STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285209	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakefield Health Care Center	306 Ash Street Wakefield, NE 68784

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G)Based on record review and interview; the facility failed to ensure Residents 5, 6 and 13's drug regimens were free from unnecessary medications as the facility failed to attempt Gradual Dose Reductions (GDR)s for Residents 13 and 6's antipsychotic (drugs that affect the mind, emotions, and behavior) medications and to ensure Resident 5's as needed antipsychotic medication was limited to 14 days. The sample size was 5 and the facility census was 31. Findings are: A. Review of the facility policy “Antipsychotic Medication Use” with a revision date of 7/2025 revealed the following: -the facility was to evaluate behavior interventions before using psychotropic medications and to eliminate unnecessary medications. The residents would be free from chemical restraints imposed for purposes of discipline or convenience or not required to treat the residents' medical symptoms. -resident were not to be given antipsychotic drugs unless the medication was necessary. -residents who used psychotropic medications received GRD’s unless clinically contraindicated, to discontinue the medications and to ensure use of the lowest possible dosage. GDRs were to be completed within accordance with federal regulations. -the use of as needed antipsychotic medications was not encouraged, and the facility ensured clear parameters, and a clear duration for use beyond 14 days. -the need to continue PRN orders for psychotropic medications were not to be renewed beyond 14 days unless the Primary Care Provider (PCP) evaluated the resident for appropriateness of the medication. -gradual dose reductions were to be completed in accordance with federal regulations. the purpose of tapering medication was to find an optimal dose or to determine if continued use of the medication was a benefit to the residents. -within the first years a resident admitted taking psychotropic medication or after the location had initiated the medication a gradual dose reduction was attempted unless clinically contraindicated. Dose reductions were attempted or must be clinically contraindicated annually. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Review of Resident 6's undated current Care Plan revealed the resident was admitted [DATE] with diagnoses of unspecified dementia with agitation, Alzheimer’s disease, and unspecified dementia with severe anxiety. The resident had behaviors which included wandering and verbal aggression toward staff. The resident was identified as taking the antipsychotic medication Seroquel. Review of Resident 6's Medication Administration Record (MAR) dated July 2025 revealed the resident took the antipsychotic medication Seroquel 25 milligrams (mg) one time daily for unspecified dementia with severe anxiety. Review of Resident 6's electronic medical record revealed no evidence a GDR was addressed and/or attempted regarding the resident’s antipsychotic medication Seroquel over the previous year. C. Review of Resident 13’s undated current Care Plan revealed the resident was admitted [DATE] with diagnoses of unspecified dementia with behavioral disturbance, and anxiety disorder. The resident had behaviors which include verbal/physical behaviors and was taking the antipsychotic medication Seroquel for behaviors related to dementia and depression. Review of Resident 13's MAR dated July 2025 revealed the resident took the antipsychotic medication Seroquel 50 mg, 1.5 tablets twice a day for unspecified dementia with behavioral disturbances. Review of Resident 13's electronic medical record revealed no evidence a GDR was addressed and/or attempted regarding the resident’s antipsychotic medication Seroquel. D. During an interview on 7/22/25 at 8:23 AM the Director of Nursing (DON) confirmed the following: -Resident 6 had an order for Seroquel 25 mg daily which was ordered for unspecified dementia with severe anxiety and had taken since admission. -no GDR had been attempted and/or addressed regarding the resident's Seroquel for the previous year. -Resident 13 had an order for Seroquel 50 mg, 1.5 tablets twice a day which was ordered for dementia with behavioral disturbances and had taken the Seroquel since admission. -no GDR had been addressed and/or attempted regarding Resident 13's ordered Seroquel. E. Review of Resident 5’s Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 4/16/25 revealed the resident had severe cognitive impairment; was dependent with toileting, dressing, hygiene and transfers; had diagnoses of Heart Disease, Alzheimer’s Dementia, Anxiety, and Depression; and received antipsychotic, antianxiety, and antidepressant medications. Review of Resident 5’s Care Plan last revised 7/17/25 revealed the resident required staff assistance with bed mobility, dressing, eating, hygiene, toileting, and transferring; received antipsychotic, antianxiety, and antidepressant medications; had severe cognitive impairment; and had diagnoses of Dementia, Heart Disease, Anxiety, Depression. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility form Order Summary Report for Resident 5 revealed the resident had an order for Haldol Injection every 8 hours as needed for agitation, aggression, or restlessness with an order date of 5/8/25 and a stop date of 8/6/25. Review of Resident 5’s MAR’s for May, June, and July 2025 revealed the resident received the as needed Haldol on 5/21, 5/29, 6/11, 6/16, and 7/6. Interview with the DON on 7/22/25 at 12:20 PM confirmed the Haldol for Resident 5 was administered past the 14-day limit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number NAC 12-006.09Based on record reviews and interviews; the facility failed to complete neurological assessments to assess for potential injury after unwitnessed falls for Residents 2 and 5. The sample size was 2 and the facility census was 31. Findings are: A. Review of the facility policy Neurological Assessment last revised October 2010 revealed guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) following a fall with a suspected head injury or trauma; or 4) when indicated by resident condition. Staff were to always include frequent vital signs and any change in vital signs or neurological status would be reported to the physician immediately. Staff were to perform neurological checks per facility protocol: Every 15 minutes x5; every 30 minutes x4; every hour x5, then every shift (AM shift was 6 AM-6 PM and PM shift was 6 PM-6 AM) for 72 hours. For residents that received anticoagulant (blood thinners), neurological checks would be done weekly for 4 weeks and then monthly for 4 months. Neurological checks included: the residents orientation to time, place and person; the resident's speech pattern and clarity; vital signs; pupil reactions; and motor ability (extremity movement). The following information would be recorded in the resident's medical record: -the date and time the procedure was performed, -the name and title of the individual who performed the procedure, -all assessment data obtained, -how the resident tolerated the procedure, -if the resident refused the procedure, the reasons why and the intervention taken, and -the signature of the person recording the data. Staff were to notify the physician of any change in a resident's neurological status, notify the supervisor if the resident refuses the procedure, and report other information in accordance with the facility policy and professional standards of practice. B. Review of Resident 5’s Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 4/16/25 revealed the resident had severe cognitive impairment; was dependent with toileting, dressing, hygiene and transfers; had diagnoses of Heart Disease, Alzheimer’s Dementia, Anxiety, and Depression; and received an anticoagulant (a medication that thins the blood to prevent blood clots). Review of Resident 5’s Care Plan last revised 7/17/25 revealed the resident was a high risk for falls; required staff assistance with bed mobility, dressing, eating, hygiene, toileting, and transferring; received anti-coagulant medications; had cognitive impairment; had diagnoses of Dementia, Heart Disease, Anxiety, Depression; and had a history of falls. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility forms Fall Investigation Form and Post Fall Assessment revealed the following unwitnessed falls were missing documented neurological (neuro) assessments: -a fall on 2/8/25 at 4:00 AM was missing assessments for 30-minute (min) neuro checks at 5:00 AM, 5:30 AM, and 6:00AM, -a fall on 2/8/25 at 3:15 PM was missing assessments for 30-min neuro checks at 6:15 PM; 1-hour (hr) assessments missing at 7:15 PM, 8:15 PM, 9:15 PM, 10:15 PM, and 11:15 PM; and shift assessments were missing for the PM shift on 2/10/25 and the AM shift on 2/11/25, -a fall on 2/11/25 at 4:45 AM was missing 30-min assessments at 6:15 AM and 7:45 AM, 1-hr assessments at 8:45 AM, 10:45 AM, 11:45 AM, and an AM shift assessment on 2/14/25, -a fall on 2/16/25 at 6:45 AM was missing 15-min assessments at 6:45 AM, 7:00 AM, 7:15 AM, 7:30 AM, 7:45 AM, 30-min assessments at 8:15 AM, 8:45 AM, 9:15 AM and 9:45 AM, and 1-hr assessments at 10:45 AM, 11:45 AM, 12:45 PM, 1:45 PM, and 2:45 PM, -a fall on 2/19/25 at 2:15 AM was missing 15-min assessments at 2:30 AM, 2:45 AM, 3:00 AM, 3:15 AM, 30-min assessments at 3:45 AM, 4:15 AM, 4:45 AM, and 5:15 AM, and a 1-hr assessment at 6:15 AM, -a fall on 2/28/25 at 5:05 PM was missing 30-min assessments at 6:35 PM and 7:35 PM, 1-hr assessments at 9:05 PM, 10:05 PM, 11:05 PM, 12:05 AM, and 1:05 AM, -a fall on 4/16/25 at 12:45 AM was missing 15-min assessments at 1:00 AM, 1:15 AM, 1:30 AM, 1:45 AM, 30-min assessments at 2:15 AM, 2:45 AM, 3:15 AM, 3:45 AM, 1-hr assessments at 4:45 AM, 5:45 AM, 6:45 AM, 8:45AM, and a PM shift assessment on 4/16/25, and -a fall on 6/28/25 at 3:00 PM was missing 1-hr assessments at 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM, and the AM and PM shift assessments on 6/29/25. An interview on 7/21/25 at 11:45 AM with Licensed Practical Nurse (LPN)-I revealed if a fall was unwitnessed by staff then the staff were to complete neurological assessments per facility protocol which was every 15-minutes x5, every 30-minutes x4, every hour x5, and every shift for 72 hours. An interview on 7/22/25 at 9:10 AM with the Director of Nursing (DON) confirmed neurological assessments were not completed per facility policy for Resident 5. C. Review of Resident 2’s MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of anemia, heart failure, high blood pressure, depression, diabetes, anxiety, psychotic disorder, and schizophrenia. The following was assessed regarding Resident 2: -cognitively intact. - pain which affected day to day activities, which was almost constant and which the resident rated at an 8 out of 10. -no falls since previous assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident’s current, undated Care Plan revealed the resident was at risk for falls related to impaired mobility and use of psychoactive medications. Review of an Incident Report dated 4/13/25 at 2:00 AM revealed the resident was observed walking with the walker to the Nurse's Station and the resident’s head was bleeding. The resident reported falling and had a wound to the back of the head and to the right elbow. Review of Post Fall Assessment Forms used for documentation of neurological assessments after an unwitnessed fall and/or a fall with a head injury revealed no neurological assessment or vital signs were completed at 2:15 AM. In addition, the facility staff failed to document any assessment other than the resident’s vital signs at 2:30 AM, 2:45 AM, 3:00 AM and at 3:30 AM. Review of an Incident Report dated 7/7/25 at 5:40 AM revealed the resident was found on the floor of the resident’s room next to the resident’s bed. The fall was unwitnessed. Review of Post Fall Assessment Forms revealed no neurological assessment and/or vital signs were completed at 6:00 AM, 6:15 AM and at 8:15 AM. An Interview with the DON on 7/22/25 at 8:22 AM confirmed the facility staff failed to complete neurological assessments and vital signs in accordance with the facility policy after the resident’s fall on 4/13/25 at 2:00 AM and on 7/7/25 at 5:40 AM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility failed to ensure Residents 6 and 13's drug regimens were free from unnecessary medications as the facility failed to attempt Gradual Dose Reductions (GDR)s for the residents psychoactive (drugs which affect mental processes such as perception, consciousness, cognition, mood and emotions) medications. The sample size was 5 and the facility census was 31. Findings are: A. Review of the facility policy “Antipsychotic Medication Use” with a revision date of 7/2025 revealed the following: -the facility was to evaluate behavior interventions before using psychotropic medications and to eliminate unnecessary medications. The residents would be free from chemical restraints imposed for purposes of discipline or convenience or not required to treat the residents' medical symptoms. -resident were not to be given antipsychotic drugs unless the medication was necessary. -residents who used psychotropic medications received GRD’s unless clinically contraindicated, to discontinue the medications and to ensure use of the lowest possible dosage. GDRs were to be completed within accordance with federal regulations. -the use of as needed antipsychotic medications was not encouraged, and the facility ensured clear parameters, and a clear duration for use beyond 14 days. -the need to continue PRN orders for psychotropic medications were not to be renewed beyond 14 days unless the Primary Care Provider (PCP) evaluated the resident for appropriateness of the medication. -gradual dose reductions were to be completed in accordance with federal regulations. the purpose of tapering medication was to find an optimal dose or to determine if continued use of the medication was a benefit to the residents. -within the first years a resident admitted taking psychotropic medication or after the location had initiated the medication a gradual dose reduction was attempted unless clinically contraindicated. Dose reductions were attempted or must be clinically contraindicated annually. B. Review of Resident 6’s current Care Plan revealed the resident was admitted [DATE] with diagnoses of Alzheimer’s disease, unspecified dementia with severe agitation and unspecified dementia with severe anxiety and depression. The resident had behaviors which included wandering and was verbally aggressive at times to the staff. The resident was identified as receiving Lorazepam (medication used to treat anxiety),Mirtazapine (medication used to treat depression), and Zoloft (medication used to treat depression. Review of Resident 6’s Medication Administration Record (MAR) for July 2025 revealed the resident was receiving Mirtazapine 7.5 mg daily, Zoloft 5 mg daily, and Lorazepam 0.25 milliliters (ml) ever 3 hours as needed for anxiety/restlessness and shortness of breath. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's electronic medical record revealed no evidence a GDR was addressed and/or attempted regarding any of the resident’s psychoactive medications over the previous year. C. Review of Resident 13's undated current Care Plan revealed the resident was admitted [DATE] with diagnoses of unspecified dementia with behavioral disturbance, depression, and anxiety disorder. The resident had behaviors which include verbal/physical behaviors toward the staff. The resident was identified as taking psychoactive medications which included Lexapro (medication used to treat depression), Lorazepam and Trazadone (medication used to treat depression). Review of Resident 13's MAR dated July 2025 revealed the resident was receiving Lexapro 10 milligrams (mg) daily, Lorazepam 0.5 mg every 4 hours as needed for anxiety, and Trazadone 50 mg daily. Review of Resident 13's electronic medical record revealed no evidence a GDR was addressed and/or attempted regarding any of the resident’s psychoactive medications over the previous year. D. During an interview on 7/22/25 at 8:23 AM the Director of Nursing (DON) confirmed the following: -no GDR had been attempted and/or addressed regarding Resident 6's psychoactive medications for the previous year. -no GDR had been addressed and/or attempted regarding Resident 13's psychoactive medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** S483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.This requirement is not met as evidenced by:LICENSURE REFERENCE NUMBER 175 NAC 12-006.12(D)(i):Based on observation, record review and interview; the facility failed to provide safe storage of drugs as: 1) Medications were left on top of the medication cart and unattended, 2) The medication cart was left unlocked with no staff in attendance, 3) The keys were in the narcotic lock box with no nurse within visualization and 4) Medications were administered to resident's without staff supervision. The total sample size was 19 and the facility census was 31.Findings are:Findings are:A. Review of the facility policy titled Storage of Medications with a revised date of 5/25 included the following:-The facility would store all drugs in a safe, secure and orderly manner,-The nursing staff would be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner, and-Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals would be locked when not in use, and trays or carts used to transport such items would not be left unattended if open or otherwise potentially available to others. Review of the facility policy titled Administering Oral Medication with a revised date of 10/10 included the following:The purpose of this procedure was to provide guidelines for the safe administration of oral medications.-Staff were to prepare:a. The correct dosage of medication,b. Confirm the identity of the resident, c. Place medications on the table,d. Allow the resident to swallow the oral tablets at his or her comfortable pace ande. Remain with the resident until all the medications had been taken. B. During an observation of the Medication Pass by Licensed Practical Nurse (LPN)-C on 7/17/25, the following was observed:-The medication cart was parked in the hall by room [ROOM NUMBER],-7:30 AM LPN-C prepared medications which consisted of Buspar (anti-anxiety), Acetaminophen, Celecoxib (pain and inflammation), Ferrous Sulfate (iron), Furosemide (diuretic), Losaartan Potassium and Sertraline (anti-depressant) for Resident 17. After removal of each of these medications from individual bubble packs, LPN-C inverted the bubble packs on top of the medication cart which contained the remainders of the medications. LPN-C walked away from the medication cart leaving the medications unattended to administer the medication to Resident 17 in room [ROOM NUMBER], (4 doors from the medication cart). LPN-C returned to the cart 7 minutes later.-8:15 AM The medication cart was in the dining room. LPN-C walked away from the medication cart leaving the medication cart unlocked and unsupervised.-8:19 AM to 8:23 AM LPN-C left the medication cart unattended and with back to the cart. The key was in the narcotic drawer lock with staff and residents walking beside the cart.On 7/21/25 at 8:25 AM Resident 9 was sitting at the dining room table, a medication cup was sitting in front of the resident with 7 pills in the cup.8:30 AM Medication Aide (MA)-F walked up to Resident 9 and reminded resident to take the medications and walked by Resident 19, asked resident if medications were gone and resident voiced yes. MA-F did not stop to check if the medication cup was empty.8:40 AM MA-F walked by Resident 9 and asked resident if the medications were gone, resident voiced yes. MA-F did not stop to check if the medication cup was empty.C. During an interview on 7/21/25 at 10:15 AM MA-F confirmed that Resident 9 and Resident 19 were not supervised when taking their medications.An interview on 7/21/25 at 11:20 AM with the Director of Nursing (DON), confirmed that:1) Medications were to be locked when not in the view of the nurse,2) The medication cart was to be locked when not in the view of the nurse administering medications,3) Keys are not to be left in the medication cart when the cart is unsupervised, and4) There are no residents that can receive medications without supervision of a nurse or MA.