STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17A020	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trego CO-Lemke Memorial Hospital Ltcu	320 N 13th St Wakeeney, KS 67672

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The facility identified a census of 30 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to ensure staff reported witnessed staff-to-resident alleged abuse incidents to facility administration. Between an unknown date in September 2025 and November 16, 2025, several facility staff witnessed numerous alleged incidents of staff-to-resident abuse by the alleged perpetrator, Certified Nurse's Aide (CNA) M, and impacted cognitively impaired Residents (R) 1, R2, and R3. Facility staff witnessed CNA M flick, yell, yank, and forcefully restrain cognitively impaired residents over the approximately 3-month time frame. The failure of numerous staff to report allegations of abuse to the facility administration placed all of the residents who resided in the facility in immediate jeopardy.Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).The Quarterly Minimum Data Set (MDS) dated 10/10/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition. The MDS documented R1 had no behaviors during the look-back period. The MDS documented R1 was independent for ambulation, was dependent on staff for toileting, and required moderate staff assistance for all other activities of daily living (ADL).The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/25/25 documented R1 had a BIMS score of zero, was unable to answer any of the questions when asked, but was able to communicate some basic needs verbally. The CAA documented R1 was frequently incontinent of bladder and required moderate staff assistance with transfers and was dependent with toileting hygiene.R1's 02/08/23 Care Plan included the following interventions: 01/22/24 - R1 had a memory impairment and required cuing and redirection as R1 was unable to make decisions without assistance. 01/22/24 - Staff directed to use task segmentation to support R1's short term memory deficits and break tasks up one step at a time.01/22/24 - Staff directed to cue, reorient, and supervise R1 as needed and to present R1 with just one thought, idea, question, or command at a time.Certified Medication Aide (CMA) R1's Notarized Witness Statement, dated 11/17/25, documented sometime in September 2025, CMA R assisted CNA M with R1 for toileting. CMA R stated R1 was hollering, which was her normal, and CNA M flicked R1 in the cheek with her finger and told R1 to shut up. R1 said, Ouch. CMA R stated she asked CNA M not to do that and left the room. CNA P's Notarized Witness Statement, dated 11/17/2025, documented on 11/10/25 CNA P assisted CNA M in getting R1 up for the day. CNA M yelled at R1 to get up out of bed. CNA M and CNA P got R1 to the bathroom. CNA M told R1 to get up off the toilet, and R1 would not get up. CNA M yelled at R1 again to get up, and when R1 would not get up, CNA M yanked R1's arm by her wrist and pulled her off the toilet. The same thing happened again after lunch.CNA O's unnotarized Witness Statement, dated 11/17/25, documented CNA M flicked R1 on her forehead when R1 was laughing and screaming to make R1 be quiet.On 11/19/25 at 11:30 AM, (continued on next page)

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

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	observation revealed R1 sat at the lunch table. R1 was able to make simple conversation, but was obviously confused. R1 required assistance with eating.On 11/19/25 at 01:30 PM, CMA R stated she had seen CMA M yell at R1 and flick her with her finger on R1's cheek to get R1 to be quiet. CMA R stated she had been trained in abuse, neglect, and exploitation, but did not report the incident to anyone because CNA M could be retaliative.On 11/19/25 at 01:45 PM, CNA P stated she had seen CNA M yell at R1 to get up multiple times and yank and pull on R1's arm to get up. CNA P stated she had been trained on abuse, neglect, and exploitation, and did not report the incident to anyone because CNA M could be mean and take things out on others, like tripping people and locking people in rooms and not letting them out.On 11/19/15 at 10:00 AM, Administrative Nurse D stated she had no idea any of this was going on with CNA M until she received an anonymous employee complaint form, which documented CNA M had abused a resident. Administrative Nurse D stated she immediately started the investigation into the allegation, and the more people she talked to, she realized there was a big problem. Administrative Nurse D stated all the employees at the facility were trained in abuse, neglect, and exploitation in July 2025.On 11/19/25 at 02:30 PM, Administrative Staff A stated the employees involved in not reporting abuse were wrong for not reporting. Administrative Staff A stated the employees chose to be a part of the problem and not a part of the solution.The facility's Abuse and Neglect Policy, dated 05/02/25, documented the purpose of the policy was to provide guidelines and a procedure for assuring residents in the long-term care were free from abuse and neglect. All residents have the right to be free from neglect and abuse. In accordance with state statutes, any person, including but not limited to physicians, professional or practical nurses, social worker, or any other personnel who knew or had reasonable cause to suspect a resident has been abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the supervisor, risk manager, administrator, or chief of staff. Staff will receive education on abuse and neglect upon hire, annually, and anytime there is a policy and procedure change, and when the quality management process indicates a need for improvement. Training will include: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; How staff should report their knowledge related to allegations without fear of reprisal; How to recognize burnout, frustration, and stress that may lead to abuse; and what constitutes abuse, neglect, and misappropriation of property. - R2's Electronic Medical Record (EMR) documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), and a history of other mental health disorders.The Quarterly Minimum Data Set (MDS) dated 09/15/25 documented R2 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R1 had no behaviors during the look-back period. The MDS documented R2 was independent with eating, transfers, and bed mobility, but required partial to substantial staff assistance with all other activities of daily living (ADL).The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/13/25 documented R2 had a diagnosis of vascular dementia with anxiety. R1 admitted from home due to not being able to take care of himself due to dementia. Staff will assist R1 with establishing daily schedules and routines.R2's 03/03/25 Care Plan included the following interventions:03/04/25 - R2 may become anxious in new settings or changes. R2 likes to sing at these times.03/04/25 - Staff directed to observe R2 for unexplained changes in mood, psychosocial status or behavior. Changes may include increased confusion, odd behavior, increased anxiety, eating changes, weight loss, tearfulness, and crying episodes.03/04/25 - Staff directed to assist R2 with all of his ADLs.CNA O's Notarized Witness Statement, dated 11/17/25, documented CNA M assisted R2 in the hallway. CNA O was unclear what CNA M said to R2, but R2 told CNA M, Don't talk to me like that. CNA O stated she stepped in to help keep R2 calm, and CNA M just walked away.On 11/19/25 at 01:00 PM, R2 sat in his recliner and moaned, I don't feel good, over and over. An unidentified CNA came to check on R2 and asked him how he did not feel (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	well.On 11/19/25 at 02:30 PM, CNA O stated she saw CNA M in the hallway with R2. CNA M leaned down in R2's face. R2 leaned back away from CNA M and said, Don't talk to me like that. CNA O stated she stepped in quickly because R2 could get upset quickly. CNA O did not hear what CNA M said to R2. CNA O stated she did not report the incident to anyone. CNA O stated she had been trained on abuse and neglect.On 11/19/15 at 10:00 AM, Administrative Nurse D stated she had no idea any of this was going on with CNA M until she received an anonymous employee complaint form, which documented CNA M had abused a resident. Administrative Nurse D stated she immediately started the investigation into the allegation, and the more people she talked to, she realized there was a big problem. Administrative Nurse D stated all the employees at the facility were trained in abuse, neglect, and exploitation in July 2025.On 11/19/25 at 02:30 PM, Administrative Staff A stated the employees involved in not reporting abuse were wrong for not reporting. Administrative Staff A stated the employees chose to be a part of the problem and not a part of the solution.The facility's Abuse and Neglect Policy, dated 05/02/25, documented the purpose of the policy was to provide guidelines and a procedure for assuring residents in the long-term care were free from abuse and neglect. All residents have the right to be free from neglect and abuse. In accordance with state statutes, any person, including but not limited to physicians, professional or practical nurses, social worker, or any other personnel who knew or had reasonable cause to suspect a resident has been abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the supervisor, risk manager, administrator, or chief of staff. Staff will receive education on abuse and neglect upon hire, annually, and anytime there is a policy and procedure change, and when the quality management process indicates a need for improvement. Training will include: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; How staff should report their knowledge related to allegations without fear of reprisal; How to recognize burnout, frustration, and stress that may lead to abuse; and what constitutes abuse, neglect, and misappropriation of property. - R3's Electronic Medical Record (EMR) documented diagnoses of Post-Traumatic Stress Disorder (PTSD-mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).R3's Quarterly Minimum Data Set (MDS) dated 11/04/25 documented R3's Brief Interview for Mental Status (BIMS) score was 00, which indicated severely impaired cognition. The MDS documented R3 had no behaviors documented in the look-back period. The MDS documented R3 was independent with ambulation, bed mobility, and transfer, but was dependent on staff for all other ADLs.The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/16/25 documented R3 had a diagnosis of vascular dementia. R3 required assistance with ADLs, including toileting, dressing, personal cares, and eating. The CAA documented R3 had difficulty communicating, and staff needed to give R3 time to respond to simple questions and offer choices when she appeared anxious.R3's 05/18/23 Care Plan included the following interventions for R3:12/05/23 - Staff directed to provide R3 for opportunities for positive interaction, stop and talk with R3as she passed by.12/05/23 - Staff directed to provide R3 distraction to help prevent or de-escalate behaviors; remove R3 from the areas causing anxiety, offer music or pet/cat videos.05/18/23 - R3 had a history of sexual abuse and may have paranoia symptoms that are sexual in nature. Cue, reorient, and supervise as needed.05/18/23 - Staff directed to assist R3 with all ADLs.CNA N's Notarized Witness Statement, dated 11/17/25, documented sometime in October 2025, R3 did not want to sit at the table during lunch. CNA M got verbally aggressive with R3 and told her she needed to stay seated, and R3 was not allowed to get up. CNA N intervened and asked CNA M if she could assist R3. CNA M mumbled under her breath towards CNA N and left the table.CNA Q's Notarized Witness Statement, dated 11/19/25, documented on 11/14/25, CNA M held R3 down in her chair and would not let R3 get up. CNA M restrained R3's hands so R3 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	could not eat or drink.On 11/19/25 at 10:00 AM, observation revealed R1 ambulated throughout the facility with her daughter.On 11/19/25 at 02:45 PM, CNA Q stated she had been at the back table in the dining room and saw CNA M forcefully hold R3 down in her chair and restrain her hand so she could not eat or drink. CNA Q stated R3 liked to ambulate around the facility aimlessly, which seemed to keep her calm, and CNA M did not want R3 to get out of her chair. CNA Q stated she had been trained on abuse and neglect. CNA Q stated she did not report the incident because she was afraid of what CNA M might do.On 11/19/15 at 10:00 AM, Administrative Nurse D stated she had no idea any of this was going on with CNA M until she received an anonymous employee complaint form, which documented CNA M had abused a resident. Administrative Nurse D stated she immediately started the investigation into the allegation, and the more people she talked to, she realized there was a big problem. Administrative Nurse D stated all the employees at the facility were trained in abuse, neglect, and exploitation in July 2025.On 11/19/25 at 02:30 PM, Administrative Staff A stated the employees involved in not reporting abuse were wrong for not reporting. Administrative Staff A stated the employees chose to be a part of the problem and not a part of the solution.The facility's Abuse and Neglect Policy, dated 05/02/25, documented the purpose of the policy was to provide guidelines and a procedure for assuring residents in the long-term care were free from abuse and neglect. All residents have the right to be free from neglect and abuse. In accordance with state statutes, any person, including but not limited to physicians, professional or practical nurses, social worker, or any other personnel who knew or had reasonable cause to suspect a resident has been abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the supervisor, risk manager, administrator, or chief of staff. Staff will receive education on abuse and neglect upon hire, annually, and anytime there is a policy and procedure change, and when the quality management process indicates a need for improvement. Training will include: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; How staff should report their knowledge related to allegations without fear of reprisal; How to recognize burnout, frustration, and stress that may lead to abuse; and what constitutes abuse, neglect, and misappropriation of property. On 11/19/25 at 03:30 PM, Administrative Staff A and Administrative Nurse D were provided the IJ template and notified of the facility's failure to report physical abuse allegations, delayed appropriate oversight, investigation, protective measures, and increased the likelihood of ongoing abuse, harm, and severe psychosocial impairment, including fear, humiliation, and mental anguish. The facility identified and implemented immediate corrective actions, which were completed on 11/19/24, prior to the surveyor entering the facility. The corrective actions included: Abuse and Neglect training with all employees completed 11/17/25, a Risk Management meeting regarding the allegations completed 11/19/25, notification of all residents families completed 11/19/25, notification of local police completed 11/19/25, social services assessments of R1, R2, and R3 to check for psychosocial concerns and will continued to meet with the residents weekly for four weeks, and completed interviews with alert and oriented residents residing in the facility.