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 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 (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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. 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.