STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Haven Nursing Home	309 North Madison Street Coleridge, NE 68727

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to report to the State Agency and submit an investigation within 5 working days of a potential elopement for 1 (Resident 4) of 4 sampled residents. The facility staff identified a census of 22. Findings are: A. Review of the facility Abuse/Neglect/Misappropriation policy and procedure (undated) following: -individual residents with needs and behaviors that might lead to conflict, or neglect will be reassessed, care planned and monitored as needed. -neglect was defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; -proper supervision was defined as care and control of a vulnerable adult which a reasonable and prudent person would exercise under similar facts and circumstances; and -potential incidents of abuse/neglect were to be reported immediately to the State Agency and an investigation was to be conducted with the results submitted to the State Agency in 5 working days. B. Review of Resident 4's Nursing Progress Notes dated 2/28/24 at 11:15 AM revealed at 6:45 AM the Director of Nursing (DON) was notified Resident 4 had exited the facility through the front door at 5:15 AM that morning. The front door alarm had sounded but when staff investigated, they were unable to visualize anyone. The staff had thought the wind had triggered the door alarm. A short time later the housekeeping (HK) staff saw Resident 4 outside and the resident was assisted into the building without any difficulty. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Witness Incident Statement dated 2/28/24 revealed at 5:15 AM, HK-G heard the front door alarming. Registered Nurse (RN)-H investigated the alarm and did not see anyone outside. RN-H had just checked the wander guard bracelets with no concerns. HK-G entered the Activity Room and was able to see Resident 4 outside. The resident indicated a need to use the bathroom and was looking for a bathroom when went outside. The staff again checked the resident's wander guard bracelet and the front door wander guard alarm, and both remained functional. Review of facility investigations of potential abuse/neglect from 1/22/24 through 9/4/24 revealed no evidence Resident 4's potential elopement from the facility on 2/28/24 at 5:15 AM was reported to the State Agency. In addition, there was no evidence the investigation completed by the facility had been submitted within 5 working days. Interview with the Administrator and the DON on 9/4/24 at 1:20 PM confirmed an investigation was completed regarding Resident 4's elopement but the incident was not reported, and the investigation was not sent to the State Agency within 5 working days.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(I) Based on observations, interview, and record review; the facility failed to ensure Residents 1 and 3, who were identified at risk for falls, were free from accident hazards related to the independent use of motorized recliners in their rooms. The sample size was 4 and the facility census was 22. Findings are: A. Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/12/24 revealed the resident was admitted [DATE] with diagnoses of dementia, prostate cancer, chronic kidney disease and congestive heart failure. The following was assessed regarding the resident: -severe cognitive impairment, -required assistance with transfers, dressing, toileting hygiene, personal hygiene, and bed mobility, and -frequently incontinent of bladder. Review of the resident's current Care Plan dated 4/14/24 revealed the resident was at risk for falls due to a history of falls, and poor safety awareness with diagnosis of dementia. The following fall prevention interventions were identified: -ensure call light was within reach and provide reminders to use when needing assistance. -follow the resident's toileting schedule which included offering toileting assist upon arising, at bedtime, throughout the night and per the resident's request. -use of wheelchair for mobility when the resident had increased weakness. Review of Resident 1's Nursing Progress Notes revealed the following: -8/12/24 at 3:14 PM the resident was found on the floor of the resident's room. The seat of the resident's motorized lift recliner was elevated, and the resident was lying face down on the floor in front of the chair. The resident had a bruise to each of the resident's knees and a hematoma/laceration/abrasion to the center of the resident's forehead. The resident was transferred to the emergency room (ER) for evaluation. -8/12/24 at 4:06 PM the resident returned from the ER. The resident had a 6.8 centimeter (cm) by 5.5 cm hematoma and skin glue had been applied to the laceration on the resident's forehead. The staff implemented a short-term intervention for a sensor alarm to be placed on the resident's recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/5/24 at 9:10 AM, Resident 1 was assisted into the motorized lift recliner in the resident's room. Nurse Aide (NA)-A ensured the call light was in reach but placed the controls for the motorized recliner into a pocket on the side of the chair. Resident 1 was unable to access the controls when seated in the chair. In addition, a sensor fall alarm was in place to the chair to alert staff to any attempts to self-transfer out of the chair. Review of the Resident's medical record revealed no evidence an assessment had been completed to determine the resident's safe use of the motorized lift recliner. Interview with the Director of Nursing (DON) on 9/4/24 at 9:40 AM verified Resident 1's use of the motorized recliner had not been evaluated to determine if the resident could safely operate the recliner independently, and to assure the resident's safety. In addition, on 8/12/24 at 3:14 PM the resident had a fall out of the recliner when the resident accidentally elevated the seat and the resident subsequently slid out of the chair. B. Review of Resident 3's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of dementia, adult failure to thrive, obsessive compulsive disorder (OCD), anxiety and major depressive disorder. The following was assessed regarding the resident: -moderate cognitive impairment, -required staff assistance with transfers, dressing, toileting, personal hygiene, and bed mobility, and -frequently incontinent of bladder. Review of the resident's current Care plan dated 7/30/24 revealed the resident was at risk for falls related to weakness and poor safety awareness due to dementia. The following fall prevention interventions were developed: -anticipate and meet needs, -assess for pain and address, -ensure call light in reach and perform frequent room checks to assure safety needs are met, -non-skid strips on the floor beside the resident's bed, and -do not leave the resident alone/unsupervised in the resident's bathroom. Observations of Resident 3 on 9/4/24 at 10:37 AM revealed the resident was seated in a motorized lift recliner in the resident's room. The controls for the recliner were draped across the arm rest of the chair and were not within reach of the resident. Review of the Resident's medical record revealed no evidence an assessment had been completed to determine the resident's safe use of the motorized lift recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 9/4/24 at 9:40 AM verified Resident 3 was at risk for falls and routinely utilized a motorized lift recliner in the resident's room. However, use of the motorized recliner had not been evaluated to determine if the resident could safely operate the recliner independently, and to assure the resident's safety.