STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285172	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilber Care Center	611 North Main Wilber, NE 68465

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. Licensure Reference 175 NAC 12-006.02(H)Based on record reviews and interviews, the facility failed to submit an investigative report for Resident 1 within the required time frame. This affected 1 of 1 residents sample for reporting. The facility census was 33.Findings are:A record review of Resident 1's Continuity of Care Document created 06-10-2026 revealed the facility admitted the resident on 04/22/2026 with diagnoses of Alzheimer's disease (the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills), and vascular dementia (a decline in thinking and reasoning skills caused by restricted or blocked blood flow to the brain).A record review of Resident 1's Resident Progress Notes revealed a note from 05/25/2026 at 5:53 PM that revealed the resident had eloped (when an individual with dementia leaves a safe or supervised area without authorization or knowledge) and that the resident's Wanderguard had not set off the door alarm on exit or entry to the building.A review of an undated preliminary report provided by the facility Administrator (ADM) revealed that on May 25, (Resident 1) exited the supervised area of the facility.A review of Intake Information Report #3025859 and attached documents on 06/09/2026 revealed no facility investigation report.An interview on 06/10/2026 at 9:19 AM with the ADM confirmed the facility had not submitted a 5-day investigative report on Resident 1's elopement.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NA 12-006.09(I)Based on record review and interviews, the facility failed to implement interventions to provide a safe environment when residents are identified as at risk for elopement (when an individual with dementia leaves a safe or supervised area without authorization or knowledge) for Resident 1, Resident 2, and Resident 3. This affected 3 of 3 residents sampled for elopement. The facility census was 33.Findings are:A.A record review of the facility's Elopement-Missing Resident policy last revised 03/01/2024 and in place at the time of Resident 1's elopement revealed that preventative measures were:-maintenance supervisor to check all doors weekly to assure the Wanderguard doors were functioning.-identify residents at risk for elopement and put a Wanderguard device on them.-at 10:00 PM the charge nurse or designated person would ensure all alarmed doors were working properly and that all exit doors were locked.B.A record review of Resident 1's Continuity of Care Document (CCD) created 06-10-2026 revealed the facility admitted the resident on 04/22/2026 with diagnoses of Alzheimer's disease (the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills), and vascular dementia (a decline in thinking and reasoning skills caused by restricted or blocked blood flow to the brain).A record review of Resident 1's Resident Progress Notes revealed a note from 04/22/2026 at 10:46 AM that stated the resident was admitted from the assisted living side due to increased wandering (aimless walking in the facility, seemingly without purpose or direction) and confusion, and that the resident wore a Wanderguard (a system that combines a wearable band and a door alarm to alert staff when a resident wearing the band approaches the alarmed door) due to exit-seeking (attempts to leave a building or secured area). There was no mention of what day the Wanderguard was applied.A record review of Resident 1's Elopement Risk report completed 04/22/2026 revealed the resident was determined to be an elopement risk and that the preventative action taken was to apply a Wanderguard band and post the resident's photo.A record review of Resident 1's Care Plan (a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed a care plan focus for wandering dated 05/14/2026 with an intervention dated 05/04/2026 of Equip resident with a device that alarms when wanders. Check for proper functioning of device daily and change per instructions. A record review of Resident 1's Medication Administration Record (MAR) from May 2026 revealed an order dated 05/04/2026 to check the Wanderguard to ensure placement and functioning once a day between 10:30 PM and 6:30 AM of the following day. Further review revealed that order was documented as Not Administered on 5/21/2026 through 5/24/2026 for the following reasons:5/21 wanderguard checker missing, 5/22 unablel [sic] to locate remote checker, 5/23 remote checker unavailable, and 5/24 test machine not available.A record review of Resident 1's Resident Progress Notes revealed a note from 05/25/2026 at 5:53 PM that revealed the resident had eloped and that the resident's Wanderguard had not set off the door alarm on exit or entry to the building.C.A record review of Resident 2's CCD created 06-10-2026 revealed the facility admitted the resident on 02/29/2024 and the resident had diagnoses of Alzheimer's disease and dementia.A record review of Resident 2's Elopement Risk report completed 05/15/2026 revealed the resident was determined to be an elopement risk and that the preventative action taken was to apply a Wanderguard band and post the resident's photo.A record review of Resident 2's Care Plan revealed a care plan focus for wandering dated 03/31/2026 with an intervention dated 03/31/2026 of Check wander guard placement and functioning every day.A record review of Resident 2's MAR from May 2026 revealed an order dated 03/31/2026 to check the Wanderguard device for proper functioning once a day between 10:00 PM and 6:00 AM of the following day. Further review revealed that order was documented as Not Administered on 5/22/2026 through 5/24/2026 for the following reasons:5/22 unable to locate remote checker, 5/23 remote checker unavailable, and 5/24 test (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	machine not available.C.A record review of Resident 3's CCD created 06-10-2026 revealed the facility admitted the resident on 09/25/2024 with a diagnosis of dementia.A record review of Resident 3's Elopement Risk report completed 05/06/2026 revealed the resident was determined to be an elopement risk and that the preventative action taken was to apply a Wanderguard band.A record review of Resident 3's Care Plan revealed a care plan focus for wandering dated 05/21/2026 with an intervention dated 05/21/2026 to Please check wander guard on my walker daily to ensure it is working properly.A record review of Resident 2's MAR from May 2026 revealed an order dated 08/05/2025 to check the Wanderguard device for proper functioning and placement daily between 10:00 PM and 6:00 AM of the following day. Further review revealed that order was documented as Not Administered on 5/21/2026 through 5/24/2026 for the following reasons:5/21 wanderguard checker missing, 5/22 unable to locate remote checker, 5/23 remote checker unavailable, and 5/24 test machine not available.D.During an initial tour of the facility 06/10/2026 from 7:40 AM to 8:10 AM, the Maintenance Supervisor (MS) confirmed there was no set schedule for testing the Wanderguard system on the doors for functionality. The MS stated that they thought the nurses checked it at night, and that the MS did random checks of the system. The MS confirmed there was no documentation of those door checks.An interview on 06/10/2026 at 9:02 AM with the Interim Director of Nursing (IDON) confirmed that they thought maintenance checked the Wanderguard system on the doors. The IDON further confirmed there was no documentation of the doors being checked by nursing.An interview on 06/10/2026 at 11:03 with the Administrator (ADM) confirmed that the nurses check the wanderguard bands and doors. The ADM stated they were uncertain which doors were checked at night and confirmed there was no documentation of door checks being done.An interview on 06/10/2026 at 11:41 AM with Licensed Practical Nurse (LPN) A confirmed that the night nurses checked the doors nightly. LPN A stated they had worked nights occasionally but had not checked the doors or written it down anywhere.An interview on 06/10/2026 at 2:29 PM with the ADM confirmed that staff had not been checking residents' Wanderguard bands prior to Resident 1's elopement and that she was uncertain whether the testing device was not functioning or was missing. The ADM further confirmed there was no documentation of the Wanderguard system on the doors being tested for functionality.