

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2024
NAME OF PROVIDER OR SUPPLIER  The Pines at Blue Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  414 North Willson Street Blue Hill, NE 68930	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41938</p> <p>Licensure Reference Number 175 NAC 12-006.09D7</p> <p>Based on observation, record review, and interview, the facility failed to ensure that staff were trained to check the function of individual resident elopement prevention equipment to prevent elopement (unsupervised wandering that leads to the resident leaving the facility without facility staff knowledge). This affected 4 (Residents 1, 2, 3, and 4) of 4 residents identified as at risk for elopement. The facility census was 33.</p> <p>Findings are:</p> <p>Record review of the facility policy titled Wandering and Elopement dated 7/1/20 revealed that the facility will provide a system to identify residents at risk for unsafe wandering and elopement. The facility will provide a program of supervision and interventions to minimize risk of resident elopements. The facility will provide staff education for effective wandering/elopement management. Staff members receive appropriate training on wandering and elopement management. This will occur at a minimum, during orientation and annually. A wandering/elopement risk evaluation is completed for each resident to identify the level of risk that may lead to elopement. If it is determined that the resident is at risk for wandering/elopement, a plan is developed and implemented immediately and reviewed with staff. Alert devices like wander guard bracelets (a bracelet placed on a resident at risk to wander/elope that triggers alarms and can lock monitored doors to prevent the resident from leaving the facility unattended) will be checked for placement and function each shift and these checks will be documented in the medical record.</p> <p>Record review of Resident 1's Admission Record dated 2/8/24 revealed Resident 1 admitted into the facility on [DATE]. Resident 1 had a diagnosis of dementia.</p> <p>Record review of Resident 1's Elopement Evaluation dated 1/2/24 revealed Resident 1 wanders and does wander aimlessly. A score of 1 or higher indicates the resident is at risk for elopement. The Elopement Evaluation revealed Resident 1 had a score of 3.</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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 1's Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 1/7/24 revealed that Resident 1 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 8 (a score of 8 indicates moderate cognitive impairment). The MDS revealed Resident 1 was independent with transferring and walking.</p> <p>Record review of Resident 1's Baseline Care Plan (BCP) (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) dated 1/2/24 revealed Resident 1 was at risk for elopement. The BCP revealed that Resident 1 has a history of dementia and wanders throughout the facility. The BCP summary section revealed that Resident 1 was found wandering in the airport in Omaha and is forgetful.</p> <p>Record review of Resident 1's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 2/8/24 revealed Resident 1 was an elopement/wander risk due to dementia and impaired safety awareness. The Care Plan identified an intervention to apply a wander guard alert bracelet and check functioning as ordered. The Care Plan identified a wander guard was placed to Resident 1's left wrist which was dated 1/3/24.</p> <p>Record review of Resident 1's Order Summary (a listing of physician orders for a resident) dated 2/8/24 revealed an order to check the wander guard for function every shift dated 1/18/24.</p> <p>Observation on 2/8/24 at 9:13 AM revealed a wander guard sensor (a sensor connected to an entry/exit door to prevent a resident with a wander guard bracelet from leaving the facility unattended) on the front main entry door of the facility.</p> <p>Observation on 2/8/24 at 10:10 AM of Resident 1's room revealed Resident 1 had a gray wander guard bracelet in place on their left wrist.</p> <p>Record review of Resident 1's Progress Note dated 1/16/24 at 12:58 AM revealed that Resident 1 wanders at night.</p> <p>Record review of Resident 1's Progress Note dated 1/18/24 at 7:23 PM revealed that a staff member that was on break called the facility. The staff member reported that they thought they saw Resident 1 walking across the road to the Dollar General store. The staff member was instructed to go over to the store and check. Resident 1 returned to the facility with the staff member. Resident 1 was assisted to put dry warm clothes on. Resident 1 stated that they went to the store to get something but forgot that they didn't have any money.</p> <p>Interview on 2/8/24 at 2:06 PM with the facility Assistant Director of Nursing (ADON) revealed the ADON was present at the time Resident 1 eloped on 1/18/24. The ADON confirmed that the wander guard alarm on the front door of the facility did not sound an alarm. The ADON did not identify any reason or check as to why the door did not alarm.</p> <p>Record review of the Wander Guard User Instructions dated 2023 revealed the section titled Testing the Signaling Device. The section revealed that each signaling device (wander guard bracelet) is tested daily using a Universal Tester (a hand-held, battery powered device used to test wander guard bracelets and door monitors/sensors) and results documented in the resident's record.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 1's Treatment Administration Record (TAR) (a record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) for February 2024 revealed the medical task to check the wander guard every shift for functioning was documented by Licensed Practical Nurse-A (LPN-A) for the day and evening shift on 2/5/24, the day and evening shift for 2/6/24, and the day shift on 2/8/24. Further, the record review revealed there were not wander guard functioning checks in place prior to Resident 1's elopement on 1/18/2024.</p> <p>Interview on 2/8/24 at 10:52 AM with Licensed Practical Nurse-A (LPN-A) revealed that resident wander guards are checked daily and documented on the Treatment Administration Record (TAR). LPN-A revealed that LPN-A visually checks that the wander guard is in place on the resident. LPN-A confirmed that they were unaware of any other checks required other than visually verifying placement of the wander guard. LPN-A was unaware of any tester.</p> <p>Interview on 2/8/24 at 11:00 AM with the facility Director of Nursing (DON) revealed that the facility currently has 4 residents with a wander guard (Residents 1, 2, 3, and 4). The DON revealed that the wander guard is to be checked every shift for placement and function. The DON confirmed the wander guard bracelet is required to be tested with the wander guard tester. The DON revealed that a green light on the wander guard tester is required to show the wander guard is functioning. The DON revealed that checks of the wander guard placement and function are documented in the electronic health record on the Treatment Administration Record (TAR) by the nurse. The DON revealed that the facility maintenance person checks the wander guard sensors at the doors with a testing device.</p> <p>Observation on 2/8/24 at 12:58 PM at the treatment cart outside the nurse's station with the facility Director of Nursing (DON) revealed that the DON brought the Wander Guard user instructions to this surveyor. The DON picked up the Universal Tester and confirmed that it is the tester used to verify that the wander guards are functioning. This surveyor asked the DON what training on the tester had been provided to LPN-A. The DON confirmed that the facility had not performed any training with LPN-A on the use of the tester. LPN-A approached the cart and asked, that is what you use?. LPN-A confirmed that LPN-A had not received training to use the tester for the wander guard checks.</p> <p>Record review of Resident 2's TAR revealed LPN-A verified placement on 2/5/24 day and evening shift, 2/6/24 day and evening shift, and 2/8/24 day shift.</p> <p>Record review of Resident 3's TAR revealed LPN-A verified placement on 2/5/24 day and evening shift, 2/6/24 day and evening shift, and 2/8/24 day shift.</p> <p>Interview on 2/8/24 at 2:38 PM with the Facility Administrator (FA) confirmed that the expectation is for wander guards to be checked for placement and proper function every day. The FA confirmed that the facility investigation for the 1/18/24 elopement of Resident 1 revealed that Resident 1 left the facility through the front door.</p> <p>Record review of the Facility Abatement Statement received on 2/8/24 at 4:54 PM from the Regional Nurse Consultant (RNC) revealed the following:</p> <p>-All wander guard amulets (bracelets) in use immediately checked for placement, functioning, and expiration date.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-Education provided immediately to all licensed nursed in the facility on monitoring the wander guard amulet for placement, functioning, and expiration date every shift every day.</p> <p>-Education will be provided to all licensed nurses, including agency licensed nurses, prior to working their next shift.</p> <p>-All newly hired licensed nurses will be educated on monitoring of wander guard amulets during general orientation.</p> <p>-All new agency licensed nurses will be educated on monitoring of wander guard amulets during orientation to the building.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>49382</p> <p>Licensure Reference Number 175 NAC 12-006.07c</p> <p>Based on record review and interview, the facility failed to develop and implement a Quality Assurance Process Improvement Plan of action (a systematic data driven approach to improving the quality of care and services provided to residents, to correct a facility identified problem) related to elopements (unsupervised wandering that leads to the resident leaving the facility without notice). This has the potential to affect 4 (Residents 1, 2, 3, and 4) residents within the facility who were identified as elopement risks. The facility census was 33.</p> <p>Findings are:</p> <p>A record review of the facility supplied document labeled Quality Assurance and Performance Improvement (QAPI) Plan dated April 2014 revealed the facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. Under objectives of the QAPI Plan are the following:</p> <ul style="list-style-type: none"> <li>- Provide a means to identify and resolve present and potential negative outcomes related to resident care and services</li> <li>- Provide structure and processes to correct identified quality and or safety deficiencies</li> <li>- Establish systems and processes to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is and effective ongoing program.</li> </ul> <p>A review of the facility supplied document labeled Wandering and Elopement dated 07/01/2020 revealed the following. Under the heading elopement drills it documented that an elopement drill evaluation is completed at the conclusion of each drill and a targeted improvement plan is developed for staff education and improvement, as indicated. Under the heading follow up it is documented the administration or designee is to complete a detailed review or investigation of the event and integrate that report into the Quality Assurance and Performance Improvement Program.</p> <p>A review of the facility supplied document labeled Elopement Drill Checklist and Evaluation revealed under the heading elopement drill checklist to evaluate and analyze the drill process and outcome, document drill results and identify areas of opportunity at the conclusion of the drill, a targeted Community Improvement Plan is to be developed for staff education and improvement.</p> <p>A review of the facility supplied document labeled Elopement Drill dated 03/30/2023 revealed documentation that most staff were slow to respond and did not go outside to look until prompted to do so and education was provided on elopement.</p> <p>A review of the facility supplied document labeled Elopement Drill dated 11/21/2023 revealed documentation that an elopement drill was conducted starting at 11:15 AM and ending at 11:45 AM.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility supplied document labeled QAPI dated 12/2023 revealed under elopement drills, date of last elopement drill documented completed by Director of Nursing (DON).</p> <p>A review of the facility supplied document labeled QAA Agenda Minutes (Quality Assessment and Assurance) dated 01/16/2024 (For December 2023) revealed under elopement drills, date of last elopement drill documented completed by DON.</p> <p>In an interview conducted on 02/13/2024 at 1:30 PM with the Facility Administrator (FA) it was confirmed that no documentation of education being provided and to who the education was provided is present or available as documented on the 03/30/2023 Elopement Drill document and there is no documentation of this education present in the QAPI review for that month. The FA confirmed the elopement drill occurring on 11/21/2023 had a negative outcome. The FA confirmed that there is no review or documentation of a review present on the QAPI review for that month.</p> <p>In an interview conducted on 02/13/2024 at 1:30 PM with the Regional Nurse Consultant (RNC) it was confirmed that results from the 03/30/2023 and 11/21/23 elopement drills should have been addressed in that months QAPI review.</p>		