

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Holdrege Memorial Homes, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 11th Avenue Holdrege, NE 68949	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484</p> <p>Licensure Reference Number 175 NAC 12-006.02(H) as directed in the Adult Protective Services Act, Neb. Rev. Stat. S 28-372.</p> <p>Based on record reviews and interviews, the facility failed to report incidents resulting in serious bodily injury within 2 hours for 2 residents, Resident 2 and Resident 6, of 4 residents sampled for reporting and for 1 resident, Resident 2, of 4 residents sampled for reporting. The facility census was 71.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility's Abuse and Neglect Prevention Protocol revised May 2024 revealed that the facility was required to report a reasonable suspicion of abuse or neglect to the state agency within 2 hours of forming the suspicion if there was a serious bodily injury, and within 24 hours of forming the suspicion if there was not a serious bodily injury.</p> <p>B.</p> <p>A record review of Resident 2's Continuity of Care Document created 12/12/2024 revealed Resident 2 was admitted on [DATE] and had diagnoses of a fractured right fibula (the bone on the outer side of the lower leg), dizziness, type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities).</p> <p>A record review of Resident 2's Progress Notes revealed a note from 10/19/2024 at 9:00 AM that stated the resident had fallen and denied injury. A note from 10/19/2024 at 5:38 PM revealed the resident had a bruise to the right inner ankle, and had pain to the right ankle. A note from 10/20/2024 at 7:30 AM revealed the resident had continued bruising and pain to the right ankle, the nurse educated the resident that the bruising could indicate a fracture or a sprain, and the resident declined going to the emergency room . A note from 10/21/2024 at 9:35 AM revealed the resident had continued bruising and pain to the right ankle, and had a physician appointment scheduled for later in the day. A note from 10/21/2024 at 4:57 PM revealed the resident had returned to the facility with a diagnosis of a fracture of the distal (farthest away from the center of the body) right fibula.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Adult Protective Services (APS) Intake Worksheet revealed the report of Resident 2's fall with serious bodily injury was received on 10/22/2024 at 3:01 PM.</p> <p>A record review of the facility's Investigation Report revealed that Resident 2's fall with serious bodily injury was called to APS on 10/22/2024 at 3: 30 PM, and was submitted to the state agency on 10/28/2024.</p> <p>An interview on 12/16/2024 at 2:27 PM with the Director of Nursing (DON) confirmed that the incident for Resident 2 resulted in serious bodily injury, was called in to APS more than two hours after forming the suspicion of abuse or neglect, and the DON further confirmed that the investigative report for Resident 2 was submitted to the state agency after more than five calendar days.</p> <p>C.</p> <p>A record review of Resident 6's Continuity of Care Document created 12/12/2024 revealed Resident 6 was admitted [DATE] and had diagnoses of a fractured right femur (thigh bone), an irregular heartbeat, heart failure, dementia, high blood pressure, and a history of a heart attack.</p> <p>A record review of Resident 6's Progress Notes revealed a note from 08/16/2024 at 8:59 PM that stated the resident had been found lying on the floor at 8:20 PM, had pain to the right side of the body near the right hip, and was unable to move their right leg, and was transported by an ambulance to the emergency room at 8:40 PM. A note from 08/17/2024 at 12:10 AM revealed the resident had a fracture of the right femur.</p> <p>A record review of the APS Intake Worksheet revealed the report of Resident 6's fall with serious bodily injury was received on 08/19/2024 at 9:20 AM.</p> <p>A record review of the facility's Investigation Report revealed that Resident 6's fall with serious bodily injury was called to APS on 08/19/2024 at 9:17 AM, and was submitted to the state agency on 08/22/2024.</p> <p>An interview on 12/16/2024 at 2:27 PM with the DON confirmed that the incident for Resident 6 resulted in serious bodily injury and was called in to APS more than two hours after forming the suspicion of abuse or neglect.</p>		