STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E197	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 29 residents. The sample included 14 residents with two reviewed for urinary catheter. Based on observation, record review, and interview, the facility failed to provide care and services to prevent a urinary tract infection (UTI-when bacteria enters into any part of the urinary tract) for Resident (R) 2, by not ensuring the catheter bag remained below the resident's bladder. Findings included: - R2's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition, required total staff assistance with toileting, personal hygiene, and had a urinary catheter (tubing inserted into the bladder to drain urine into a collection bag). The Urinary Care Area Assessment (CAA), dated 01/27/20, documented the resident incontinent of bowel and bladder, dependent of staff assistance for all Activities of Daily Living (ADLs), and wore incontinent briefs for dignity and hygiene during the daytime hours. The CAA documented staff administered the resident [MEDICATION NAME] (treats high blood pressure and enlarged prostate) for [MEDICAL CONDITION], checked and changed the resident every two hours to manage incontinence, and used a urinal during the night. The revised Catheter Care Plan, dated 09/08/20, documented on 07/27/20 staff attempted a voiding trial for R2 from 07/24/20 to 07/27/20 but the resident unable to void and had to be straight catheterized (the insertion of a catheter through the urethra into the urinary bladder for withdrawal of urine, straight catheters are used for intermittent withdrawals) multiple times. The care plan documented staff received a new order to reinsert the urinary catheter to dependent drainage for [MEDICAL CONDITION] with [MEDICAL CONDITION] (lack of ability to urinate and empty the bladder). The 08/26/20 update documented a urology consult completed with recommendation to continue indwelling urinary catheter and follow up in one year. The care plan directed staff to ensure catheter tubing anchored to the resident's thigh to help prevent tugging of the catheter, perform catheter care every shift, change urinary catheter every 30 days and as needed, and observe for signs and symptoms of UTI. R2's medical record documented the facility admitted the resident from the hospital on [DATE] with a [DIAGNOSES REDACTED]. On 09/14/20 at 02:21 PM, observation revealed R2 with a urinary leg bag (discreet urine collection bag) attached to catheter tubing while lying in bed and urinary leg bag not positioned below the bladder. On 09/15/20 at 01:42 PM, observation revealed R2 lying in bed with the leg bag secured to his left leg and bag not below the resident's bladder. Observation revealed Certified Nurse Aide (CNA) O applied gloves, cleansed the urinary meatus (opening into the penis), cleansed the catheter tubing, cleansed the peri area each with a clean sanitary wipes, and drained dark yellow urine from the catheter bag into a graduated cylinder. On 09/16/20 at 10:30 AM, observation revealed R2 lying in bed with the leg bag attached to the catheter tubing and bag not below the bladder. On 09/15/20 at 01:48 PM, CNA O stated the resident wore a leg bag all day and staff changed the leg bag to a full drainage bag when the resident went to bed at night. On 09/16/20 at 01:09 PM, Licensed Nurse (LN) H stated the resident always wore a leg bag throughout the day even when in bed. On 09/16/20 at 02:18 PM, CNA Q stated the resident wore a leg bag all day even in bed, so the catheter tubing didn't pull, and the night shift changed the leg bag to a full drainage bag on the night shift. On 09/17/20 at 09:45 AM, Administrator Nurse D stated staff were to change the resident's leg bag to a full drainage bag at night and when the resident laid down, his leg bag should be below his bladder. The facilities Urinary Catheter policy, dated January 2013, documented a resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. The facility failed to ensure R2's urinary catheter bag remained below his bladder, placing the resident at risk for infection.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** The facility had a census of 29 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to ensure two of five Certified Nurse Aides (CNAs) employed at the facility one year or longer completed the minimum 12 hours in-service training per year. Findings included: - Review of the facility's training records for CNAs who had been employed at the facility one year or longer revealed a lack of 12 hour in-service training for the following CNAs: - CNA M, date of hire 11/06/17, completed 8 hours. - CNA N, date of hire 06/12/17, completed 11.5 hours. On 09/15/20 at 01:13 PM, Administrative Staff A stated there were two CNAs that had not completed the required 12 hours in-service and training. The facility's Required Training and In-Services of Certified Nursing Assistants policy, dated 03/21/19, documented the facility's Medical Record department verifies credentials and documents verification at the time of employment and when the credentials are renewed or updated. The facility's Medical Records department documents that each applicant has the education and experience required by his/her job responsibilities. The facility failed to ensure every CNA employed at the facility one year or longer completed the minimum 12 hours in-service training per year, placing the residents at risk for inadequate care and services.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** The facility had a census of 29 residents. Based on observation, record review, and interview, the facility failed to provide a certified dietary manager to carry out the functions of food and nutritional services for the 29 residents who resided in the facility and received meals from the facility kitchen. Findings included: - On 09/16/20 at 10:43 AM, observation revealed Dietary Staff (DS) BB participated and provided oversight of the noon meal preparation and service. On 09/16/20 at 10:30 AM, DS BB stated she was not certified but currently attended classes to become certified and would be finished in December 2020. On 09/21/20 at 09:00, Administrative Staff A stated DS BB was not certified, was taking classes to become certified, and would be finished in December 2020. The facility failed to provide a certified dietary manager to carry out the functions of food and nutritional services, placing the 29 residents who received meals from the facility kitchen at risk for nutritional problems and weight loss.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** The facility had a census of 29 residents. Based on observation, record review, and interview, the facility failed to prepare food by methods that conserved the nutritive value for three of three residents who received pureed meals. Findings included: - On 09/16/20 at 10:43 AM, observation revealed Dietary Staff (DS) CC placed two 8-ounce (oz) scoops of tuna casserole into a blender, added half a piece of whole wheat bread, an unmeasured amount of milk, and blended to a nectar consistency. DS CC placed the pureed tuna noodle casserole into three one cup bowls and checked the temperature with a

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

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) finding of 118 degrees Fahrenheit (F). DS CC placed the three bowls on a plate and microwaved them together for 30 seconds at a time until they reached a temperature of 174 F. DS CC covered the bowls of tuna noodle casserole and placed on the steam table. Observation revealed DS CC retrieved a new blender container and placed three four-oz scoops of carrots, two four-oz scoops of juices from the cooked carrots, and half a slice of whole wheat bread into the blender and blended to nectar consistency. DS CC placed pureed carrots into three one-cup bowls and checked the temperature with a finding of 133 F. DS CC placed all three bowls into the microwave for 30 seconds at a time until the temperature reached 165 F. Observation revealed DS CC covered the bowls and placed them on the steam table. On 09/16/20 at 11:15 PM, DS CC verified that she did not use a recipe for preparing the pureed tuna noodle casserole meals. On 09/16/20 at 11:00 AM, DS BB verified there was no recipe for the pureed tuna noodle casserole. The facilities undated Pureed Food policy documented the pureed diet follows the regular diet with foods pureed or soaked as needed. This diet is recommended when choking tendencies, difficulty chewing, or swallowing are noted, and no other consistency can be tolerated. Foods that cannot be adequately pureed are altered as indicated on menu. Pureed recipes are located in a separate binder. The facility failed to prepare pureed food by methods that conserved the nutritive value for the three residents who received pureed textured meals, placing the residents at risk for unmet nutritional needs.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** The facility had a census of 29 residents. The sample included 14 residents with five reviewed for immunizations. Based on observation, record review, and interview, the facility failed to provide five of five sampled residents, or their representative, current Influenza and Pneumonia Immunization information, Resident (R) 129, R13, R2, R10, R24. Findings included: - Review of Resident (R) 129's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed 09/27/19 by R129's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. Review of R13's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed 08/23/20 by R13's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. Review of R2's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed 08/22/20 by R2's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. Review of R10's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed 08/23/20 by R10's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. Review of R24's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/2015, signed 08/24/20 by R24's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. On 09/17/20 at 02:15 PM, Administrative Staff B verified the Influenza Vaccine Information Statements provided by the Department of Health and Human Services, Centers for Disease Control and Prevention provided to the resident's and/or representative were dated 08/07/15 and she received them from the Health Department. Upon request, the facility failed to provide a policy regarding Immunizations. The facility failed to provide R129, R13, R2, R10, and R24, or their representative, the current Influenza and Pneumonia Immunization education, placing the residents or their representative at risk for making an uninformed decision.