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 08/21/2023

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	F 000		

The following citations are the result of abbreviated survey and complaint investigation KS00182200 and KS00182161.

On 08/21/23 at 12:45 PM the facility received a copy of the "Immediate Jeopardy [IJ] Templates" and was informed of the immediate jeopardy involving Resident (R) 1.

On 08/14/23 at approximately 07:30 AM Certified Medication Aide (CMA) R entered Resident(R) 1's room and offered the resident a shower. R1 stated she would like a shower but requested assistance to the bathroom first. CMA R asked Licensed Nurse (LN) G to assist with toileting R1, who required extensive assistance from two staff for toileting and transfer. CMA R and LN G assisted R1 onto the toilet, CMA R stayed in the bathroom with the resident, and LN G stepped back into the resident's room. LN G then became frustrated with waiting, entered the bathroom, grabbed R1 by the arm, and by the gait belt around R1's waist and attempted to pull R1 off the toilet while stating she had other residents to take care of. R1 resisted saying she still need to void. CMA R asked LN G to leave the room. LN G proceeded to leave the bathroom and as she did, she flung R1's wheelchair out of the way and the wheelchair struck R1 in the right leg. LN G exited the room and slammed the door.

The facility failed to ensure residents remained free from abuse and mistreatment. This deficient practice placed R1 in immediate jeopardy.

On 08/16/23 the facility completed corrective actions which included an all-staff in-service on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/05/2023

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 08/21/2023

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WAKEFIELD CARE AND REHAB	**509 GROVE STREET WAKEFIELD, KS 67487**

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F 000	Continued From page 1 preventing abuse, neglect and exploitation and reporting abuse. The facility provided staff training on "CARES Values." The corrective actions were completed prior to the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of "J." The facility failed to ensure staff identified a situation of abuse and mistreatment and failed to immediately report to the LNHA. On 08/16/23 the facility completed corrective actions which included an all-staff in-service on preventing abuse, neglect and exploitation and reporting abuse. The facility provided staff training on "CARES Values." The corrective actions were completed prior to the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of "K." The 2567 was sent electronically on 09/05/23.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

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WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 2 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to ensure residents remained free from abuse and mistreatment. On 08/14/23 at approximately 07:30 AM Certified Medication Aide (CMA) R entered Resident(R) 1's room and offered the resident a shower. R1 stated she would like a shower but requested assistance to the bathroom first. CMA R asked Licensed Nurse (LN) G to assist with toileting R1, who required extensive assistance from two staff for toileting and transfer. CMA R and LN G assisted R1 onto the toilet, CMA R stayed in the bathroom with the resident, and LN G stepped back into the resident's room. LN G then became frustrated with waiting, entered the bathroom, grabbed R1 by the arm, and by the gait belt around R1's waist and attempted to pull R1 off the toilet while stating she had other residents to take care of. R1 resisted saying she still need to void. CMA R asked LN G to leave the room. LN G proceeded to leave the bathroom and as she did, she flung R1's wheelchair out of the way and the wheelchair struck R1 in the right leg. LN G exited the room and slammed the door. This placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR)	F 600	Past noncompliance: no plan of correction required.	

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

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F 600	Continued From page 3	F 600		

documented R1 had diagnoses of Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder).

The "Quarterly Minimum Data Set (MDS)," dated 08/05/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 required extensive assistance of two staff for all activities of daily living except for eating.

The "Activity of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA)," dated 10/21/22, documented R1 had a diagnosis of Huntington's disease and required extensive assistance of two staff for all activities of daily living except eating.

The "Huntington's Disease Care Plan," revised 05/04/23, directed staff to provide R1 with a calm approach and utilize redirection as needed. The care plan directed staff to provide R1 with active listening and implement problem solving skills when R1 was calm and able to communicate effectively and appropriately.

The "Performance Review," dated March 2023, documented LN G had the following areas that required improvement in her employment as a licensed nurse at the facility: LN G lost her temper too easily, LN G did not start her workdays in a positive manner, and LN G announced things to others in the open.

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 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 4	F 600		

Development actions prescribed included LN G needed a way to catch herself prior to losing her temper, LN G needed to try not to set her whole day up for failure, and LN G needed to understand not everyone needed to hear about call-ins or others short comings. The "Performance Review" documented LN G was occasionally disruptive and discourteous, slow to help others, exhibited less than adequate responsiveness and courteousness to patients, and would occasionally ignore problems.

The "Witness Statement," dated 08/15/23, documented CMA R went into R1's room. R1 told CMA R she needed to use the bathroom first. CMA R told R1 to give her a moment to try and find another staff to assist getting R1 onto the toilet. CMA R looked out into the hall and saw LN G and asked if LN G would help her to transfer R1 to the toilet. CMA R stated after she and LN G transferred R1 to the toilet, CMA R stayed in the bathroom with R1 and LN G waited in R1's room. CMA R stated after around two minutes R1 had not gone to the bathroom and LN G was getting visibly frustrated. LN G stated to R1 since she had not gone to the bathroom yet R1 needed to get off of the toilet because LN G had stuff to do. CMA R stated R1 said, "No," and was upset with LN G. R1 stated she still needed to use the bathroom. CMA R stated she tried to diffuse the situation by telling R1 maybe she could try to go to the bathroom later or maybe R1 could pee in the shower, not ideal but it would be okay. R1 did not like that idea and CMA R assured R1 they could wait. LN G said, "No she needs to get up now." R1 said, "No." LN G then began to pull on R1's arm and the gait belt. LN G told R1 she needed to get off of the toilet in a loud frustrated voice. R1 resisted and stated, "No I still need to

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 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 5	F 600		

pee. I will tell my kids." CMA R then told LN G to leave the room and CMA R would find someone else to help transfer R1 off of the toilet. LN G then proceeded to fling R1's wheelchair out of her way causing the wheelchair to hit R1's right calf and knee. LN G left and slammed the door on the way out.

The "Facility Incident Report," dated 08/18/23, documented R1 was on her way to be showered. They were leaving R1's room and R1 stated she had to go to the restroom. CMA M and LN G helped R1 onto the stool in R1's room. R1 sat on the stool for a few minutes and did not go. LN G told her that she needed to help other residents and if R1 could not go now then she needed to get up and try again later. R1 stated she could get herself off of the toilet. LN G stated no that was not safe and LN G took R1's arm and started pulling to help her to stand up. R1 resisted and LN G became frustrated and used an inappropriate firm authoritative voice to get R1 to comply. To deescalate the situation, CMA M told LN G that she would stay with R1, and LN G could go on to the next resident. As LN G was leaving, LN G pushed the wheelchair out of her way, and it ran into the leg of R1. R1 then sat on the toilet a while longer and went to the bathroom and was then escorted to the shower room.

On 08/21/23, at 09:30 AM, R1 sat at the breakfast table in her wheelchair and watched other residents and staff. R1 had spastic movements.

On 08/21/23 at 09:45 AM, R1 stated LN G told her that she was going to get off of the toilet and grabbed her arm. R1 told LN G that she was not done. R1 told LN G not to treat her like that. R1 stated LN G pushed her wheelchair out of the

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 08/21/2023

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WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 6	F 600		

way and the wheelchair hit her leg. R1 stated she was scared of LN G but since LN G was gone, she was sleeping much better.

On 08/21/23 at 10:30 AM, CMA S stated LN G was easily frustrated and when LN G started to get frustrated LN G would get loud. CMA S stated she would pull LN G into the office and ask LN G what was going on and allow her to vent.

On 08/21/23 at 10:45 AM, Administrative Nurse D stated a couple of weeks ago, LN G was voicing her frustration regarding a resident being needy in an open area of the facility where others could hear her, and Administrative Nurse D took LN G to the office and told her it was inappropriate to express her feelings about a resident's wants where anyone could hear. Administrative Nurse D reported LN G may have had some personal stressors which factored in but stated the incident was unanticipated.

On 08/21/23 at 11:00 AM, Administrative Staff A stated CMA R did not report the incident until about 03:00 PM when her shift was over; CMA R stated she did not report it because she did not want to make the working relationship between her and LN G strained or uncomfortable. Administrative Staff A stated he expected all staff to report allegations of abuse and neglect to him immediately and that all staff had been re-educated on the abuse policy.

On 08/21/23 at 11:30 AM, CMA R stated that LN G got frustrated easily when she was on shift and staff walked on eggshells around her. CMA R stated LN G did not act appropriately with R1 on the day of the incident. CMA R said LN G went

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 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 7	F 600		

into the bathroom and grabbed R1's arm roughly and then grabbed the gait belt and pulled R1 half-way off of the toilet trying to get R1 to stand up. CMA R stated she had to scoot R1 back onto the toilet to keep her from falling off the toilet. CMA R stated she did not report the incident with R1 and LN G until after her shift was over, then she reported it to social services at the facility. CMA R stated she knew now that the incident should have been reported immediately to protect R1 and the other residents in the facility.

The facility's "Abuse Prevention Program," revised August 2022, documented residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, exploitation, and involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical condition. The facility administration and employees are committed to protecting residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.

The facility failed to ensure residents remained free from abuse and mistreatment. This deficient practice placed R1 in immediate jeopardy.

On 08/16/23 the facility completed corrective actions which included an all-staff in-service on preventing abuse, neglect and exploitation and reporting abuse. The facility provided staff training on "CARES Values."

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 600	Continued From page 8 The corrective actions were completed prior to the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of "J."	F 600		
F 609 SS=K	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents	F 609	Past noncompliance: no plan of	

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 609	Continued From page 9	F 609		

with three residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to ensure staff identified a situation of abuse and mistreatment and failed to immediately report to the facility administrator (LNHA). On 08/14/23 at approximately 07:30 AM Certified Medication Aide (CMA) R entered Resident(R) 1's room and offered the resident a shower. R1 stated she would like a shower but requested assistance to the bathroom first. CMA R asked Licensed Nurse (LN) G to assist with toileting R1, who required extensive assistance from two staff for toileting and transfer. CMA R and LN G assisted R1 onto the toilet, CMA R stayed in the bathroom with the resident, and LN G stepped back into the resident's room. LN G then became frustrated with waiting, entered the bathroom, grabbed R1 by the arm, and by the gait belt around R1's waist and attempted to pull R1 off the toilet while stating she had other residents to take care of. R1 resisted saying she still need to void. CMA R asked LN G to leave the room. LN G proceeded to leave the bathroom and as she did, she flung R1's wheelchair out of the way and the wheelchair struck R1 in the right leg. LN G exited the room and slammed the door. This placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear),

correction required.

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 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 609	Continued From page 10	F 609		

and major depressive disorder (major mood disorder).

The "Quarterly Minimum Data Set (MDS)," dated 08/05/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 required extensive assistance of two staff for all activities of daily living except for eating.

The "Activity of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA)," dated 10/21/22, documented R1 had a diagnosis of Huntington's disease and required extensive assistance of two staff for all activities of daily living except eating.

The "Huntington's Disease Care Plan," revised 05/04/23, directed staff to provide R1 with a calm approach and utilize redirection as needed. The care plan directed staff to provide R1 with active listening and implement problem solving skills when R1 was calm and able to communicate effectively and appropriately.

The "Performance Review," dated March 2023, documented LN G had the following areas that required improvement in her employment as a licensed nurse at the facility: LN G lost her temper too easily, LN G did not start her workdays in a positive manner, and LN G announced things to others in the open. Development actions prescribed included LN G needed a way to catch herself prior to losing her temper, LN G needed to try not to set her whole day up for failure, and LN G needed to understand not everyone needed to hear about call-ins or others short comings. The "Performance Review" documented LN G was

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 609	Continued From page 11	F 609		

occasionally disruptive and discourteous, slow to help others, exhibited less than adequate responsiveness and courteousness to patients, and would occasionally ignore problems.

The "Witness Statement," dated 08/15/23, documented CMA R went into R1's room. R1 told CMA R she needed to use the bathroom first. CMA R told R1 to give her a moment to try and find another staff to assist getting R1 onto the toilet. CMA R looked out into the hall and saw LN G and asked if LN G would help her to transfer R1 to the toilet. CMA R stated after she and LN G transferred R1 to the toilet, CMA R stayed in the bathroom with R1 and LN G waited in R1's room. CMA R stated after around two minutes R1 had not gone to the bathroom and LN G was getting visibly frustrated. LN G stated to R1 since she had not gone to the bathroom yet R1 needed to get off of the toilet because LN G had stuff to do. CMA R stated R1 said, "No," and was upset with LN G. R1 stated she still needed to use the bathroom. CMA R stated she tried to diffuse the situation by telling R1 maybe she could try to go to the bathroom later or maybe R1 could pee in the shower, not ideal but it would be okay. R1 did not like that idea and CMA R assured R1 they could wait. LN G said, "No she needs to get up now." R1 said, "No." LN G then began to pull on R1's arm and the gait belt. LN G told R1 she needed to get off of the toilet in a loud frustrated voice. R1 resisted and stated, "No I still need to pee. I will tell my kids." CMA R then told LN G to leave the room and CMA R would find someone else to help transfer R1 off of the toilet. LN G then proceeded to fling R1's wheelchair out of her way causing the wheelchair to hit R1's right calf and knee. LN G left and slammed the door on the way out.

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	175272	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEFIELD CARE AND REHAB	509 GROVE STREET WAKEFIELD, KS 67487

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F 609	Continued From page 12	F 609		

The "Facility Incident Report," dated 08/18/23, documented R1 was on her way to be showered. They were leaving R1's room and R1 stated she had to go to the restroom. CMA M and LN G helped R1 onto the stool in R1's room. R1 sat on the stool for a few minutes and did not go. LN G told her that she needed to help other residents and if R1 could not go now then she needed to get up and try again later. R1 stated she could get herself off of the toilet. LN G stated no that was not safe and LN G took R1's arm and started pulling to help her to stand up. R1 resisted and LN G became frustrated and used an inappropriate firm authoritative voice to get R1 to comply. To deescalate the situation, CMA M told LN G that she would stay with R1, and LN G could go on to the next resident. As LN G was leaving, LN G pushed the wheelchair out of her way, and it ran into the leg of R1. R1 then sat on the toilet a while longer and went to the bathroom and was then escorted to the shower room.

On 08/21/23, at 09:30 AM, R1 sat at the breakfast table in her wheelchair and watched other residents and staff. R1 had spastic movements.

On 08/21/23 at 09:45 AM, R1 stated LN G told her that she was going to get off of the toilet and grabbed her arm. R1 told LN G that she was not done. R1 told LN G not to treat her like that. R1 stated LN G pushed her wheelchair out of the way and the wheelchair hit her leg. R1 stated she was scared of LN G but since LN G was gone, she was sleeping much better.

On 08/21/23 at 10:30 AM, CMA S stated LN G was easily frustrated and when LN G started to get frustrated LN G would get loud. CMA S

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 08/21/2023

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 609	Continued From page 13	F 609		

stated she would pull LN G into the office and ask LN G what was going on and allow her to vent.

On 08/21/23 at 10:45 AM, Administrative Nurse D stated a couple of weeks ago, LN G was voicing her frustration regarding a resident being needy in an open area of the facility where others could hear her, and Administrative Nurse D took LN G to the office and told her it was inappropriate to express her feelings about a resident's wants where anyone could hear. Administrative Nurse D reported LN G may have had some personal stressors which factored in but stated the incident was unanticipated.

On 08/21/23 at 11:00 AM, Administrative Staff A stated CMA R did not report the incident until about 03:00 PM when her shift was over; CMA R stated she did not report it because she did not want to make the working relationship between her and LN G strained or uncomfortable. Administrative Staff A stated he expected all staff to report allegations of abuse and neglect to him immediately and that all staff had been re-educated on the abuse policy.

On 08/21/23 at 11:30 AM, CMA R stated that LN G got frustrated easily when she was on shift and staff walked on eggshells around her. CMA R stated LN G did not act appropriately with R1 on the day of the incident. CMA R said LN G went into the bathroom and grabbed R1's arm roughly and then grabbed the gait belt and pulled R1 half-way off of the toilet trying to get R1 to stand up. CMA R stated she had to scoot R1 back onto the toilet to keep her from falling off the toilet. CMA R stated she did not report the incident with R1 and LN G until after her shift was over, then

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F 609	Continued From page 14	F 609		

she reported it to social services at the facility. CMA R stated she knew now that the incident should have been reported immediately to protect R1 and the other residents in the facility.

The facility's "Abuse Prevention Program," revised August 2022, documented residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, exploitation, and involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical condition. The facility administration and employees are committed to protecting residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.

The facility failed to ensure staff identified a situation of abuse and mistreatment and failed to immediately report to the facility administrator (LNHA).

On 08/16/23 the facility completed corrective actions which included an all-staff in-service on preventing abuse, neglect and exploitation and reporting abuse. The facility provided staff training on "CARES Values."

The corrective actions were completed prior to the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of "K."