviors, impaired cognition, and hallucinations. The care plan directed staff to administer R4's antipsychotic, antidepressant, and pain medications as ordered. The EMR indicated R4 did not receive the following medications on the night of 02/07/26: cephalexin (an antibiotic for a urinary tract infection), duloxetine (an antidepressant), Seroquel (an antipsychotic), and gabapentin (for nerve pain). The Nurse's Note, dated 02/07/26, documented R4 came out of her room and stated she had been held captive at the facility for three years, her daughter was getting married, and she had to get out to go and get her a dress. R4 stated she was all packed, the police knew, and she would leave at midnight. On 03/23/26 at 10:30 AM, observation revealed R4 in her wheelchair pedaling up and down the hall. R2, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, and R15 did not receive multiple other medications the night of 02/07/26, such as stool softeners, pain medications, cholesterol medications, and sleep medications. On 03/23/26 at 11:30 AM, Administrative Nurse D stated she went through the black trash sack and sorted all of the medications that were in the bag. Administrative Nurse D stated none of the controlled substances that were supposed to be given to the fifteen residents who were cognitively impaired were located. Administrative Nurse D stated she thought CMA R had specifically chosen those residents to target because they would not remember if they took medications or not. Administrative Nurse D stated CMA R did not administer any of the medications to the fifteen residents. Administrative Nurse D stated law enforcement was notified, CMA R refused to take a drug test, and quit. Administrative Nurse D stated all of the residents who were affected were assessed that day and for the next seventy-two (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	hours. On 03/23/26 at 01:00 PM, Administrative Staff A, during the exit interview, stated education on drug diversion and misappropriation of property had been presented to all the staff on 03/04/26, which was verified through appropriate documentation of the in-service. The facility's Abuse, Neglect, and Exploitation Policy, dated 02/12/26, documents that each resident in the community has the right to be free from abuse, neglect, and misappropriation of their property. The community will enforce the policies and procedures that protect each resident from abuse, neglect, and misappropriation of property by employees of the community, other residents, consultants, volunteers, employees of other agencies, family members, legal guardians, friends, or other individuals. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The facility completed all corrective actions on 03/04/26, prior to the onsite survey therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of a G to represent actual harm using the reasonable person concept. This was applied due to inability of the cognitively impaired residents to verbalize the impact of their increased discomfort and pain.