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 _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	**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 000	INITIAL COMMENTS The following citations represent the result of complaint investigation KS00176427. The 2567 was sent electronically on 01/26/23.	F 000		
F 689 SS=G	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 identified a census of 40 residents with three residents reviewed for falls. Based on record review and interview, the facility failed to provide activities of daily living (ADL) assistance with the appropriate number of staff in order to prevent accidents for Resident (R)1. On 11/25/22 Licensed Nurse (LN) G provided incontinence care to R1 without secondary staff assistance when LN G lost her balance, let go of R1causing R1 to fall to the floor, face first. As a result, R1 sustained a laceration to her left eyebrow and a large, complicated tongue laceration, despite not having any teeth, which required suturing by a specialized physician. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia	F 689		

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

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.

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(progressive mental disorder characterized by failing memory, confusion), protein calorie malnutrition, and muscle weakness.

The "Quarterly Minimum Data Set (MDS)," dated 10/07/22, documented R1 was severely cognitively impaired and had short- and long-term memory loss. The MDS further documented R1 was totally dependent on two staff for toileting and bathing. R1 was totally dependent on one staff for personal hygiene and locomotion on and off the unit. R1 required extensive assistance from two staff for bed mobility, transfer, and dressing.

The "Fall Care Area Assessment (CAA)," dated 03/22/22, documented R1 was at risk for falls due to poor balance and strength during transfers and transitioning and R1 needed assistance of two staff and a full body lift.

The ADL CAA did not trigger.

The "ADL Care Plan," revised 04/22/22, documented R1 required one to two staff for bed mobility and two staff for toileting.

The "Communication to Physician Note," dated 10/23/22, documented R1's dementia was continuing to cause her to decline in functioning and R1's blood pressure medication had to be held for three days.

The "Nursing Note," dated 11/10/22 documented R1 was oriented to herself only and staff anticipated all of her needs. The note included R1 was harder and harder to keep awake and when R1 was awake, it was difficult for her to hold her head up. Nursing noted that for the past few

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F 689	Continued From page 2	F 689		

weeks R1 preferred to be in bed asleep rather than be out of bed, for any reason. The note documented R1's decline had become very apparent to the nursing staff.

The "Nursing Note," dated 11/11/22, documented R1 struggled to swallow liquids and was letting the liquids run out of her mouth or hold it in her cheeks. R1's decline was documented as being increasingly noticeable.

The "Nursing Note," dated 11/16/22, documented R1 had not taken in enough food to measure. R1 appeared to pocket food in her cheeks or chew the same bite for over five minutes and then refused to swallow. The staff were constantly having to wake up R1 or ask R1 to hold up her head so she could drink.

The "Nursing Note," dated 11/20/22 documented R1 struggled to hold her head up and was not swallowing even with verbal cues from staff.

The "Nursing Note," dated 11/25/22, documented a call for help was heard from R1's room. When the nurse entered R1's room, she saw LN G on the floor on her knees and R1 lying face down on the floor beside her bed with a pool of blood around her. LN G reported she had been changing R1 [providing peri-care and changing incontinence brief] by herself and had rolled R1 towards the edge of the bed. LN G then fell backwards and R1 rolled out of bed. A complete body check was performed. R1 had a deep laceration to the left side of her nose and two other areas to the left side of her head. The areas were cleansed, and pressure was applied. R1's range of motion was within normal limits. The staff notified R1's primary care physician of the

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fall and received orders to send R1 to the emergency room for evaluation and treatment.

The "Emergency Room Note," dated 11/25/22, documented R1 sustained a laceration to the bridge of her nose and a significant laceration to her tongue despite not having any teeth. R1 would be transferred to a higher level of care due to acute injury and the need for an Ear, Nose, and Throat (ENT) doctor to suture R1's tongue.

The "Hospital Physical Therapy Note," dated 11/26/22, documented R1 required total assistance of two staff for right and left rolling and was dependent for peri-cares of cleansing during the session, with extreme fatigue on exertion noted. R1 exhibited poor trunk and head control, decreased strength, decreased endurance, limited range of motion, incoordination, inability to execute purposeful movements, lack of coordination of muscle movement, poor safety awareness, decreased attention, inability to follow directions, poor balance, and impaired cognition.

On 01/11/23 at 10:00 AM, Certified Medication Aide (CMA) R stated R1 required assistance of two staff for bed mobility and incontinence care because when staff rolled her, she was flaccid and had no muscle control. CMA R stated when she assisted R1 with incontinence care, there were always two staff performing the task.

On 01/11/23 at 10:15 AM, Certified Nurse Aide (CNA) M stated R1 needed to have two staff assist her with incontinence care because when staff rolled R1, R1 did not have any control of her body and did not assist in any way.

On 01/11/23 at 10:30 AM, CNA N stated when

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she assisted R1 with bed mobility or incontinence care two staff were needed to perform cares safely.

On 01/11/23 at 11:00 AM, LN H stated R1 required one to two staff assistance with bed mobility and incontinence care depending on how R1 was doing each day, how awake R1 was, whether R1 could follow directions, but most of the time two staff assisted R1 for safety reasons.

On 01/11/23 at 01:30 PM, Administrative Nurse D verified if LN G had used two staff to provide incontinent care to R1, R1 would not have fallen. Administrative Nurse D verified R1's MDS documented R1 required extensive assistance of two staff for bed mobility and was totally dependent on two staff for toileting.

The facility's "Managing Falls and Fall Risk," dated October 2022, documented staff will identify interventions related to a resident's specific risks and causes to try and prevent the resident from falling and try to minimize complications from falling. Factors that may result in a fall include but are not limited to: acute changes in condition, functional impairments, and cognitive impairment.

The facility failed to provide ADL care with the appropriate number of staff in order to prevent accidents for R1 which resulted in R1 falling out of bed onto her face. As a result, she sustained injuries that required her to be transferred to a higher level of care for treatment to receive sutures in her tongue.