STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 A complaint survey was conducted regarding the allegations in KS00189594 The investigation revealed noncompliance was found related to the allegations and the following deficiencies were cited.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

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
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 657	Continued From page 1	F 657		

The facility reported a census of 40 residents, with three residents sampled. Based on observation, interview, and record review the facility failed to revise Resident (R)1's care plan to reflect interventions related to R1's personal hygiene.

Findings included:

- Review of the "Physician Order" dated 06/20/24 revealed Resident (R) 1 had the following diagnoses: dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion) and prolapse bladder (a condition that occurs when the muscles and ligament that support the bladder weaken and causing the bladder to bulge into the vaginal canal).

Review of the "Annual Minimum Data Set" (MDS) dated 12/27/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, indicating moderately impaired cognition. R1 was independent with Activities of Daily Living (ADLs).

Review of the "Quarterly Minimum Data Set" dated 06/04/24 revealed R1 had a (BIMS) score of 08, which indicated moderately impaired cognition. The MDS noted R1 refused bathing.

The "Care Plan" dated 06/20/24 revealed R1 required one person assistance with ADLs due to decreased mobility and dementia. The care plan further noted staff were to ask R1 if she wanted a bath, daily. The care plan documented R1 would refuse (bathing) and the staff were to notify the charge nurse and noted the staff must approach three times. The care plan lacked revision to include notification of the resident's family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 657	Continued From page 2	F 657		

member when R1 refused to bathe.

Review of the "Bathing Sheets" from 06/30/24 to 07/23/24 indicated R1 did not receive a bath for 24 days.

The "Physician Order" dated 08/14/24 revealed an order for R1 to have a bath daily.

Review of the "Nurses Notes" on 08/17/24, 08/18/24, 08/21/24, 08/23/24, 08/25/24 R1 refused her bath, and the facility did not contact R1's family member.

Review of the "Nurses Notes" from 06/02/24 to 08/23/24 indicated R1 did refuse bathing, the notes lacked evidence of notification to R1's family member.

During an observation on 08/26/24 at 10:30 AM, R1 sat in a recliner in the commons area. R1 then ambulated to her room, using her front wheeled walker, without difficulty. R1 clothes looked clean, and no foul odors were observed.

Interview with R1's family member on 08/26/24 at 12:06 PM revealed the staff were to give R1 a daily bath, and if R1 refused to take a bath the facility staff were to "contact me".

During an interview on 08/26/24 at 12:40 PM, revealed Certified Nurse Aide (CNA) D revealed the staff did offer a bath daily. CNA D said R1 preferred to have her baths at night before bedtime but with them now on day shift, R1 refuses the bath. If R1's family member was in the facility, she will help to encourage her to take a bath. CNA D said she did know the staff did not follow the protocol of documenting like they are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 657	Continued From page 3 suppose too when a resident refuses a bath During an interview on 08/26/24 at 02:00 PM, Licensed Nurse (LN) C revealed R1 liked her bath before going to bed, but staff moved her shower to the day shift because the facility had a bath aide on the day shift. LN C did not know the staff were to contact R1's family member if R1 refused to take a bath. During an interview on 08/26/24 at 02:50 PM Administrative Nurse B knew the nurses were to contact R1's family member if R1 refused a bath. The facility's policy "Care Plans, Comprehensive Person-Centered" dated March 2023 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents condition change. The facility failed to revise R1's care plan to reflect interventions related to R1's personal hygiene.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 676	Continued From page 4	F 676		

that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 40 residents, with three residents sampled. Based on observation, interview, and record review the facility failed to ensure staff provided Resident (R)1 the necessary bathing services to maintain good grooming and personal hygiene.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 676	Continued From page 5	F 676		

- Review of the "Physician Order" dated 06/20/24 revealed Resident (R)1 had the following diagnoses: dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion) and prolapse bladder (a condition that occurs when the muscles and ligament that support the bladder weaken and causing the bladder to bulge into the vaginal canal).

Review of the "Annual Minimum Data Set" (MDS) dated 12/27/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, indicating moderately impaired cognition. R1 was independent with Activities of Daily Living (ADLs).

Review of the "Quarterly Minimum Data Set" dated 06/04/24 revealed R1 had a (BIMS) score of 08, which indicated moderately impaired cognition. The MDS noted R1 refused bathing.

The "Care Plan" dated 06/20/24 revealed R1 required one person assistance with ADLs due to decreased mobility and dementia. The "care plan further noted staff were to ask R1 if she wanted a bath, daily. The care plan documented R1 would refuse (bathing) and the staff were to notify the charge nurse and noted the staff must approach three times.

Review of the "Bathing Sheets" from 06/30/24 to 07/23/24 indicated R1 did not receive a bath for 24 days.

The "Physician Order" dated 08/14/24 revealed an order for R1 to have a bath daily.

Review of the "Nurses Notes on 08/17/24,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 676	Continued From page 6	F 676		

08/18/24, 08/21/24, 08/23/24, 08/25/24 R1 refused her bath, and the facility did not contact R1's family member.

Review of the "Nurses Notes" from 06/02/24 to 08/23/24 indicated R1 did refuse bathing, the notes lacked evidence of notification to R1's family member.

During an observation on 08/26/24 at 10:30 AM, R1 sat in a recliner in the commons area. R1 then ambulated to her room, using her front wheeled walker, without difficulty. R1 clothes looked clean and no foul odors were observed.

Interview with R1's family member on 08/26/24 at 12:06 PM revealed the staff were to give R1 a daily bath, and if R1 refused to take a bath the facility staff were to "contact me".

During an interview on 08/26/24 at 12:40 PM, revealed Certified Nurse Aide (CNA) D revealed the staff did offer a bath daily. CNA D said R1 preferred to have her baths at night before bedtime but with them now on day shift, R1 refuses the bath. If R1's family member was in the facility, she will help to encourage her to take a bath. CNA D said she did know the staff did not follow the protocol of documenting like they are suppose too when a resident refuses a bath

During an interview on 08/26/24 at 02:00 PM, Licensed Nurse (LN) C revealed R1 liked her bath before going to bed, but staff moved her shower to the day shift because the facility had a bath aide on the day shift. LN C did not know the staff were to contact R1's family member if R1 refused to take a bath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 676	Continued From page 7 During an interview on 08/26/24 at 02:50 PM Administrative Nurse B knew the nurses were to contact R1's family member if R1 refused a bath. The facility's undated policy "Bath/Shower Policy and Procedure Manual" included to provide residents with safe hygiene, and thorough bathing assistance, document bathing assistance provided. The facility failed to provide R1 with necessary bathing services to maintain good grooming and personal hygiene.	F 676		