STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 12-006.02 (8) Based on record review and interview, the facility failed to report to Adult Protective Service and submit investigation to state agency within 5 working days 2 elopements involving 1 [Resident 1] of 4 sampled residents. The facility had a total census of 85 residents. Findings are: A. A review of the Admission Record revealed Resident 1 was admitted to the facility on [DATE] with a diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. A review of the MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 2/8/24 revealed Resident 1 had a BIMS [Brief Interview for Mental Status is used to get a quick snapshot of how well you are functioning cognitively at the moment] score of 3 indicating severe cognitive impairment. A review of Resident 1's Care Plan revealed a problem of being at risk for elopement with history of attempts to leave facility unattended and impaired safety awareness dated 7/27/23 with the following interventions: -Add resident to the Elopement book dated 7/27/23, -Complete Elopement Risk assessment dated [DATE], -Document wandering behavior and attempted diversional interventions in behavior, -The resident will not leave facility unattended dated 7/27/23, -Encourage to participate in activities to divert from exit seeking behavior dated 12/19/23, -Frequent monitoring dated 7/27/23, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide for safe wandering-resident is an elopement risk, -Wanderguard dated 2/12/24. A review of Progress Note for Resident 1 dated 7/26/23 at 1:20 PM revealed Resident 1 was found walking up the hill. Staff drove and retrieved Resident 1. Resident 1 was drove back down to the facility. Resident 1 was noted not to have sustained any injuries. Wanderguard was placed on Resident 1. A review of Incident Report for Resident 1 dated 11/24/23 at 6:05 PM revealed housekeeping found Resident 1 walking outside on the front side of the building and informed nurse. Nurse rushed to the outside and found Resident 1 at the end of the building side walk returning back to the front door. Resident 1 reported Resident 1 was walking. A check of Resident 1's Wanderguard bracelet revealed it was working according to Incident Report. In interviews on 4/1/24 at 2:43 PM and 3:59 PM, the Administrator confirmed Resident 1's elopements on 7/26/23 and 11/24/23 were not reported to Adult Protective Services or an investigation submitted to the state agency. The Administrator reported that Resident 1's was not considered to have eloped as Resident 1 did not leave the facility grounds. B. A review of facility policy titled Missing Residents/Actual Elopement Event revised 4/5/23 revealed the following: -Elopement definition-This occurs when a resident leaves the premises or a safe area without authorization (i. e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. -Procedure-The Executive Director or designee will report the event to all appropriate agencies as well as the regional and divisional team.

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 12-006.09D7 Based on observation, interview, and record review, the facility failed to ensure monitoring of Wanderguard bracelet placement and function to prevent potential elopement from the facility for 1 [Resident 1] of 3 sampled residents at risk for elopement. The facility had a total census of 85. Findings are: A. A review of Admission Record revealed Resident 1 was admitted to the facility on [DATE] with a diagnoses of hemiplegia [severe or complete loss of strength or paralysis on one side of the body] and hemiparesis [mild or partial weakness or loss of strength on one side of the body] following cerebral infarction affecting right dominant side. Observations on 4/1/24 at 5:58 PM revealed Resident 1 with a Wanderguard bracelet [a bracelet worn by a resident that triggers an alarm if resident attempts to exit a facility] on right wrist. RN [Registered Nurse]-B checked the bracelet with the tester machine and the braclet was functioning. A review of MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 2/8/24 revealed Resident 1 had a BIMS [Brief Interview for Mental Status is used to get a quick snapshot of how well you are functioning cognitively at the moment] score of 3 suggesting severe cognitive impairment. A review of Resident 1's care plan revealed a problem of being at risk for elopement with history of attempts to leave facility unattended and impaired safety awareness dated 7/27/23 with the following interventions: -Add resident to the Elopement book dated 7/27/23, -Complete Elopement Risk assessment dated [DATE], -Document wandering behavior and attempted diversional interventions in behavior, -The resident will not leave facility unattended dated 7/27/23, -Encourage to participate in activities to divert from exit seeking behavior dated 12/19/23, -Frequent monitoring dated 7/27/23, -Provide for safe wandering-resident is an elopement risk dated 7/27/23, -Wanderguard dated 2/12/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Elopement Risk Evaluations completed for Resident 1 revealed the following: -2/9/2023 Resident 1 is not at risk for elopement. -5/9/2023 Resident 1 is not at risk for elopement. -7/26/2023 Resident 1 is at risk for elopement. -8/9/2023 Resident 1 is not at risk for elopement. -11/15/2023 Resident 1 is not at risk for elopement. -11/24/2023 Resident is at risk for elopement. -3/4/2024 Resident 1 not at risk for elopement. -4/1/2024 Resident 1 is at risk for elopement. A review of Progress Note for Resident 1 dated 7/26/23 at 1:20 PM revealed Resident 1 found walking up the hill. Staff drove and retrieved Resident 1. Resident 1 was drove back down to the facility. Resident 1 was noted not to have sustained any injuries. Wanderguard was placed on Resident 1. A review of Incident Report for Resident 1 dated 11/24/23 at 6:05 PM revealed housekeeping found Resident 1 walking outside on the front side of the building and informed nurse. Nurse rushed to the outside and found Resident 1 at the end of the building sidewalk returning back to the front door. Resident 1 reported Resident 1 was walking. A check of Resident 1's Wanderguard bracelet revealed it was working according to the Incident Report. In an interview on 4/1/24 at 3:40 PM, RN-B reported the Wanderguard did not sound when Resident 1 went out the door on 11/24/23 but it sounded when Resident 1 came back inside and was working when checked with the tester. A review of Progress Note for Resident 1 dated 12/30/23 at 8:32 AM revealed Resident 1 was attempting to leave the building. Resident 1 was redirected back to the common area. A review of Progress Note for Resident 1 dated 12/31/23 at 2 PM revealed Resident 1 dressed in coat and hat. Resident 1 was seeking exit and trying to get out front door as well as side exit door. Wanderguard was in place and functioning. Resident 1 was on 1:1 for an hour with a nurse aide until Resident agreed to go to room and rest. A review of Progress Note for Resident 1 dated 2/11/24 at 11:30 AM revealed Resident 1 was attempting to exit front door of the facility. Resident 1 became angry when attempting to re-direct. Resident 1's Wanderguard was not working properly or alarming. Resident 1's Wanderguard was replaced. In an interview on 4/1/24 at 10:31 AM, LPN [Licensed Practical Nurse]-A reported that [gender] had checked this morning and Resident 1's Wanderguard bracelet was functioning. LPN-A confirmed that Resident 1 will watch the door and attempt to leave. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's TARs [Treatment Administration Records] for 7/2034, 8/2023, 9/2023, 10/2023, 11/2023, 12/2023, 1/2024, 2/2024, and 3/2024 revealed no documentation of Resident 1's Wanderguard bracelet being monitored for placement or function. A review of Resident 1's Order Summary Report revealed an order dated 4/1/2023 to check Wanderguard placement and function every shift. In an interview on 4/1/23 at 1:11 PM, the ADON [Assistant Director of Nursing] confirmed [gender] had added Wanderguard monitoring to Resident 1's TAR that day. In interviews on 4/1/24 at 1:11 PM and 2:35 PM, the ADON confirmed the Wanderguard bracelet was placed on Resident 1 on 7/26/23 and there was no evidence that monitoring of placement or function had been completed between 7/26/23 and today. The DON reported the process is to add to the care plan and TAR for monitoring when placed on resident. In a follow-up interview on 4/1/24 at 3:23 PM, the DON reported there was no policy on monitoring function of Wanderguard bracelets. A review of facility policy titled Area of Focus: Elopement reviewed 11/28/23 revealed the following: -Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. -The interdisciplinary team will review and revise the resident's unsafe wandering management care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS and upon an unsafe wandering or elopement event. B. The facility implemented the following interventions on 4/1/2024 to remove the immediacy of the situation and to protect the residents: Resident 1: Resident was immediately assessed to confirm placement and function of Wanderguard. The physician order for monitoring function daily and placement every shift has been written. The care plan has been updated to reflect the current status of the resident. The following interventions were implemented to protect other residents that may be at risk for elopement: -A one-time review of current resident population will be completed by 04.02.24 to validate residents have been assessed for elopement risk. -A one-time review of current residents identified at risk for elopement confirming they have a wander guard bracelet on their person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A one-time review of residents identified as being at risk of elopement have been reviewed validating the monitoring orders are in place on the Treatment Administration Record. -A one-time review has been completed validating the elopement binder is up to date with the current list of residents identified at risk for elopement with resident characteristics and picture. -Going forward, the IDT [Interdisciplinary Team] will be responsible to review new admissions, readmissions, quarterly, and significant change assessments to validate the elopement assessments are completed accurately and the elopement process was followed weekly for 2 months, then monthly for 2 months. -An Ad hoc QAPI meeting has been completed with the Medical Director to review the plan. The medical director is in agreement with the plan. Education to staff: Facility staff on the PM shift have been re-educated on wander guard placement and function monitoring, documentation of monitoring process, and elopement prevention. Night shift will be educated 04.01.24. Day shift 04.02.24 at begin of shift. Following 4/2/24, staff re-education will be completed prior to the next shift scheduled for both facility associate and agency staff. Education on elopement prevention is completed with any new associate and/or agency staff hires during the orientation process or at the beginning of the shift for new agency staff. Auditing: The Director of Nursing/Designee will be responsible for monitoring wander guard function and placement completion and documentation on Treatment Records 5 times weekly for 2 weeks, weekly for 2 weeks, monthly for 3 months.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 04577 Based on observation, record review, and interview, the facility failed to ensure posting of daily nursing staffing. The facility had a total census of 85 residents. Findings are: Observations on 4/2/24 at 1:00 PM revealed daily nursing staffing posting was dated 3/13/24. A review of facility staff posting revealed the census and staffing hours were from 3/13/24. In an interview on 4/2/24 at 1:11 PM, the Administrator confirmed that the daily nursing staffing positing was not up-to-date. The Administrator reported that a new scheduler had just been hired.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 04577 Licensure reference: 12-006.04B2a Based on record review and interview, the facility failed to ensure 2 [Nurse Aide C and D] of 5 sampled nurse aides had completed 12 hours of yearly in-service training and failed to complete dementia and abuse in-service training for 1[Nurse Aide C] of 5 sampled nurse aides. The facility had a total census of 85 residents. Findings are: A review of employee list with an effective date of 3/7/24 revealed a hire date of 11/28/17 for Nurse Aide-C. A review of Nurse Aide-C's completion certificates revealed Nurse Aide-C completed 1.95 hour of continuing education between service dates of 11/28/22 to 11/28/23. The completion certificates did not include any training on abuse prevention or dementia for the service year. A review of employee list with an effective date of 3/7/24 revealed a hire date of 10/5/18. A review of Nurse Aide-D's completion certificates revealed Nurse Aide D completed 1.03 hours of continuing education between service dates of 10/5/22-10/5/23. In an interview on 4/3/24 at 10:30 AM, the Director of Nursing confirmed Nurse Aide-C and Nurse Aide-D had not completed 12 hours of continuing education per year.