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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakefield Care and Rehab	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one kitchen. This deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness.Findings included:- On 09/09/25 at 09:00 AM, observation in the kitchen revealed a three-door refrigerator had the following:An unlabeled, undated container of steak fry casserole.An unlabeled, undated plastic bag with salad and cheese.A three-door refrigerator located in the dry storage room had an unlabeled, undated plastic bag with sliced ham and lacked a backup thermometer.On 09/09/25 at 11:15 AM, Certified Dietary Manager (CDM) BB verified the above observations, stated there should be a backup thermometer in the dry storage refrigerator, and staff should label and date all food items before placing them in the refrigerators.On 09/10/25 at 11:30 AM, observation in the kitchen revealed the following:The pipes, approximately 4 feet long, located underneath the sink in the dishwasher area where the dirty dishes enter the dishwasher, had numerous different-sized areas of brownish stains. The 13 vents, approximately six inches (in) by 4 in, located underneath the ceiling air conditioner, had a gray fuzzy substance in them.On 09/10/25 at 11:35 AM, CDM BB verified the above findings and stated the kitchen staff were responsible for cleaning them.The Kitchen Cleaning Schedule had tasks listed for staff to complete daily, weekly, and monthly.The facility's Sanitation Policy, revised 10/24, documented all kitchen, kitchen areas, and dining areas shall be kept clean and free from rubbish.The facility's Food Safety Policy, revised 10/24, documented all foods stored in the refrigerator or freezer would be covered, labeled, and dated.

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.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents, with two reviewed for hospitalization. Based on record review and interview, the facility failed to provide the resident or her representative with the bed hold policy when Resident (R) 1 was transferred to the hospital. This placed the residents at risk for uninformed care choices. Findings included:- R1's Electronic Medical Record (EMR) documented the resident had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R1 required partial to moderate staff assistance with lower body dressing, putting on and or taking off footwear, showering, supervision with oral hygiene, toileting hygiene, upper body dressing, lying to sitting position, ambulation less than 150 feet (ft), and picking up objects off the floor. R1 required setup assistance with eating and sitting to lying position, independent with transfers.R1's Care Plan, revised 08/13/25, documented R1 had COPD and instructed staff to administer medication and breathing treatments as the physician ordered. The plan instructed staff to educate R1 on the importance of quitting smoking, encourage her to comply with fluid restriction, and diet. The plan documented R1 had a history of leaving her oxygen tubing and nebulizer mask in her bed, on her end table, or on the floor, and instructed staff to remind R1 of the importance of keeping these items bagged. The plan instructed staff to monitor R1 for signs or symptoms of shortness of breath, lethargy, pain, and sputum production. R1's Progress Notes dated 07/31/25 at 05:09 AM documented the resident was transferred to the hospital.R1's clinical record lacked evidence that either R1, or her representative was notified of the bed hold policy. On 09/09/25 at 02:00 PM, observation revealed R1 sat in a chair in her room, with no signs or symptoms of respiratory distress.On 09/10/25 at 01:10 PM, Social Service Designee (SSD) X stated that when residents are transferred to the hospital, the nurse on duty at that time is responsible for notifying the resident or representative of the bed hold policy. On 09/10/25 at 01:36 PM, Administrative Nurse D stated the nurse was responsible for providing the bed-hold policy to the resident or representative unless it was an emergency, then SSD X should follow up on providing it.Upon request, the facility failed to provide a bed-hold policy.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 45 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to include a hospice (a program that gives special care to people who are near the end of life) service visit frequency, medications, medical equipment, and preferences for Resident (R) 38. This deficient practice placed the resident at risk of not receiving resident-directed end-of-life care.Findings included:- R38's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), shortness of breath, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, major depressive disorder (major mood disorder that causes persistent feelings of sadness), low back pain, demoralization (loss of hope) and apathy (lack of interest), adjustment disorder (excessive reactions to stress involving negative thoughts), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), cardiomegaly (enlarged heart), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and fractures (broken bone) of the upper right humerus (upper arm bone) and the neck of the right femur (thigh bone) with delayed healing.R38's Significant Change Minimum Data Set (MDS), dated [DATE], documented that R38 had severe cognitive impairment, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and was dependent on staff for functional abilities. R38 received scheduled pain medication, as-needed pain medication, and non-medication interventions for moderate pain. The MDS further documented that R38 had a condition or disease that may result in a life expectancy of less than six months and received hospice care.The Psychosocial Well-Being Care Area Assessment (CAA), dated 06/30/25, documented that R38 received hospice service, had a broken hip that was not healing, and was not a candidate for surgical interventions due to his heart failure. R38's nutritional needs were not being met due to skipping meals and minimal intake. The CAA further documented that R38 had been readying for end of life for the past two years.R38's Care Plan dated 07/21/25, documented R38 was on hospice for Parkinson's disease and delayed healing of his right femur fracture. The Care Plan included the name of the hospice provider, the telephone number, and directed staff to follow orders for symptom control. The Care Plan lacked specifics of delegation of hospice staff services, visit frequency, medications, medical equipment, and personal hygiene supplies. The Physician Order dated 06/16/25 directed staff to admit R38 to hospice for Parkinson's disease and the fracture to the right femur with delayed healing.The Progress Note dated 06/06/25 at 10:44 AM documented that the hospice provider wanted to meet with R38 and his representatives to explain in detail what hospice could provide.The Progress Note dated 06/11/25 at 12:18 PM documented that the hospice provider would admit R38 to hospice.On 09/09/25 at 8:01 AM, R38 remained in bed, wearing oxygen, eyes closed, and the room was quiet and dark.On 09/10/25 at 09:05 AM, Certified Medication Aide (CMA) R reported that the hospice service provided certain medications for R38, and CMA R would ask the nurse on duty about services and medication for R38. CMA R also stated that the facility provided incontinence products and personal care for hospice residents, and she was not aware of where she would look to find specifics related to the hospice and the facility responsible for supplies needed to care for R38.On 09/10/25 at 09:09 AM, Administrative Nurse F reported that hospice provided a list of medications they would supply to R38, and the hospice nurse would come to see the resident twice a week, unless the resident was actively dying, and then the hospice nurse would come daily. Administrative Nurse F stated that a hospice aide usually did not come because the facility's staff met his personal needs. Administrative Nurse F reported that staff lacked a list of supplies furnished (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by hospice for R38.On 09/10/25 at 10:44 AM, Administrative Nurse D reported the facility's Care Plan lacked specifics related to the hospice provider provided and what the facility was responsible for in the end-of-life care and services for R38.The facility's Hospice Program policy, dated 10/2024, documented promoting continuity of care, collaborating with the hospice, nursing home, and resident/representative on a coordinated care plan to ensure the resident receives all necessary care and services. Although the hospice provider retains primary responsibility for the provision of the following hospice care and services, including but not limited to providing medical direction, nursing, counseling, medical supplies, durable medical equipment, and all other services that are necessary for the care of the resident's terminal illness and related conditions.