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	04/10/2024

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

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 - Immediate jeopardy to resident health or safety 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** 43204 The facility identified a census of 32 residents with three residents reviewed for elopements. Based on record review, observation, and interview, the facility failed to ensure all door alarms were in functional working order to alert staff to residents exiting the facility unattended. On 04/01/24 at 11:13 PM, Resident (R) 1, who was cognitively impaired and at risk for elopement and falls, walked past Certified Nurse Aide (CNA) M in the commons area and headed toward the day room. At 11:15 PM, R1 exited out of the [NAME] dining room. The [NAME] dining room door did not alarm or set off the alarm panel. R1 went out into the courtyard off the dining room with his walker. The chain link fence that enclosed the courtyard was locked with a spring-loaded chain. R1 unhooked the chain, exited the courtyard, then relocked the chain. R1 left his walker on the outside of the fence and proceeded to walk east of the facility about 100 to 150 yards. R1 crossed a busy highway with posted speeds of 40 miles per hour and approached a neighboring house. R1 knocked on the door and told the occupant of the house that he was looking for his home. The occupant called the police. At 11:44 PM, the police notified Licensed Nurse (LN) G of R1's location and informed the nurse EMS (Emergency Medical Service) was on the way. LN G went across the highway to assess R1 along with EMS. EMS then transported R1 back to the facility and LN G performed a full body assessment. R1 had a couple of scratches on his nose but had no other injuries. R1 wore a coat, shirt, pants, and shoes but not his glasses. The failure to ensure door alarms were functional to alert staff to R1's elopement placed R1 in immediate jeopardy. Findings included: - The Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had short and long-term memory problems, knew the location of his room, and his cognitive skills for daily decision-making were severely impaired. The MDS documented R1 did not have any wandering behaviors during the assessment period. The MDS documented R1 was independent with most of his activities of daily living. The Cognitive Loss/Dementia Care Are Assessment, (CAA) dated 11/09/23, documented R1 was able to complete a Brief Interview for Mental Status (BIMS) exam and his score was three which indicated severely impaired cognition. The CAA documented R1 had a diagnosis of Alzheimer's disease. (continued on next page)

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

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	04/10/2024

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

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Fall CAA, dated 11/09/23, documented R1 had a history of falls and his fall risk evaluation documented R1 was at risk for falls. The CAA documented R1 was up independently with his walker but required supervision, as R1 had previously attempted to leave the facility unattended. R1's Care Plan documented R1 would not leave the facility unattended. Staff were directed to identify whether R1's pattern of wandering was purposeful, aimless, or escapist or if R1 was looking for something or needed more exercise and directed staff to intervene as appropriate (01/25/23). The care plan documented R1 voiced and showed staff he knew the code to open the front doors and silence the alarms, so the code was changed. Staff were directed to remind all visitors not to allow R1 to see them put in the new code (09/08/23). The Fall Risk Assessment, dated 11/10/23, documented R1's fall risk score was 12 and R1 was at risk for falls. The Elopement Risk Assessment, dated 01/02/24, documented R1 was at risk for elopement with a score of two. R1's WanderGuard (a bracelet used to alarm if a resident approaches an exit) was discontinued on this date as R1's elopement risk had decreased. Clinical interventions were to monitor R1's location frequently. The Elopement Risk Assessment, dated 04/02/24, documented R1 was at risk for elopement and had a score of six. Staff placed a WanderGuard on R1's right ankle. Clinical interventions were to apply a WanderGuard to R1's right ankle, monitor R1's location frequently, and notify staff of R1's elopement and wandering risk. The Incident Note, dated 04/02/24 at 12:45 AM, documented LN G received a phone call from the Sheriff's department informing LN G that R1 was found outside of the facility, at a home across the highway. LN G called Administrative Nurse D immediately and instructed a CNA to check the doors and do a head count of the residents. LN G went across the highway to check on R1. Upon arriving, R1 sat on a couch inside the neighbor's house. R1's vital signs were within normal limits. R1 had no bruising or open areas noted. R1 stated his arms and legs hurt a little and R1 had full range of motion to all his extremities. LN G and EMS personnel assisted R1 off the couch and R1 walked outside, and EMS loaded R1 into the ambulance and took R1 back to the facility. Upon R1's return to the facility, staff completed a full head-to-toe assessment of R1, with no bruising or open areas noted except some scratches on R1's nose. LN G asked how R1 got the scratches to his nose and R1 responded, I don't know. I want to lay down. The facility posted a CNA outside of R1's room. (continued on next page)

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	04/10/2024

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

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Incident Report, dated 04/05/24, documented on 04/01/24 at 11:13 PM, R1 was seen leaving his room and headed towards the Day Room. R1 passed CNA M who was in the commons area. CNA M stated this was a normal practice for R1 to go to the Day Room in the evenings. At 11:44 PM, the police department notified LN G that R1 was at a residence across the street to the east, and EMS had been contacted. LN G immediately notified Administrative Staff A and Administrative Nurse D. LN G instructed staff in the facility to conduct a head count of all other residents. LN G notified staff in the building she was going to the residence across the street to assist R1. While LN G was at the residence, Administrative Staff A arrived at the facility. LN G observed R1 did not have his walker or his glasses. R1 wore a coat, pants, shirt, socks, and shoes. When asked what happened, R1 replied, I wanted to go home to lie down. Administrative Staff A asked the homeowner what happened, and he stated, I heard a faint knock at the door and let him in. The homeowner stated R1 said he was cold and wanted to go home. After EMS assessed R1, EMS and LN G walked R1 to the stretcher outside of the residence and helped R1 onto the stretcher to transport him back to the facility. EMS assisted R1 into his bed at the facility. LN G conducted a thorough, full-body assessment and noted R1 had a full range of motion to all four extremities. There were no injuries or bruising found, except a couple of small scratches on R1's nose. At this time, Administrative Staff A started an investigation and began to review the cameras. Administrative Staff A instructed facility staff to place a WanderGuard bracelet on R1's right ankle. Staff conducted a resident head count and all residents were accounted for; staff closed the double doors leading into the Day Room and Dining Room, and a staff member was required to sit in the Commons Area to have full visual contact with both wings to ensure no residents were able to enter the Dining Room until the door was fixed. All other doors were checked to determine if the doors were functioning properly with the alarm system. It was identified all door alarms were working properly except for the Dining Room door. It was identified at the control panel, and it showed the Dining Room door was actively set to alarm, however, when the door was pushed open, the audible alarm did not go off at the panel. Cameras were reviewed and revealed R1 exited his room at 11:13 PM and walked past CNA M who was in the Commons Area. R1 walked with his walker to the front double doors and attempted to exit through these doors. R1 went from the front entrance to the Dining Room and went to the Dining Room door which could be seen in the video removing the Velcro stop sign from the door and proceeded to exit the door at 11:15 PM. Administrative Staff A was unable to see anything on video after R1 was outside the door. R1's walker was found outside of the gate which enclosed the courtyard. On 04/02/24, R1's primary care provider was notified of the incident and recommended to check R1 for a urinary tract infection. Administrative Staff A contacted the fire alarm specialists to get the door alarm fixed. The dining room door was fixed and functioning properly on 04/02/24 at 01:30 PM. Once the door was checked and verified to be alarming properly and all other doors were checked, door monitoring by staff was discontinued. R1 had a urinary tract infection and was started on an antibiotic on 04/03/24. Since the incident, R1 was not exit-seeking and returned to his normal activities. R1's last Elopement Assessment completed on 01/02/24 noted R1 was not at risk for elopement and did not require a wander bracelet. CNA M's undated Witness Statement, documented CNA M saw R1 leave his room shortly after 11:00 PM. CNA M saw R1 walk past her and headed to the Day Room where R1 liked to sit and watch television. About half an hour later, LN G came out of the nurse's station and asked CNA M to go meet EMS across the street because R1 had gotten out of the facility and crossed the street. CNA M was instructed to do a head count and test the doors because no alarm had gone off when R1 got out of the facility. Observation on 04/10/23 at 10:30 AM, revealed R1 sleeping in his bed without covers, and wore a WanderGuard on his right ankle. (continued on next page)

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	04/10/2024

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

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/10/23 at 10:45 AM, CNA N stated R1 wandered around the facility but had never even gone towards a door in the year that she had been at the facility. On 04/10/24 at 11:00 AM, LN H stated R1 was a high risk for wandering and at one point did wear a WanderGuard. LN H said R1 would tear it off and then later deemed it as not needed. On 04/10/24 at 11:15 AM, Administrative Nurse D stated the door alarm on the [NAME] dining room door did not work the night of the incident to alert staff R1 was exiting the door. Staff did not know R1 was gone until the police called and informed them of R1's whereabouts. Administrative Nurse D demonstrated R1's route. Observation with Administrative Nurse D revealed there was a locked gate out of the courtyard that was spring-loaded. Administrative Nurse D stated R1's walker was found outside of the fence and the gait had been closed and relocked. Administrative Nurse D stated that before this incident there was no policy about door alarm checks and the previous maintenance personnel was supposed to be checking the door alarms, but the facility could not find any documentation regarding the door alarm checks. Administrative Nurse D ensured the door alarms were being checked every evening before the evening shift started. The facility's Wandering, Unsafe Resident Policy, dated August 2014, documented the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). They will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety such as a detailed monitoring plan will be included. The facility failed to ensure all door alarms were in functional working order to alert staff to R1 exiting the facility unattended. The failure to ensure door alarms were functional to alert staff to R1's elopement placed R1 in immediate jeopardy. The facility's corrective action included an elopement assessment completed for R1 on 04/02/24. Staff placed a WanderGuard bracelet on R1 on 04/02/24. Staff were posted to ensure constant visualization of the door until the alarm was fixed. The Dining Room door was fixed and alarming correctly on 04/02/24 and daily door alarm checks for all doors were implemented on 04/02/24. The corrective actions were completed before the onsite survey therefore the deficient practice was deemed past noncompliance and remained at a scope and severity of J.