STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49766 Licensure Reference 175 NAC 12-006.09(I) Based on interviews and record reviews, the facility failed to identify causative factors, and develop and implement new interventions for falls for 3 (Resident 1, 3, 4) of 4 sampled residents. The facility also failed to develop and implement interventions for 1 (Resident 5) of 4 sampled resident at-risk for elopement. The facility identified a census of 54. The facility was notified on 10/16/2024 at 8:40 PM of an Immediate Jeopardy (IJ) which began on 7/4/2024. The IJ was removed on 10/17/2024, as confirmed by the surveyor onsite verification. Findings are: A record review of facility policy Fall Prevention Program with a last revised date of 10/16/23 revealed when a resident experiences a fall, the facility will review and update the resident's care plan. The policy did not include identifying causative factors of falls. A. A record review of an Admission Record indicated the facility admitted Resident 1 on 7/4/2024 with diagnoses of vascular dementia, disorientation, muscle weakness, and repeated falls. A record review of Resident 1's discharge Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), with a date of 9/30/2024, indicated Resident 1 had moderate cognitive impairment. A record review of Resident 1's Progress Notes with a date of 7/4/2024 revealed Resident 1 was found on the room of their floor. Resident 1 had a skin tear to their right elbow. A record review of a Post Fall Assessment with a date of 7/4/2024 revealed the causative factor of Resident 1's fall as unknown. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident 1's Progress Notes with a date of 8/7/2024 at 7:20 AM revealed Resident 1 was found sitting on the floor in front of their closet. Resident 1 had complained of excruciating lower back pain and had two skin tears to their right elbow. Resident 1 was sent to the Emergency Department for evaluation. A record review of an Unwitnessed Fall without Injury report with a date of 8/7/24 revealed Resident 1 was observed sitting on the floor in front of their closet and stated he was trying to get pants. Confusion, noncompliance, and impaired memory were identified as causative factors of the fall. A record review of Resident 1's Progress Notes with a date of 8/7/2024 at 11:00 AM revealed Resident 1 was being admitted to the hospital with lumbar compression fracture and pneumonia. A record review of Resident 1's Progress Notes with a date of 8/12/2024 revealed Resident 1 was observed laying on the floor. Resident 1 had been complaining of chest pain. Resident 1 also suffered a skin tear to their right elbow. A record review of an Unwitnessed Fall without Injury report with a date of 8/12/24 revealed Resident 1 was laying found on the floor. Identified causative factor was poor lighting. A record review of an Unwitnessed Fall without Injury report with a date of 8/13/24 revealed resident was found on the bathroom on their knees. Resident 1 had stated they were trying to get back in their wheelchair when they lost their strength when trying to stand. Confusion and gait imbalance were identified as causative factors and ambulating without assistance. A record review of Resident 1's Progress Notes with a date of 9/28/2024 revealed Resident 1 had arrived from the Emergency Department. Resident 1 was found 20 minutes later on the floor and had been laying in a puddle of blood. Resident 1 was transported by the ambulance back to the hospital. Resident 1 later returned to the facility with a glued facial wound. Resident 1 was placed on 1 on 1 cares. A record review of a Post Fall Assessment with a date of 9/28/2024 revealed the causative factor of Resident 1's fall as noncompliance. A record review of Resident 1's Progress Notes with a date of 9/29/2024 revealed Resident 1 was being non-compliant with staying in the bed. A record review of Resident 1's Progress Notes with a date of 9/30/2024 revealed Resident 1 was found on the ground noted to be bleeding from a previous laceration to his face. Resident was transferred to the Emergency Department by the ambulance. A record review of Resident 1's Progress Notes with a date of 9/30/2024 revealed Resident 1 had been admitted to the hospital following the CT results of having a brain bleed and was also noted to have a cut to their left ear, four stitches to their left eyebrow, a skin tear to their left elbow, and an abrasion to their left shoulder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of an Unwitnessed Fall with Injury report with a date of 9/30/2024 indicated Resident 1's post fall Emergency Department notes indicated Resident 1 was hospitalized with a brain bleed after fall. It also revealed non-compliance, gait imbalance, and ambulating without assistance as causative factors for the fall. A record review of Resident 1's fall care plan revealed Resident 1 was at risk for falls due to cognitive impairment, confusion, unaware of safety needs, and wandering. It also revealed no interventions were placed after Resident 1's fall on 7/4/2024 and the intervention for Resident 1 was 1 to 1with the resident by a staff member from 9/28/2024 was not resolved until 10/4/2024. It also revealed the intervention for Resident 1's fall identified as due to poor lighting was to schedule a doctor's appointment. An interview on 10/16/24 at 5:10 PM with Nurse Aide (NA) - C revealed that fall mats, side rails, and cameras were the only fall interventions NA-C was aware of. Regarding Resident 1, NA-C stated Resident 1 did not like female staff assisting them and would get upset when female staff tried to redirect [gender] or assist [gender]. An interview on 10/16/24 at 5:15 PM with LPN-B revealed that when a resident has a fall, LPN-B does not put new interventions into place for the residents. LPN-B stated they would, however, make sure the resident's bed was in low position and their call light was within reach. When asked about fall interventions, LPN-B stated the only fall interventions they were aware of for the residents were to make sure the residents' beds were in low position and that their call lights were within reach. An interview on 10/16/2024 at 8:12 PM with the Administrator confirmed mental status and noncompliance were not causative factors of falls as the residents are vulnerable adults and lack the safety awareness to protect themselves from falls. The interview also confirmed no causative factor was identified or follow up intervention placed after Resident 1's fall on 7/4/2024. Interview also revealed an intervention of 1 to 1 with staff until settled was placed for Resident 1's fall on 9/28/2024, but no causative factor was identified. The Administrator stated 1 to 1 with staff was discontinued, but was unsure of when, but believed it was on 9/29/2024. The Administrator did confirm the intervention was not resolved off the care plan until 10/4/2024 and confirmed no documentation 1 to 1 with staff was removed or Resident 1 had settled, the Administrator also acknowledge the Progress Note written on 9/29/2024 stated that Resident 1 had been non-compliant with staying in bed. The Administrator also confirmed intervention for Resident 1's fall on 8/12/24 was not appropriate. B. A record review of an Admission Record indicated the facility admitted Resident 4 on 2/16/2024 with diagnoses of chronic pain and repeated falls. A record review of Resident 4's quarterly MDS with a date of 8/15/2024 indicated Resident 4 had severe cognitive impairment. It also indicated Resident 4 had two or more falls since their last assessment. A record review of Resident 4's Progress Notes with a date of 7/1/2024 revealed Resident 4 was in the restroom and had fallen. The progress note did not identify a causative factor of the fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident 4's Fall report with a date of 7/1/2024 revealed no causative factors of Resident 4's fall had been identified. A record review of Resident 4's Progress Notes with a date of 8/6/2024 revealed Resident 4 was found sitting on the floor by the end of their roommate's bed. The progress note did not identify a causative factor of the fall. A record review of Resident 4's Unwitnessed Fall without Injury with a date of 8/6/2024 revealed no causative factors of Resident 4's had been identified. A record review of Resident 4's Progress Notes with a date of 8/27/2024 revealed Resident 4 had a witnessed fall while sliding off their bed. A record review of an Unwitnessed Fall without Injury report with a date of 8/27/2024 revealed Resident 4 had slid off their bed and fell . A causative factor had been identified as wet floor. A record review of Resident 4's Progress Notes with a date of 8/29/2024 revealed Resident 4 had an unwitnessed fall. Resident 4 had tried to slide from the bed to the trashcan to have a bowel movement and fell . Resident 4 had no injuries. A record review of an Unwitnessed Fall without Injury report with a date of 8/29/2024 revealed resident was attempting to transfer from bed to the trashcan due to needing to have an urgent bowel movement. Causative factors were identified as incontinence and ambulating without assist. A record review of Resident 4's Progress Notes with a date of 9/11/2024 revealed Resident 4 was found laying in the lobby between a chair and their wheelchair. Resident 4 reported [gender] had hit [gender] head. The on-call physician had recommended Resident 4 be sent to the emergency room for evaluation due to being on a blood thinner. The family declined. A record review of an Unwitnessed Fall without Injury report with a date of 9/11/2024 revealed Resident 4 had fallen in the lobby. Causative factors of confusion and noncompliance had been identified for Resident 4's fall. A record review of Resident 4's Progress Notes with a date of 9/29/2024 revealed Resident 4 was found sitting on their bottom with their legs under the bed. Resident was unable to explain what they were doing at the time of fall. Resident 4 had no injuries. A record review of an Unwitnessed Fall without Injury report with a date of 9/29/2024 revealed Resident 4 was observed sitting on their bottom with legs under the bed. Resident 4 was unable to explain what they had been doing doing. Identified causes of Resident 4's fall were determined as poor lighting and improper footwear. A record review of Resident 4's Progress Notes with a date of 10/1/2024 revealed Resident 4 was found sitting on the floor next to their bed and had stated they were trying to get ready for bed. Resident 4 had no injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of an Unwitnessed Fall without Injury report with a date of 10/1/2024 revealed Resident 4 was observed sitting on the floor next to their bed, and had stated I was going to bed. It also revealed causative factor identified as impaired memory, confusion, and ambulating without assist. A record review of Resident 4's fall care plan with a date initiated of 3/7/2024 revealed Resident 4 was at risk for falls due to dementia/confusion, gait imbalance, incontinence, and unaware of safety needs. It also revealed the following: - Intervention from fall on 10/1/2024 was a duplicate of 9/27/2024 to educate staff. - An intervention for Resident 4's fall on 9/11/2024 had not been developed and implemented on the care plan. - The intervention for Resident 4's fall on 8/27/2024 was to ensure appropriate footwear, when Resident 4 rolled out of bed. An interview on 10/16/2024 with the Director of Nursing (DON) confirmed no causative factors were identified for Resident 4's falls on 8/6/2024, 7/1/2024. The DON also confirmed Resident 4's intervention for 8/29/2024 and 9/29/2024 were not appropriate. The DON also confirmed Resident 4's fall on 8/27/2024 causative factor and interventions were not appropriate. An interview on 10/16/2024 at 6:17 PM with the Administrator confirmed Resident 4's fall intervention for 10/1/2024 was already used on 9/27/2024. An interview on 10/16/2024 at 6:45 PM with the Administrator confirmed mental status and noncompliance were not causative factors of falls as the residents are vulnerable adults and lack the safety awareness to protect themselves from falls. The Administrator also confirmed the intervention for Resident 4's fall on 8/27/2024 was not appropriate. C. A record review of an Admission Record indicated the facility admitted Resident 3 on 3/8/2022 and had diagnoses of cognitive communication deficit, muscle weakness, repeated falls, difficulty in walking, and osteoporosis. A record review of Resident 3's annual MDS with a date of 8/7/2024 revealed Resident 3 had moderate cognitive impairment. It also revealed Resident 3 had fallen two or more times since the last assessment. A record review of Resident 3's fall care plan with an initiated date of 11/22/2021 revealed Resident 3 was at risk for falls and had recent falls. A record review of Resident 3's Progress Notes with a date of 9/7/2024 revealed Resident 3 had been heard yelling for help. Resident 3 was found sitting on the floor next to their bedroom door. Resident 3 had no injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident 3's AS- Post Fall Assessment with a date of 9/7/2024 revealed root cause analysis and interventions boxes were left uncompleted. An interview on 10/16/2024 at 5:48 PM with the Director of Nursing (DON) confirmed a causative factor of Resident 3's fall on 9/7/2024 had not been identified at the time of Resident 3's fall. An interview on 10/16/2024 at 8:06 PM with the Administrator confirmed a causative factor of Resident 3's fall on 9/7/2024 had not been identified at the time of Resident 3's fall. D. A record review of an undated facility policy titled Elopements and Wandering Residents revealed the facility will identify and assess risk and implement interventions when a resident is at risk for elopement. The policy also revealed the team will evaluate unique factors contributing to the resident's risk in order to develop a person-centered care plan. A record review of an Admission Record indicated the facility admitted Resident 5 on 10/2/2024 with diagnoses of heart failure, Chronic Kidney Disease, and Type II Diabetes Mellitus. A record review of the facility's Elopement Log, the facility's list of residents who have been identified to be at-risk for elopement, revealed that Resident 5 was added to the Elopement Log, on 9/4/2024. A record review of Resident 5's undated Care Plan revealed Resident 5 had no care plan focus, goals, or interventions related to elopement, exit seeking, or wandering. A record review of Resident 5's physician's orders revealed Resident 5 had no orders related to their Wanderguard or other orders of interventions for exit seeking. An interview on 10/16/24 at 7:50 PM with Licensed Practical Nurse (LPN) - A revealed they were unaware Resident 5 was at risk for elopement and were unaware Resident 5 had a Wanderguard. LPN-A also confirmed they check the functionality of Wanderguards on nightshift, but had not been checking Resident 5's Wanderguard. An interview on 10/16/2024 at 7:00 PM with the DON confirmed Resident 5 had no focus area regarding elopement or wandering on their care plan. The DON also confirmed Resident 5 had no orders for the Wanderguard or to check the functionality placed in their orders. The facility took the following immediate actions to remove the immediacy of the situation: Facility Abatement Statement: How are we going to identify residents at risk for fall and Elopement: -Fall assessment upon admission -Elopement assessment upon admission (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	How will you remove the deficient practice and when? -Resident 1 (as of 10-16-2024) resident is no longer residing in the facility -Residents 3 and 4 (environmental check will be completed to ensure room is free of clutter, fall hazards and new interventions will be implemented as indicated after check is completed by end of day 10-16-2024) -Resident 5 Wander guarded location and functionality order to monitor was placed on the TAR and Care Plan updated to reflect elopement risk. 10-16-2024 -All staff present now will be educated regarding fall prevention, root cause analysis and elopement, and all other staff will be educated prior to working their next shift. -A Fall Risk assessment will be completed on all HC residents by end of day 10-17-2024 any resident identified as at risk for falls will have appropriate interventions implemented and an care plan updated. -An Elopement assessment will be completed on all HC residents by end of day 10-16-2024 any resident identified as at risk for elopement will have appropriate interventions implemented and care plan updated. -Fall Care Plan created upon admission and reviewed quarterly and as indicated by Fall assessment score. -Residents at risk for falls will have fall care plans (baseline initially) and comprehensive care plan with interventions in place. -With each fall a post fall assessment will be completed, and a root cause analysis will be completed to determine the cause of the fall, and appropriate interventions will be added to prevent a recurrence. -Residents at high risk for elopement as identified by the Elopement assessment score will be provided a wander guard, they will be added to the elopement binder, and an order for monitoring the device will be placed in the orders (location and functionality) every day and night shift. -Risk for elopement will be placed on the care plan with interventions. -Staff will be educated on the location of the Elopement book at the nurse's station, a reminder sign will be added to the staff bulletin board, and a list posted on the facility bulletin board in PCC. -All staff present now will be educated regarding falls and elopement, and all other staff will be educated prior to working their next shift. -A Fall Risk assessment will be completed on all HC residents by end of day 10-17-2024 any resident identified as at risk for falls will have appropriate interventions implemented and an care plan updated. (continued on next page)

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