STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175272	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WAKEFIELD OPERATOR LLC	509 GROVE STREET WAKEFIELD, KS 67487

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 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Post nurse staffing information every day.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents. Based on observation and interview, the facility failed to display staffing information in a prominent place accessible to residents and visitors when the facility posted staffing hours inside the nurse's station charting room not readily available in a readable format. Findings included: - On 09/29/20 at 10:00 AM, observation revealed no visible posting of nursing staff hours. On 09/30/20 at 10:30 AM, observation revealed no visible posting of nursing staff hours. On 10/01/20 at 10:01 AM, License Nurse (LN) G stated staffing hours were kept on a clip board in a file [MEDICATION NAME] on top of a desk inside the nurse's charting room. On 10/01/20 at 02:40 AM, Administrative Nurse D verified the staffing hours were kept in the nurse's station on a clip board inside the nurses charting room, but should be posted on the wall outside the nurse's charting room. The facility's Posting Direct Care Daily Staffing Numbers policy, dated January 2020, documented the facility will post in a prominent location (assessable to residents and visitors), on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The facility failed to display daily staffing information in a readable format visible to staff and visitors, placing residents and visitors at risk for being uninformed of nursing staff hours.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to provide an appropriate end date for one as needed (PRN) antianxiety medication (class of medications that calm and relax people with excessive mental or emotional reaction characterized by apprehension, uncertainty and irrational fear, nervousness, or tension) for one of six sampled residents, Resident (R) 87. Findings included: - R87's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of six, indicating severely impaired cognition. The MDS documented the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), physical and verbal behavioral symptoms directed towards others, behavioral symptoms not directed toward others, and rejection of care one to three days during the look back period. The MDS documented the resident required supervision with all activities of daily living (ADLs) except toilet use which required limited assistance. The MDS documented the resident received insulin (medication used to treat people who produce little or no insulin), antipsychotic (class of medications used to treat a major mental disorder characterized by a gross impairment in reality and other mental emotional conditions), antidepressant (class of medications used to treat mood disorders and relieve symptoms of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diuretic (medication to promote the formation and excretion of urine) medications seven days during the look back period. The Risk for Adverse Reaction Care Plan, dated 08/20/20, directed staff to administer the resident [MEDICATION NAME] (antianxiety medication) and monitor for side effects of increased risk for falls, Central Nervous System (CNS-nerve tissues that control the activities of the body) and respiratory depression (a breathing disorder characterized by slow and ineffective breathing). The care plan documented the physician reviewed and evaluated the resident's medications. The Physician order [REDACTED]. The order lacked an end date for the medication. On 09/30/20 at 09:30 AM, observation revealed the resident ambulated independently from her room to the dining room table, sat in a chair, and visited with the resident across the table. On 10/05/20 at 01:38 PM, Administrative Nurse D verified the resident's [MEDICATION NAME], 0.5 mg order had no end date and stated the facility used the mega rule which allowed the facility to not apply an end date to the resident's PRN [MEDICATION NAME]. The nurse practitioner saw the resident every one to two weeks through tele medicine (the process of providing health care from a distance through technology, often using video conferencing), but could not produce documentation regarding the mega rule. The facility's Unnecessary Drugs, [MEDICAL CONDITION] Use policy, dated January 2020, documented the facility would limit PRN orders for antianxiety drugs to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur. The facility failed to provide an appropriate end date for R87's PRN [MEDICATION NAME], placing the resident at risk for receiving unnecessary [MEDICAL CONDITION] medications.
F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents with one reviewed for nutrition. Based on observation, record review, and interview, the facility failed to provide meals and assistance to Resident (R) 23 in a prompt and conducive manner. Findings included: - R23's Physician order [REDACTED]. or hopeless, and physical that can occur because of having a hard time coping) with depressed mood, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident had severe cognitive impairment, required extensive assistance of one staff for eating, and loss of liquid and solids from her mouth when eating or drinking. The MDS documented the resident held food in mouth and cheeks or residual food in mouth after meals and coughed or choked during meals or swallowing medication. The MDS further documented the resident had impaired range of motion on one side of upper body, significant weight loss, and received a mechanically altered diet. The Nutritional Status Care Area Assessment (CAA), dated 09/24/20, documented R23 had a 10% weight loss, not on a prescribed weight loss regimen, and received a mechanically altered diet. The CAA documented the resident received nectar thick liquids, supplements, poor appetite, liked cranberry juice, and directed staff to try to find foods the resident would accept. The Nutritional Care Plan, dated 08/27/20, instructed staff to provide the resident a fortified pureed diet with nectar thick liquids and a supplement three time a day. The care plan further documented the resident liked diet coke, hot cereal with brown sugar, lemon and tapioca pudding, and family reported she was not a picky eater. The POS, dated 09/21/20, directed staff to provide the resident a supplement three times a day, pureed diet, and nectar thick liquids. The Nutritional Assessment, dated 09/14/20, by Consultant (C) GG, documented a loss of nine lbs. in

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

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F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) one month and intake of 0-25% of pureed and nectar thick liquids. C GG recommended a pureed diet, increased nectar thickened liquid amounts, and increased supplement amounts. C GG further recommended speech therapy and a goal to maintain weight of 111 pounds or more. On 09/30/20 at 11:26 AM, observation revealed R23 entered the dining room with walker and two staff. At 12:03 PM, continue observation revealed the resident sat with her eyes closed at the desk in the dining room, no food or fluids present. At 12:17 PM, continued observation revealed staff woke the resident and informed her the kitchen was preparing her food, then staff brought R23 a cup of red nectar thick liquid with a sippy lid and handles on each side and unwrapped silverware . The resident picked up each piece of silverware separately and made motion as if taking a bite. At 12:21 PM, continued observation revealed staff delivered pureed food and placed it in front of the resident. Certified Medication Aide (CMA) R offered the resident a bite of pudding and R23 pushed CMA R's hand away. (55 minutes to receive the meal) On 10/01/20 at 09:22 AM, observation revealed CMA T ambulated R23 to the dining room, provided the resident with a nectar thick supplement drink and hot tea in cups with sipper lids and handles. Continued observation revealed staff encouraged the resident to drink, but did not stay to assist her. At 09:38 AM, continued observation revealed the resident sat with her eyes closed, no food provided. At 09:57 AM, continued observation revealed staff moved the resident's chair to the end of the table to adhere to social distancing of another resident seated at the table, no food provided, and staff stated to each other the kitchen had been notified of resident being in the dining room. At 10:15 AM, continued observation revealed R23 slept at the table. At 10:24 AM, continued observation revealed one staff assisted the resident to the bathroom with her walker. After toileting, staff alerted the resident had not received a breakfast meal, so staff returned R23 to the table, provided her pudding, and attempted to give the resident bites, but she did not eat and closed her eyes. At 10:44 AM, continued observation revealed staff transferred R23 to a recliner in the commons area. (62 minutes until toileted and returned to dining room) On 10/05/20 at 10:53 AM, CMA T reported R23 required assistance and encouragement of one staff with eating, and at times would try to feed herself. CMA T stated the resident had a poor appetite and received a pureed diet with nectar thick liquids. CMA T stated the resident ate better later in the day and when staff sat with her one on one in her room. On 10/05/20 at 11:09 AM, LN H reported it was difficult to get the resident to eat, the resident ate in the dining room with her back to the room of residents so she did not get distracted. On 10/05/20 at 01:31 PM Dietary Staff (DS) CC stated when R23 was brought to the dining room staff were to let dietary know she was ready for her meal. DS CC stated the residents should not have to wait 30 minutes to be served the meal or assisted to eat. On 10/05/20 at 02:30 PM, Administrative Nurse D stated the resident should be served promptly, assisted in the dining room, and a 30-minute wait was too long. The facility's Nutrition (Impaired)/ Unplanned Weight Loss Clinical Protocol policy, dated February 2020, documented residents with functional impairment most likely need some form of assistance with eating, to ensure food is served to the resident in a conducive dining. The facility failed to provide R23 meals and assistance within 45 minutes of being placed in the dining room, placing the resident at risk for poor nutrition 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 41 residents. Based on observation, record review, and interview, the facility failed to provide food prepared by methods that conserved nutritive value, flavor and appearance for one of two residents who received pureed meals, Resident (R) 23. Findings included: - On 10/01/20 at 11:05 AM, observation during pureed food preparation revealed Dietary Staff (DS) BB, with DS CC overlooking, placed 2/3 cup of mixed vegetables into the blender, added two teaspoons (tsp) of thickener, and blended. DS BB stated the mixture was not the right consistency, added 2/3 cup of juice from the mixed vegetables in the steam table, and blended to a pudding consistency. DS BB placed the mixture onto a plate and placed it on the counter beside the steam table. Observation revealed DS BB placed 1/3 cup of ground country fried steak into the blender, added 1/3 cup of gravy, and blended. DS BB stated the mixture was not the right consistency, poured unmeasured milk into the mixture, and blended to mashed potato consistency, and placed the mixture on the plate with the pureed mixed vegetable. Further observation revealed DS BB placed a bread roll into a blender, added unmeasured milk, and blended the mixture to mashed potato consistency. DS BB placed an unmeasured amount of the mixture on the plate with the other pureed food items, leaving some of the pureed mixture in the blender. On 10/01/20 at 11:15 AM, DS BB verified the above finding, obtained a plastic-coated sheet of paper titled, Puree Recipes, this is only to be used as a back-up for recipes on production sheets, and stated she used that document. On 10/01/20 at 11:16 AM, DS CC verified DS BB had not followed a recipe and brought out a white binder, stated DS BB should have followed the pureed recipe in the binder, and measured each item she placed in the blender. On 10/01/20 at 11:17 AM, DS BB stated she was unaware the kitchen had a recipe book. The facility's Standardized Recipes policy, dated February 2020, documented standardized recipes shall be developed and used in the preparation of foods. The food services manager will maintain the recipe file and make it available to food services staff as necessary. The facility failed to follow a recipe when preparing R23's pureed meal, placing the resident at risk for impaired nutrition.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility had a census of 41 resident. Based on observation, record review, and interview, the facility failed to use gloved hands when staff picked up food and assisted residents with eating, and failed to properly clean the blender between preparing different pureed (a paste or thick liquid suspension usually made from cooked food ground finely) food items. Findings included: - On 10/01/20 at 08:15 AM, observation revealed Certified Medication Aide (CMA) R sat at the counter on Resident (R) 22's left side and assisted the resident with her breakfast meal. Observation revealed CMA R stood up, ambulated to the activity director room, picked up a ponytail holder, and with ungloved hands placed his hair up into a ponytail on his head. Observation revealed CMA R returned to the dining room counter, sat in the chair to the left of R22, picked up a slice of her toast with his left ungloved hand, and gave R22 a bite. On 10/01/20 at 08:39 AM, observation revealed Licensed Nurse (LN) G propelled R22 in her wheelchair back to her food on the counter, picked up a piece of R22's toast with her ungloved hands, and placed the toast in R22's mouth. On 10/01/20 at 09:05 AM, observation revealed Certified Nurses Aide (CNA) M picked up a piece of bacon in her ungloved hand and placed the bacon up to R27's mouth. On 10/01/20 at 11:05 AM, observation revealed Dietary Staff (DS) BB placed two (1/3 cup) portions of mixed vegetables in a blender, added thickener and vegetable juice , and blended the vegetables to a pudding consistency. Observation revealed DS BB rinsed the blender lid and container in hot water several times then placed 1/3 cup of ground country fried steak, 1/3 cup of gravy, and an unmeasured amount of milk in the blender and blended to consistency of mashed potatoes. Observation revealed DS BB rinsed the blender container and lid several times with hot water then placed a roll into the blender, added unmeasured milk, and blended to a consistency of mashed potatoes, topped with unmeasured butter, and placed it on the plate with the other food items. On 10/05/20 12:18 PM, observation revealed CMA S placed her ungloved hand on R35's sandwich and cut off the crust with a butter knife in her right hand. On 10/01/20 at 11:05 AM, DS CC stated staff always rinse the blender between food items in the same way and she was unaware the blender were supposed to be sanitized between different foods. On 10/05/20 at 01:48 PM, Administrative Nurse D stated staff should not use their ungloved hands to pick up food items. The facility's Preventing Foodborne Illness-Food Handling F812 policy, dated November 2017, documented that all employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. All food service equipment and utensils will be sanitized according to current guidelines and manufacturer's recommendations. The facility failed to ensure dietary staff cleansed and sanitized the blender container between pureed food items and failed to ensure staff wore gloves when they assisted residents eat their food, placing the residents at risk for foodborne illness.