STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.04(f)(i)(5) Based on observation, record review and interview; the facility failed to ensure follow up was completed with the physician to obtain x-rays after complaints of pain were made by Resident 1 and failed to ensure x-ray recommendations were followed timely for Resident 1. X-rays showed that Resident 1 sustained a fracture of the right shoulder. The facility census was 239. Findings are: Record review of Resident 1's Face Sheet revealed a admitted [DATE] with diagnoses that included restlessness and agitation, altered mental status, schizophrenia, psychosis and mood affective disorder. Record review of Resident 1's quarterly MDS (Minimum Data Set-a comprehensive assessment used to develop a resident's care plan) dated 4/30/24 revealed a BIMS (Brief interview for mental status, a brief screener that aids in detecting cognitive impairment) score of 15, which indicated that Resident 1 was cognitively intact. The MDS showed that resident 1 was independent with all activity of daily living needs and had no falls since the previous assessment in January 2024. A Fall Risk Assessment was completed on 4/26/24 with a score of 2. This score identified that Resident 1 was at low risk for falls. Record review of Resident 1's Progress Notes revealed the following: - 5/15/24 09:45: Fax to [resident physician] due to resident wants [gender] shoulder x-rayed, stating it hurts. - 5/17/24 14:44: continues to ask about arm X-ray. Dr was faxed 2 days ago, no bruise but says it hurts. - 5/17/24 15:08: x-ray orders to do Monday [5/20/24] [Scheduled by outside Hospital for 5/21/24] - 5/21/24 08:30: went to have shoulder x-ray with NA [nursing assistant] (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/30/24 16:39: Results from bilateral shoulder x-rays results faxed to [Resident 1's physician]. - 6/19/24 12:52: [Resident 1's physician] faxed over asking when is [Resident 1's] repeat X-ray scheduled? - 6/21/24 08:30: Resident went out for an x-ray of the right shoulder at the [outpatient radiology center]. Resident was accompanied by staff - 6/27/24 11:11: x-ray results from 2 view shoulder completed on 6/21/24 faxed to [Resident 1's physician]. - 6/27/24 16:45: APS [Adult Protective Services] called at this time due to: healing non-displaced right greater tuberosity fracture. - 6/27/24 17:40: POA [power of attorney] made aware of x-ray results showing healing non-displaced right greater tuberosity fracture. - 6/27/24 17:51: [Resident 1] was interviewed and asked if [gender] knew possible causative factors for [gender] right greater tuberosity fracture. [Resident 1] verbalized not knowing how [gender] could had fractured self. Record review of X-ray results dated 5/21/24 revealed a possible non displaced right greater tuberosity fracture. Recommendation by the Radiologist read: : Follow-up radiographs in 10-14 days could be obtained for further evaluation. Record review of X-ray's completed on 6/21/24 and faxed to the facility on [DATE] revealed healing non-displaced right greater tuberosity fracture right shoulder. Record review of Resident 1's Electronic Medical record [EMR] including doctor orders, progress notes and miscellaneous records revealed no follow up with Resident 1's physician had been attempted by the facility staff between 5/15 and 5/17 to try to obtain x-rays for Resident 1's right shoulder. Record review of Resident 1's Progress Notes on 5/15/24 and 5/17/24 indicated that Resident 1 was having continued pain to the right shoulder. Record review of Resident 1's Mediation Administration Record dated May 2024 revealed that Resident 1 received the following scheduled pain medication: - Acetaminophen 500 mg 1 tab three times daily for headache / mild pain with a start date of 4/1/24. - Acetaminophen with Codeine #3 1 tab twice daily for Migraine with a start date of 4/29/24. Record review of Resident 1's Doctor orders and Progress note dated 6/19/24 revealed the following: - When is [Resident 1] scheduled for [gender] repeat x-ray at [outside hospital]. Patient needed a follow up per radiologist 10-14 days. Orders were sent to [phone number]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 1's Electronic Medical record [EMR] including doctor orders, progress notes and miscellaneous records revealed no attempts to follow up with Resident 1's physician regarding the recommendations for follow up x-rays within 10 - 14 days. Observation on 7/17/24 at 11:45 AM revealed Resident 1 standing in [gender] room shaving at the mirror. The resident was using the right arm to shave and had good range of motion with the right arm. Resident 1 exhibited no signs of pain or discomfort during the observation. Interview on 7/17/24 at 11:48 AM with Resident 1 stated that x-rays showed [gender] had a broken right shoulder and the resident didn't know how that had happened. The resident stated that there was no pain now and it was healed. Interview on 7/17/24 at 10:06 AM with the Assistant Director of Nursing [ADON] confirmed that Resident 1 had sustained a fracture to the right shoulder and exhibited pain on 5/15/24 when Resident 1 approached the nurse and complained of right arm pain and wanted an x-ray done. The ADON confirmed that there was no follow up attempts to reach Resident 1's physician between 5/15 and 5/17 when the resident re-approached the staff and continued to complain of right arm pain. The ADON confirmed that the staff should have tried to call the physician on 5/16/24 after 24 hours had gone by with no response from the physician. Interview on 7/17/24 at 10:47 AM with Registered Nurse (RN) A Nurse Manager confirmed that that there had been no attempts to follow up with Resident 1's physician after the X-ray report dated 5/21/24 was received by the facility. RN A confirmed that the X-ray radiologist recommended a follow up X-ray within 10-14 days and the 14 th day would have been 6/4/24. RN A confirmed that facility staff did not follow up with Resident 1's physician about the recommendation by the radiologist until they received a question from Resident 1's physician regarding a follow up X-ray and an order for a new X-ray on 6/19/24. RN A confirmed that this was a total of 15 days elapsed with no follow up after the recommended time frame for the follow up x-rays and a total of 30 days between the X-ray on 5/21/24 which showed a possible fracture and 6/21/24 that showed a healing fracture for Resident 1. Interview on 7/17/24 at 2:39 PM with the facility Director of Nursing [DON] confirmed that after Resident 1's initial report of pain and physician notification on 5/15/24. According to the DON the staff should have tried to contact the physician the following day, 5/16/24, because the physician hadn't gotten back to them. The DON stated I would expect my staff to follow up due to continued reports of pain by the resident. I would expect my staff to call and clarify if the physician wanted a follow up X-ray after we saw the X-ray results on 5/21/24 with the radiologist recommendations. This didn't happen and Resident 1 went an additional 2 weeks after the recommended 14 days to get a follow up X-ray completed. Record review of a facility policy and procedures entitled Guidelines for Physician Notification dated 12/27/23 revealed the following: - Immediate notification: Any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change (more severe) in relation to usual symptoms and signs or, unrelieved by measures already prescribed. - X-ray: report immediately to the physician new or unsuspected finding (e.g. fracture). Old or long standing findings with no change report next working day. (continued on next page)

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