

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4102 Woolworth Avenue Omaha, NE 68105	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>31524</p> <p>Based on interview, and record review; the facility failed to implement a care planned intervention for 1 (Resident #2) of 6 residents whose care plans were reviewed. Specifically, following an incident on 04/22/2023 involving Resident #2 and another resident, the facility implemented a new intervention consisting of a magnetic barrier attached to Resident #2's door frame to deter other residents from entering Resident #2's room. This intervention was never discontinued, but the barrier was removed, and additional resident to resident altercations involving Resident #2 and Resident #3 occurred on 10/17/2023 and 11/22/2023, when Resident #3 entered Resident #2's room.</p> <p>Findings included:</p> <p>The facility's policy titled, Interdisciplinary Plan of Care, reviewed on 04/23/2024, indicated, Members of the Interdisciplinary Team are responsible for updating the plan of care, as indicated, as the resident's status changes or as other problems/needs are identified. Interdisciplinary Team members will review and evaluate the plan of care to make recommendations and revisions as needed. The policy further indicated, Record the date the care/treatment/intervention was initiated/evaluated. Include month, day and year. EVALUATION/PROGRESS: Document the team's evaluation of the current problem, plan of care, and progress made. Make certain to note if/when a need is resolved, therefore no longer active.</p> <p>A record review of the Admission Record revealed the facility admitted Resident #2 on 04/13/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia with agitation and major depressive disorder without psychotic features.</p> <p>A record review of quarterly Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date (ARD) of 09/18/2023, revealed Resident #2 had a Brief Interview for Mental Status (BIMS, test is used to get a quick snapshot of how well you are functioning cognitively at the moment) score of 6, which indicated the resident had severe cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #2's care plan included a Focus area, initiated on 04/22/2023 and revised on 10/20/2023, that indicated the resident had the potential to be physically aggressive related to dementia with agitation. Per the care plan, Resident #2 had a history of altercations with other residents, including an incident on 04/22/2023 in which Resident #2 bear hugged another resident from behind and told them to get out of Resident #2's room. The care plan reflected an active intervention initiated on 04/22/2023 that directed staff to apply a magnetic barrier attached to the door frame to deter other residents from entering Resident #2's room.</p> <p>A document from the Chief Nursing Officer (CNO) to the state survey agency, dated 10/19/2023, revealed that on 10/17/2023 it was reported Resident #3 wandered into Resident #2's room, and Resident #2 pushed Resident #3 out of the room with enough force to propel Resident #3 into the hall, causing Resident #3 to fall and hit their head. Per this document, a door net was ordered for Resident #2's room, despite the care plan already reflecting an active intervention for the use of a magnetic door barrier.</p> <p>A record review of Resident #2's care plan Focus area addressing the potential for physical aggression was updated following the incident on 10/17/2023 to reflect Resident #2 pushed peer violently out of room causing a fall in which the other resident (Resident #3) hit their head on the floor. On 10/17/2023, an intervention was added to the care plan that indicated an orange mesh door curtain was ordered to prevent peers from wandering into Resident #2's room, despite the care plan already reflecting an active intervention for the use of a magnetic door barrier. There was no indication any of the listed interventions had been discontinued.</p> <p>A document from the CNO to the state survey agency, dated 11/29/2023, revealed that on 11/22/2023 a resident altercation occurred, involving Resident #2 and Resident #3. Per the document, Resident #3 entered Resident #2's room, and Resident #2 pushed Resident #3 out and yelled at them to leave. The document indicated the force of [Resident #2's] pushing caused [Resident #3] to fall backwards across the hall and strike [his/her] head on the handrail.</p> <p>During an interview on 05/14/2024 at 10:56 AM, Unit Manager I stated Resident #2 had unpredictable, aggressive behavior.</p> <p>During a follow-up interview on 05/14/2024 at 2:35 PM, Unit Manager I stated a magnetic mesh barrier was put up on Resident #2's doorway to prevent residents from entering their room in April 2023, because Resident #2 was territorial when other residents entered their room. Unit Manager I further stated the use of magnetic barriers was subjective based on each resident. Unit Manager I said if staff saw an issue, staff put the barrier up for a period of time, then stated the mesh barrier on Resident #2's door probably came down sometime after it was initially put up in April 2023.</p> <p>During an interview on 05/14/2024 at 3:46 PM, the Compliance Officer stated the facility was remodeling the memory care unit where Resident #2 and Resident #3 resided from 07/26/2023 to 11/10/2023. Per the Compliance Officer, Resident #2's magnetic barrier would have come down during that time for painting, and because the resident was stable at that time, staff did not put the barrier back in place on Resident #2's door. During the interview, the Compliance Officer stated she would review interdisciplinary team notes to see if she could locate any documentation regarding a decision to remove Resident #2's magnetic barrier due to the resident being stable. After reviewing notes, the Compliance Officer returned with documentation related to remodeling the memory care unit but had no documentation related to a decision to discontinue the use of Resident #2's magnetic door barrier.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/15/2024 at 9:50 AM, the Administrator said Resident #2 did not like other people in their space, so staff placed a physical barrier up over the doorframe to Resident #2's room for a while, which staff utilized periodically. Per the Administrator, the use of the physical barriers was dependent on the resident. The Administrator indicated if a resident became stable, the mesh barrier could come down and staff would adjust the care plan accordingly.</p> <p>During an interview on 05/15/2024 at 2:06 PM, Unit Manager I stated interventions listed on a resident's care plan were interventions staff could use and described them as tools in a toolbelt where staff could use them some days and use other interventions different days; however, Unit Manager I stated there was no documentation regarding conversations about removing the mesh barrier or documentation indicating the mesh barrier was discontinued because Resident #2 was stable.</p> <p>During an interview on 05/15/2024 at 4:31 PM, the Assistant Director of Nursing (ADON) stated she expected staff to follow the care plan because care plans were individualized for resident care. The ADON said she could not speak to whether the mesh barrier used on Resident #2's door to keep other residents out of their room was an effective intervention or not. The ADON further stated she did not know if staff would have removed the intervention for the mesh barrier from the care plan if it was taken down. She stated if an incident occurred, staff could look at the care plan to see if there was a useful intervention they could put in place, as opposed to routinely implementing care planned interventions to prevent further incidents.</p> <p>During an interview on 05/15/2024 at 4:42 PM, the Compliance Officer stated anyone who worked on the memory care unit knew Resident #2 could be explosive, depending on the day. The Compliance Officer further stated a care plan was a flexible document but said she expected staff know a resident's care plan and follow it.</p>