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	175272	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE & REHABILITATION CENTER, LLC	**509 GROVE STREET WAKEFIELD, KS 67487**

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #139933. The 2567 was electronically sent to the facility on 4/08/19.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview the facility failed to provide necessary care and treatment for a draining wound for 1 of 14 sampled residents. Findings included: - Resident #8's admission (MDS) Minimum Data Set assessment, dated 1/21/2019, documented the resident had severe impaired cognition, independent for bed mobility, transfers, toilet use, and had venous and arterial ulcers. The (CAA) Care Area Assessment for pain, dated 1/23/2019, recorded the resident had arterial and diabetic wounds, and his/her hygiene care and skin integrity were risk factors with the resident.	F 684		

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

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The 1/11/2019 care plan directed staff to change the resident's UNNA (a special gauze bandage, impregnated with zinc, glycerin, or calamine that becomes rigid when it dries, approximately 4 inches by 10 yards long), boot on his/her left lower extremity every Friday, and as needed due to chronic venous ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) and inflammation of his/her left lower extremity, which could be used for the treatment of venous ulcers and other venous insufficiencies of the leg.

The 3/01/2019 physicians order directed the nurse to change the UNNA boot to the resident's left lower extremity on Fridays, place aquacel AG (a sterile dressing with silver used to cover a wound and prevent infection) to open wound, apply UNNA boot, wrap with gauze-kling and stabilize with coban (a self-adherent compression bandage used for protection and swelling control).

The 3/14/2019 at 3:50 PM, nurse's notes recorded the resident returned from the physician's office with orders to continue with the current care on the resident's left lower extremity, and follow up with the physician in 6 weeks.

The 3/22/2019 at 11:09 AM, nurse's notes documented the nurse changed the resident's left lower leg dressing and noted the wound was yellow and purple colored, with yellow drainage, and odor noted.

The 3/29/2019 at 4:55 AM, nurse's notes documented the resident's left lower leg dressing was changed last night due to leaking foul smelling greenish/yellowish drainage, when the

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dressing was removed. Continued observation revealed the leg was macerated (softening and breaking down of the skin resulting from prolonged exposure to moisture), cleansed with wound cleanser, the resident requested to leave the leg open to air, and staff respected his/her wishes. The nurse placed (ABD) abdominal gauze pads to absorb drainage from the wounds, and tape around his/her leg to prevent his/her pants from rubbing on the wound of his/her leg. The resident called his/her relative and explained he/she had drainage coming from his/her wound, the relative called the facility and requested the resident be seen at the emergency room first thing in the morning.

The 4/01/2019 at 3:59 AM, nurse's notes documented the resident's wound had a large amount of watery green drainage, the nurse placed an ABD pad wrapped with gauze to the resident's heel and bottom of foot to absorb any drainage.

The 4/03/2019 at 9:18 AM, nurse's notes documented the nurse removed the left lower leg dressing and observed green drainage with a foul odor with dark purple skin and multiple open areas.

On 4/03/2019 at 9:00 AM, observation revealed Nurse H removed the UNNA boot from the resident's left lower extremity, cleansed the wound with normal saline gauze, and patted dry. Continued observation revealed the leg had yellowish/green drainage, and Nurse H applied calcium alginate over the three open areas on the top of the resident's shin and back of the calf. Continued observation revealed Nurse H applied the UNNA boot dressing, secured with a 4 inch

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gauze wrap, applied two 6 inch ABDs for drainage and absorption, then applied a 4 inch kling dressing, secured with coban.

On 4/03/2019 at 9:00 AM, Nurse H verified the resident was admitted to the facility in January after left leg vein surgery. Nurse H stated the resident was on antibiotics, and after the antibiotics were finished the resident started developing the drainage and foul odor from the wounds. Nurse H verified he/she sent a fax to the physician over the weekend, March 31, and requested to obtain a culture or a different wound treatment, but had not received correspondence back as of 4/03/2019.

The 7/01/2013 Wound Care Management policy documented to choose the appropriate option and secure a physician order, specifying type, size, and amount of all dressings utilized.
The facility utilized zinc with a calamine compression bandage system (UNNA Boot) and follow the following procedure:
The nurse scrubbed the skin surface of wound bed tissue vigorously with normal saline gauze, or skin integrity wound cleanser.
Allow the area around the wound to dry.
Apply honey dressing to ulcerated areas.
Apply UNNA boot bandage, start just above the toes and wrap up in a spiral, stopping just below the back of the knee.
Change every 5-7 days or when drainage strikes through the dressing.
If no improvement in 14 days, notify the physician for further evaluation.

The facility failed to provide Resident #8 with adequate treatment for his/her draining left lower leg wound, placing the resident at risk for

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F 684	Continued From page 4 discomfort and prolonged treatment.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 14 sampled residents. (#32) Findings included: - Resident #32's quarterly (MDS) Minimum Data Set assessment, dated 2/24/19, recorded the resident had severely impaired cognition with inattention and disorganized thinking. The MDS also recorded the resident required extensive staff assistance with all (ADLs) Activities of Daily Living and used a wheelchair for mobility. The 7/30/18 admission (CAA) Care Area Assessment for falls recorded the resident was a high risk for falls due to his/her weakness, immobility and severely impaired cognition. The 3/15/19 care plan recorded the resident was at risk for falls due to weakness, immobility, and	F 689		

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poor safety awareness, The care plan directed staff to transfer the resident with a sit to stand lift (assistive device provides support for person to stand), and transport the resident in his/her wheelchair.

On 4/01/19 at 11:11 AM, observation revealed the resident sat in a wheelchair with no foot pedals, and his/her feet rested on the floor. Continued observation revealed the resident had a pressure relief boot on his/her left foot, a sock on his/her right foot, and the resident's feet slid on the floor, when staff pushed the resident's wheelchair to the dining room.

Multiple observations, during the 4 day survey process, revealed staff pushed the resident's wheelchair, and the resident's feet slid on the floor.

On 4/03/19 at 11:02 AM, Nurse G stated the resident was a fall risk due to severely impaired cognition and limited mobility, and was dependent on staff to push his/her wheelchair.

On 4/04/19 at 8:00 AM, Administrative Nurse D stated the resident was a fall risk, and dependent on staff for his/her wheelchair mobility. Administrative Nurse D stated staff should place foot pedals on the resident's wheelchair to prevent an accident or injury.

The facility's Positioning Policy, dated 5/2011, directed staff to position residents to ensure comfort and safety.

The facility failed to provide adequate supervision and assistive devices to prevent accidents for Resident #32, placing the resident at risk for falls

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F 689	Continued From page 6 and injuries.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		

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§483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents, of which 5 residents were reviewed for unnecessary medications. Based on observation, record review and interview the facility failed to ensure an appropriate diagnosis for the use of antipsychotic medications (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental illness conditions) for 1 of 5 sampled residents. (#25)

Findings included:

- Resident #25's physician's order, dated 3/14/19, recorded the following diagnoses: dementia (progressive mental disorder characterized by failing memory and confusion), and depression (abnormal emotional state characterized by exaggerated feelings of sadness and worthlessness).

The admission (MDS) Minimum Data Set assessment, dated 2/25/19, recorded the resident had a (BIMS) Brief Interview for Mental Status

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score of 3 (severely impaired cognition), and no behaviors. The MDS recorded the resident required staff supervision with transfers and walking, and received an antipsychotic medication.

The admission (CAA) Care Area Assessment for psychotropic drug use, dated 2/25/19, recorded the resident had wandering behaviors related to dementia. The CAA recorded the resident received scheduled Seroquel (antipsychotic medication) for dementia without behaviors, and was at risk for adverse side effects.

The 3/08/19 care plan recorded the resident wandered, attempted to elope (exit the facility without supervision), and had impulsive behaviors related to dementia. The care plan recorded the resident received scheduled Seroquel with the following (BBW) Black Box Warning (strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug): Seroquel is not approved for dementia-related psychosis due to the medication is not effective for the treatment of dementia related behaviors, and can increase mortality (death) risk and adverse side effects in elderly dementia residents.

The physician order, dated 2/22/19, directed staff to administer Seroquel, 25 (mg) milligrams everyday for dementia without behaviors.

Review of the resident's behavior monitoring report for the past 30 days (3/02/19 to 4/02/19) recorded the resident had wandering behaviors 32 times and verbal behaviors 2 times.

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F 758	Continued From page 9 On 4/03/19 at 8:17 AM, observation revealed the resident walked independently without an assistive device to the dining room. Continued observation revealed the resident was smiling, well groomed, neatly dressed, and visited with staff and other residents. On 4/03/19 at 11:04 AM, Nurse H stated the resident was pleasantly confused, cooperative, and had wandering behaviors which had improved since his/her admission. Nurse H stated the resident received scheduled Seroquel for dementia without behaviors. On 4/03/19 at 10:19 AM, Nurse Aide M stated the resident was mostly independent with (ADLs) Activities of Daily Living, wandered into other residents' rooms at times, and was easily redirected without behaviors. On 4/04/19 at 8:00 AM, Administrative Nurse D stated the resident received a scheduled antipsychotic medication for dementia. Administrative Nurse D stated the resident did not have an appropriate diagnosis for the use of an antipsychotic medication. The facility's Psychotropic Medication Policy, dated 9/2013, directed staff to ensure the resident had an appropriate condition or diagnoses for treatment with an antipsychotic medication. The facility failed to ensure an appropriate diagnosis for Resident #25's use of the antipsychotic medication, Seroquel for Resident #25, placing the resident at risk for adverse side effects.	F 758		

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F 791	Continued From page 10	F 791		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility	F 791		

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policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to provide dental care for 1 of 1 resident reviewed for dental. (#30)

Findings included:

- Resident #30's quarterly (MDS) Minimum Data Set assessment, dated 3/04/2019, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 12, indicating moderate impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff for personal hygiene, had mouth/facial pain, and difficulty chewing.

The (CAA) Care Area Assessment, dated 4/20/2018, for (ADLs) Activities for Daily Living documented the resident had pain from dental health problems, staff administered oral pain medications, and applied topical oral gel to help alleviate the oral/dental pain and discomfort.

The care plan, dated 3/28/2019, directed staff to assist the resident with personal hygiene, and coordinate arrangements for dental care and transportation as needed. The care plan documented the resident had dental health problems due to broken teeth and staff encouraged the resident to brush his/her teeth

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with gentle oral cares every morning and night. The care plan directed the staff to monitor the resident for pain or discomfort due to any dental needs, administer pain medication as ordered, apply oral pain relieving gel up to four times a day for tooth pain, and report/notify the physician of any signs and symptoms of lower gum infection related to the broken teeth.

The 3/27/2019 at 1:06 PM, nurse's notes documented the resident complained of his/her teeth hurting when he/she placed pressure on the teeth, and he/she did not eat breakfast.

The 3/28/2019 at 1:51 PM, nurse's notes documented the resident complained of mouth pain and had several teeth bothering him/her. The nurse administered oral pain relieving gel for the tooth pain.

The 3/28/2019 at 5:04 PM, nurse's notes documented the nurse applied oral pain relieving gel to the resident's mouth for the tooth pain, and administration was effective.

The 3/30/2019 at 7:20 PM, nurse's notes documented the resident complained of daily pain to his/her mouth, hands, knees, and cried. The nurse's notes documented the administration of the as needed Tylenol was ineffective and the resident rated his/her pain at an 8 on a 1-10 scale. (1 no pain, 10 worst pain)

The 4/01/2019 at 11:00 AM, nurse's notes documented the resident complained of mouth, hands, knee pain, and the nurse administered Tylenol 325 (mg) milligrams.

The 4/01/2019 at 11:48 AM, nurse's notes

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recorded staff set up a dental appointment for the resident to evaluate his/her mouth pain. The notes documented the residents Norco (pain medication) was discontinued when he/she returned from the behavioral special care unit on 3/20/2019.

The 4/03/2019 at 1:11 PM, nurse's notes documented the resident complained of pain and the nurse administered two, Tylenol 325 mg tablets. The follow up assessment revealed the resident continued to complain of pain in his/her mouth, hands and knees.

The 4/03/2019 at 2:37 PM, nurse's notes documented the resident complained of pain so the nurse administered two, Tylenol 325 mg tablets. The follow up assessment revealed the resident continued to complain of pain in his/her mouth, hands and knees, and was tearful due to the pain. The notes documented staff awaited a new pain medication order from the primary care physician.

The 4/03/2019 at 3:00 PM, nurse's notes documented the facility received a fax from the physician documenting the resident's Norco pain medication had been discontinued when he/she was a resident at the behavioral special care unit and questioned if the Norco had helped in the past. The physician documented to restart the resident's pain medication, however the behavioral special care unit felt the medication was not necessary. The facility requested a clarification of the pain medication the physician would prescribe and stated the resident had an order for Tramadol (narcotic pain medication) but it was ineffective.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175272	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE & REHABILITATION CENTER, LLC	509 GROVE STREET WAKEFIELD, KS 67487

(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 791	Continued From page 14	F 791		

The 4/04/2019 at 8:03 AM, nurse's notes documented the following physicians order:
1) Norco 5-325 mg, 1 tablet three times a day for pain
2) Norco 5-325 mg, 1 tablet every 4 hours as needed for severe breakthrough pain.
3) Tramadol 50 mg, 2 tablets every 8 hours as needed for moderate breakthrough pain
4) Discontinue the scheduled Tramadol

The 4/04/2019 at 10:25 AM, nurse's notes documented the resident complained of mouth, knees and hand pain and the nurse administered Norco tablet 5-325 mg, 1 tablet every 4 hours as needed for severe breakthrough pain.

On 4/03/2019 at 3:30 PM, observation revealed the resident sat in his/her wheelchair and propelled himself/herself down hall B. The surveyor asked the resident how he/she was doing and he/she pointed to the left side of his/her face. The surveyor asked the resident if he/she was hurting and the resident shook his/her head "yes", became tearful and started shaking all over. The surveyor immediately went to the charge nurse and asked if if he/she was aware the resident was having severe mouth pain,

On 4/03/2019 at 3:35 PM, License Nurse H verified the resident had reported pain daily to his/her mouth, hands and knees, cried and became tearful, and staff administered Tylenol, which had been ineffective. Nurse H verified he/she sent a fax to the physician indicating the resident had ineffective pain control and the behavioral healthcare unit had taken the resident off the Norco.

The 11/2017 Pain Management policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175272	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE & REHABILITATION CENTER, LLC	**509 GROVE STREET WAKEFIELD, KS 67487**

(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 791	Continued From page 15 documented the facility must ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal preference. The policy documented if the resident's pain was not controlled by the current treatment regimen, the Practitioner should be notified. The interdisciplinary team and the resident collaborated to arrive at pertinent, realistic and measurable goals for treatment. The policy documented the staff would reassess patients with pain regularly based on the facility's established intervals, and if re-assessment findings indicate pain was not adequately controlled, revise the pain management regimen and plan of care as indicated. The facility failed to evaluate Resident #30's pain due to his/her broken, carious (decayed) teeth, placing him/her at risk for infection, weight loss and poor hygiene.	F 791		