

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Crowell Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 245 South 22nd Street Blair, NE 68008	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G)</p> <p>Based on observation, interview, and record review, the facility staff failed to ensure individualize use of restraints to include identification of medical symptoms for use, duration of use, evaluation of less restrictive alternatives, review of risk and benefits, and re-evaluation of need for a restraint in accordance with facility policy for restraint use for 3 [Residents 1, 2, and 5] of 3 sampled residents. The facility had a total census of 63 residents.</p> <p>Findings are:</p> <p>A. A review of undated facility policy titled Restraint Free Environment revealed the following:</p> <p>-Physical Restraint: refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: .Placing a resident in an enclosed framed wheeled walker, in which the resident cannot open the front gate, or if the device has been altered to prevent the resident from exiting the device.</p> <p>A review of undated facility policy titled Restraint Free Environment under Compliance Guidelines revealed the following:</p> <p>-1. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.</p> <p>-2. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constitute self-injurious behavior or a medical symptoms that warrants the use of a physical restraints.</p> <p>-3. Behavioral interventions should be used and exhausted prior to the application of a physical restraint or administration of medications that could be perceived as a chemical restraint.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-4. A physician's order alone is not sufficient to warrant the use of a physical restraint or a medication that could be construed as a chemical restraint. The facility is responsible for the appropriateness of the determination to use a physical restraint.</p> <p>-5. Before a resident is physically restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine:</p> <p>a. How the use of restraints would treat the medical symptoms(s).</p> <p>b. The length of time the restraint is anticipated to be used to treat the medical symptom(s), who may apply the restraint, and the time and frequency that the restraint will be released.</p> <p>c. The type of direct monitoring and supervision that will be provided during use of the restraint.</p> <p>d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place.</p> <p>e. How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.</p> <p>-6. Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptoms. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint.</p> <p>-7. If a medication was initially administered for a medical symptom and continues to be administered in the absence of such symptom, the facility should re-evaluate the need for such medication to ensure that it does not sedate the resident or make it easier for the staff to care for the resident, causing it to be deemed a chemical restraint.</p> <p>-8. The resident/resident's representative may request the use of a physical restraint; however, the facility is responsible for evaluating the appropriateness of the request. The facility shall explain to the resident/resident's representative, the potential risks and benefits of using a restraint, not using a restraint, and alternative to restraint use. Potential negative outcomes should also be explained including, but not limited to:</p> <p>a. Decline in physical functioning</p> <p>b. Decreased muscle condition</p> <p>c. Contractures</p> <p>d. Increased risk for infection</p> <p>e. Pressure ulcers/injuries</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Keep call light and frequently used items within reach dated 1/9/25 -Make sure bed alarm is not under pillow dated 1/9/25 -Offer routine/as needed toileting dated 1/9/25 -Resident 1's pad alarm to be on Resident 1's wheelchair at all times. Wheelchair is only used for transporting Resident 1. Resident 1 is not to rest in Resident 1's wheelchair dated 1/9/25 -Pharmacy to monitor Resident 1's medications increasing risk for falls monthly and as needed dated 1/9/25 -Resident 1 to transfer using walker and gait belt with staff present at all times dated 1/9/25 -Resident 1 not to be transferred to wheelchair and left alone. Resident 1 to be transferred to Merry walker with chair pad alarm on and functioning properly dated 1/9/25 <p>A review of Resident 1's Care Plan revealed a problem dated 9/14/23 related to activities of daily living functional with the following intervention related to use of Merry Walker:</p> <ul style="list-style-type: none"> -Utilize Merry [NAME] for ambulation. Remove from Merry [NAME] every 2 hours: toilet, position in recliner/bed for at least 15 minutes. <p>Observations on 4/16/25 at 7:41 AM revealed Resident 1 up in wheelchair in hallway near nurses' station with pad alarm in place on wheelchair. Resident 1 was observed to have 2 dark purple eyes.</p> <p>A review of undated facility investigation for Resident 1 revealed on 4/12/25 at 1:10 AM Medication Aide A heard stairwell alarm sounding by assisted living room [ROOM NUMBER]. Medication Aide A saw a Merry [NAME] lying on its side on second landing and Resident 1 lying on left side on first landing. Conclusion from facility investigation revealed that Resident 1 was in Merry [NAME] and went through the fire doors on 2 North sounding the door alarm. Resident continued down the hallway went through the stairway door by room [ROOM NUMBER] and fell down the stairs. Resident 1 was transferred to the hospital and returned to the facility on 4/14/25 with no injury.</p> <p>A review of Resident 1's physician's orders revealed an order dated 1/2/24 for physical therapy to evaluate Resident 1 for a Merry Walker.</p> <p>A review of Resident 1's Progress Note dated 4/13/25 at 4:33 AM revealed Resident 1 had multiple bruises all over including black and blue right eye, bruising to forehead, pain to right knee and head.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Physical Therapy (PT) Progress Note dated 1/4/24 revealed Resident 1 was evaluated for safety and appropriateness to utilize a Merry Walker. Resident 1's Progress Note identified Resident 1 could safely complete sit to stand transfers without tipping laterally but may need increased practice to shift weight forward with the walker rolling backwards. According to the PT Progress Note dated 1/4/2024 care givers were to monitor for Resident 1 possible fidgeting with latch in an attempt to exit the walker unsupervised. Physical Therapy recommendation included Resident 1 remain in the Merry [NAME] for a bursts of time when active and mobile but return to other sitting surface for meals or when resting for greatest skin integrity.</p> <p>A review of Resident 1 medical record didn't reveal any additional information related to the use of Merry Walker.</p> <p>In an interview on 4/17/25 at 9:05 AM, Nurse Aide D reported Resident 1 is up in Merry [NAME] other than during meals. Nurse Aide D reported Resident 1 is placed in recliner when sleepy. Nurse Aide D reported being unaware of timeframe for Resident 1 to be in the Merry [NAME] but is gotten out after breakfast and before lunch for toileting. Nurse Aide D reported Resident 1 can't get out of the Merry [NAME] by themselves.</p> <p>In an interview on 4/17/25 at 9:11 AM, LPN E [Licensed Practical Nurse] reported Resident 1 is placed in Merry [NAME] when Resident 1 wants to go and used so that Resident 1 can get around independently. LPN E reported Resident 1 is to be out every 2 hours, for meals, and when tired. LPN E reported that LPN E has never seen Resident 1 get out of the Merry [NAME] by themselves.</p> <p>In an interview on 4/17/25 at 9:49 AM, PT F [Physical Therapist] reported getting orders for a physical therapy evaluation for use of a Merry Walker. PT F reported the focus of the evaluation is to determine if the use of the Merry [NAME] is safe and not a restraint. PT F reported focusing evaluation on safety of the memory walker and was not aware of the definition of a restraint in federal regulations. PT F reported Resident 1 was utilizing the Merry [NAME] due to delirium and restlessness and should be used for 2 hours but may be extended if restlessness continues. PT F reported the PT F has not reevaluated Resident 1's use of the Merry [NAME] since 1/4/24 and it is up to nursing to discontinue the Merry [NAME] if no longer safe.</p> <p>In interviews 4/17/25 at 9:30 AM and 11:32 AM, Registered Nurse I confirmed that Registered Nurse I was not coding use of Merry [NAME] as a restraint on the MDS. In further interviews, Registered Nurse I reported that use of Merry [NAME] needed to documented as a restraint on the MDS and put on the care plan.</p> <p>In interviews on 4/17/25 at 10:26 AM and 11:28 AM, the DON [Director of Nursing] confirmed Resident 1 can't get out of the Merry [NAME] by themselves and no risk benefit statement was signed by Resident 1's responsible party had been completed. If the guideline is that they have to be able to open the Merry Walker, it would be considered a restraint. The DON would consider it more of a restraint if the resident could not walk by themselves.</p> <p>C. A review of Resident 2's Face Sheet revealed Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia, muscle weakness, and at admission intertrochanteric fracture of right femur [hip fracture].</p> <p>A review of Resident 2's quarterly MDS dated [DATE] revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident 2 had a BIMS [Brief Interview for Mental Status] score of 2. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment</p> <p>-Resident 2 required partial/moderate assistance for walking</p> <p>-Resident 2 used a bed alarm, chair alarm, and wander/elopement alarm daily</p> <p>-Resident 2 was not identified as utilizing a restraint</p> <p>A review of Resident 2's Care Plan revealed a problem of falls dated 6/11/23 with the following interventions related to use of Merry Walker:</p> <p>-Provide Resident 1 with safety device/appliance: utilize Merry Walker</p> <p>-When Resident 2 utilizes recliner in lounge, ensure current plan of care safeguards are in place such as alarm, check on every 15-30 minutes to see if Resident is ready to change position, go to bathroom or use Merry Walker.</p> <p>A review of Physical Therapy Progress Note dated 9/29/22 revealed Resident 2 did not have finger strength or cognitive level to unhook a latch but did not attempt to get out of Merry [NAME] without asking for assistance.</p> <p>A review of Resident 2 medical record didn't reveal any additional information related to use of Merry Walker.</p> <p>Observations on 4/16/25 at 2:58 PM and 3:49 PM revealed Resident 2 up in Merry Walker.</p> <p>Observations on 4/17/25 at 11:26 AM revealed Resident 2 up in Merry Walker. Medication Aide G requested Resident 2 open up latch on Merry [NAME] revealing Resident 2 did not attempt to open latch and stated I don't think I will.</p> <p>In an interview on 4/17/25 at 9:16 AM, Medication Aide G reported that Resident 2 is placed in Merry [NAME] when Resident 2 gets up in the morning. Resident 2 gets out every 2 hours and lays down when tired or placed in recliner. Medication Aide G reported that Resident 2 uses Merry [NAME] for ambulation and Medication Aide G has never seen Resident 2 try to get out of it.</p> <p>In an interview on 4/17/25 at 9:20 AM, Nurse Aide C reported that Resident 2 sleeps late and will get up between 11:20-12 PM and be put in Merry Walker. Nurse Aide C reported Resident 2 is fed in Merry [NAME] and may still be in Merry [NAME] when Nurse Aide C leaves shift at 1:30 PM.</p> <p>In interviews 4/17/25 at 9:30 AM and 11:32 AM, Registered Nurse I confirmed that Registered Nurse I was not coding use of Merry [NAME] as a restraint on the MDS. In further interviews, Registered Nurse I reported that use of Merry [NAME] needed to be documented as a restraint on the MDS and put on the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interviews on 4/17/25 at 10:06 AM and 11:14 AM, PT F reported Resident 2 utilized Merry [NAME] for symptoms of restlessness and delirium. PT F reported Resident 2 could be in the Merry [NAME] for 2 hours but if continued to be restless that could be extended. PT F reported Resident 2 was evaluated for use of Merry [NAME] while on a skilled stay and that there was not a specific order for an evaluation for use of a Merry Walker. PT F confirmed that Resident 2 has not been reevaluated for use of Merry [NAME] as Resident 2 is now on hospice.</p> <p>In interviews on 4/17/25 at 10:26 AM and 11:28 AM, the DON [Director of Nursing] confirmed Resident 2 can't get out of the Merry [NAME] by self and no risk benefit statement signed by Resident 2's responsible party had been completed. If the guideline is that they have to be able to open the Merry Walker, it would be considered a restraint. The DON would consider it more of a restraint if the resident could not walk by themselves.</p> <p>D. A review of Resident 5's Care Plan revealed Resident 5 was admitted on [DATE] and had diagnoses of Alzheimer's disease and an admission diagnosis of encounter for fracture of medial malleolus of right tibia with routine healing.</p> <p>A review of Resident 5's Care Plan revealed a problem of falls dated 9/5/24 with intervention of therapy to screen and evaluate for use of Merry [NAME] dated 4/17/25.</p> <p>A review of Resident 5's Progress Notes revealed the following:</p> <p>-4/16/25 at 11:20 AM Resident 5 found lying on the floor on back in front of nurses' desk. Full range of motion done with no noted injuries. Resident 5 rubbing right side and back. Resident 5 leaves the facility with the squad for transfer to emergency room.</p> <p>-4/16/25 at 1:30 PM Resident 5 returned to facility with no fracture. Resident 5 was placed in a Merry Walker.</p> <p>-4/17/25 at 2:29 AM Resident 5 up as desired in Merry Walker.</p> <p>A review of Resident 5's medical record didn't reveal any additional information related to use of Merry Walker.</p> <p>Observations on 4/17/25 at 8:36 AM revealed Resident 5 up in Merry Walker.</p> <p>Observations on 4/17/25 at 11:25 AM revealed Resident 5 up in Merry Walker. Nurse Aide H requested Resident 5 open the latch on the Merry Walker. Resident 5 did not respond to the command.</p> <p>In an interview on 4/17/25 at 9:19 AM, Nurse Aide C reported being directed by DON to put Resident 5 in Merry [NAME] today.</p> <p>In an interview on 4/17/25 at 10:10 AM, PT F reported starting an evaluation of Resident 5's use of Merry [NAME] yesterday but had not yet completed it. PT F reported Resident 5 was not in a restless state at the time of the evaluation and needed to be in a restless state to complete the evaluation. PT F report having an order from Resident 5's physician to evaluate for use of a Merry Walker.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interviews on 4/17/25 at 10:26 AM and 11:28 AM, the DON [Director of Nursing] confirmed Resident 5 can't get out of the Merry [NAME] by self and no risk benefit statement signed by Resident 5's responsible party had been completed. The DON confirmed directing staff to place Resident 5 in a Merry [NAME] as Resident 5 is unsteady and unsafe to ambulate by self.</p> <p>E. In an interview on 4/17/25 at 10:26 AM, the DON reported the following procedure for use of a Merry Walker: an order is gotten from the physician to screen the resident for use of a Merry Walker, the physical therapist makes a recommendation, and the Merry walker is implemented. The DON reported the only physician order is for the screen for use of a Merry Walker. The DON confirmed the decision to discontinue use of the Merry [NAME] would be made by the DON.</p> <p>F. Facility was encouraged to provide any additional information relevant to this tag at exit with no additional information being provided at time of report completion.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number NAC 12-006.09(D)</p> <p>Based on record review and interview, the facility failed to accurately code MDS [Minimum Data Set; a comprehensive assessment used in care planning] related to use of restraint for 2 [Residents 1 and 2] of 3 sampled residents utilizing a Merry Walker. The facility had a total census of 63 residents.</p> <p>Findings are:</p> <p>A. A review of Resident 1's Face sheet revealed Resident 1 was admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>A review of Resident 1's quarterly MDS [Minimum Data Set; a comprehensive assessment used in care planning] dated 3/28/25 revealed the following</p> <ul style="list-style-type: none"> -Resident 1 had a BIMS [Brief Interview for Mental Status] score of 4. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment -Resident 1 required supervision or touching assistance for walking -Resident 1 used a bed alarm, chair alarm, and wander/elopement alarm daily -Resident 1 was not identified as utilizing a restraint <p>A review of Resident 2's Care Plan revealed a problem of falls dated 6/11/23 with the following interventions related to use of Merry Walker:</p> <ul style="list-style-type: none"> -Provide Resident 1 with safety device/appliance: utilize Merry Walker -When Resident 2 utilizes recliner in lounge, ensure current plan of care safeguards are in place such as alarm, check on every 15-30 minutes to see if Resident is ready to change position, go to bathroom or use Merry Walker. <p>A review of Resident 1's physician's orders revealed an order dated 1/2/24 for physical therapy to evaluate Resident 1 for a Merry Walker.</p> <p>In an interview on 4/17/25 at 9:05 AM, Nurse Aide D reported Resident 1 is up in Merry [NAME] other than during meals. Nurse Aide D reported Resident 1 is placed in recliner when sleepy. Nurse Aide D reported being unaware of timeframe for being in Merry [NAME] but is gotten out after breakfast and before lunch for toileting. Nurse Aide D reported Resident 1 can't get out of the Merry [NAME] by self.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/17/25 at 9:11 AM, LPN E [Licensed Practical Nurse] reported Resident 1 is placed in Merry [NAME] when Resident 1 wants to go and used so that Resident 1 can get around independently. LPN E reported Resident 1 is to be out every 2 hours, for meals, and when tired. LPN E reported that LPN E has never seen Resident 1 get of the Merry [NAME] by self.</p> <p>In interviews 4/17/25 at 9:30 AM and 11:32 AM, Registered Nurse I confirmed that Registered Nurse I was not coding use of Merry [NAME] as a restraint on the MDS. Registered Nurse I reported that use of Merry [NAME] needed to documented as a restraint on the MDS and put on the care plan.</p> <p>B. A review of Resident 2's Face Sheet revealed Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia, muscle weakness, and on admission intertrochanteric fracture of right femur [hip fracture].</p> <p>A review of Resident 2's quarterly MDS dated [DATE] revealed the following:</p> <ul style="list-style-type: none"> -Resident 2 had a BIMS [Brief Interview for Mental Status] score of 2. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment -Resident 2 required partial/moderate assistance for walking -Resident 2 used a bed alarm, chair alarm, and wander/elopement alarm daily -Resident 2 was not identified as utilizing a restraint <p>A review of Resident 2's Care Plan revealed a problem of falls dated 6/11/23 with the following interventions related to use of Merry Walker:</p> <ul style="list-style-type: none"> -Provide Resident 1 with safety device/appliance: utilize Merry Walker -When Resident 2 utilizes recliner in lounge, ensure current plan of care safeguards are in place such as alarm, check on every 15-30 minutes to see if Resident is ready to change position, go to bathroom or use Merry Walker. <p>Observations on 4/16/25 at 2:58 PM and 3:49 PM revealed Resident 2 up in Merry Walker.</p> <p>Observations on 4/17/25 at 11:26 AM revealed Resident 2 up in Merry Walker. Medication Aide G requested Resident 2 open up latch on Merry [NAME] revealing Resident 2 did not attempt to open latch and stated I don't think I will.</p> <p>In an interview on 4/17/25 at 9:16 AM, Medication Aide G Resident 2 gets is placed in Merry [NAME] when Resident 2 wakes up. Medication Aide G reported Resident 2 gets out every 2 hours and lays down when tired or placed in recliner. Medication Aide G reported Resident 2 uses the Merry [NAME] for ambulation has never seen Resident 2 try to get out of it.</p> <p>In an interview on 4/17/25 at 9:20 AM, Nurse Aide C reported Resident 2 sleeps late and will get up between 11:20-12 PM and be put in Merry Walker. Nurse Aide C reported Resident 2 is fed in Merry [NAME] and may still be in Merry [NAME] when Nurse Aide C leaves shift at 1:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C. In interviews 4/17/25 at 9:30 AM and 11:32 AM, Registered Nurse I confirmed that Registered Nurse I was not coding use of Merry [NAME] as a restraint on the MDS. Registered Nurse I reported that use of Merry [NAME] needed to be documented as a restraint on the MDS and put on the care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 006.09(l)</p> <p>Based on observation, interview, and record review, the facility failed to ensure supervision to protect residents from elopement for 3 [Residents 1, 4, and 6] of 3 sampled residents at risk for elopement. The facility had a total census of 63 residents.</p> <p>Findings are:</p> <p>A. A review of Resident 1's Face sheet revealed Resident 1 was admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>A review of Resident 1's quarterly MDS [Minimum Data Set; a comprehensive assessment used in care planning] dated 3/28/25 revealed the following</p> <ul style="list-style-type: none"> -Resident 1 had a BIMS [Brief Interview for Mental Status] score of 4. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment -Resident 1 required supervision or touching assistance for walking -Resident 1 used a bed alarm, chair alarm, and wander/elopement alarm daily <p>A review of Resident 1's Care plan revealed a problem dated 9/14/23 of falls with the following interventions:</p> <ul style="list-style-type: none"> -Ensure Resident 1's pad alarm in in place when in recliner in 2 North lunge area with recliner reclined back dated 4/14/25 -Educate staff to know Resident 1's where about's at all times, assign a staff member to monitor Resident 1 and if staff member leaves, staff member must let the manager know and some one will be assigned to monitor Resident 1 dated 4/13/25 -After Resident 1 is up and dressed Resident 1 will be taken to the 2 N lounge area dated 1/9/25. -Resident 1 utilizes a bed alarm dated 1/9/25 -Resident 1 chair pad alarm is to be under Resident 1 in Merry walker [an enclosed framed wheeled walker] dated 1/9/25 -Fall assessment upon admission, quarterly, annually and as needed dated 1/9/25 -Gait belt changed to latching style belt dated 1/9/25 -Keep call light and frequently used items within reach dated 1/9/25 <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Make sure bed alarm is not under pillow dated 1/9/25</p> <p>-Offer routine/as needed toileting dated 1/9/25</p> <p>-Resident 1's pad alarm to be on Resident 1's wheelchair at all times. Wheelchair is only used for transporting Resident 1. Resident 1 is not to rest in Resident 1's wheelchair dated 1/9/25</p> <p>-Pharmacy to monitor Resident 1's medications increasing risk for falls monthly and as needed dated 1/9/25</p> <p>-Resident 1 to transfer using walker and gait belt with staff present at all times dated 1/9/25</p> <p>-Resident 1 not to be transferred to wheelchair and left alone. Resident 1 to be transferred to Merry walker with chair pad alarm on and functioning properly dated 1/9/25</p> <p>A review of Resident 1's Care Plan revealed a problem dated 9/14/23 of wandering with the following interventions:</p> <p>-Approach Resident 1 from the front. Walk in step with Resident 1 first before redirecting dated 1/9/25</p> <p>-Assure Resident 1 has proper fitting and appropriate foot attire dated 1/9/25</p> <p>-Avoid over-stimulation dated 1/9/25</p> <p>-Convey an attitude of acceptance toward Resident 1 dated 1/9/25</p> <p>-Equip Resident 1 with a device that alarms when Resident 1 wanders. Check for proper functioning of device every shift dated 1/9/25</p> <p>-If Resident 1 looks for family/significant other reassure that other know where to find him/her dated 1/9/25</p> <p>-Label Resident 1 belongings and environment to promote recognition dated 1/9/25</p> <p>-Maintain a calm environment and approach to Resident 1 dated 1/9/25</p> <p>-Removed Resident 1 from other resident's rooms an unsafe situations dated 1/9/25</p> <p>-When Resident 1 begins to wander, provide comfort measures for basic needs dated 1/9/25</p> <p>Observations on 4/16/25 at 7:41 AM revealed Resident 1 up in wheelchair in hallway near nurses' station with a pad alarm in place on wheelchair and had 2 dark purple eyes.</p> <p>Observations on 4/16/25 at 11:39 AM revealed Wanderguard [an alarm system in which a bracelet worn by a resident trips an audible alarm when passing a unit installed in the wall] bracelet on Resident 1's right wrist.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of undated facility investigation for Resident 1 revealed on 4/12/25 at 1:10 AM Medication Aide A heard stairwell alarm sounding by assisted living room [ROOM NUMBER]. Medication Aide A saw Merry walker lying on its side on second landing and Resident 1 lying on left side on first landing. Conclusion from facility investigation revealed Resident 1 was in Merry [NAME] and went through the fire doors on 2 North sounding the door alarm. Resident continued down the hallway went through the stairway door by room [ROOM NUMBER] and fell down the stairs. Resident 1 was transferred to the hospital and returned to the facility on 4/14/25 with no injury. The facility investigation revealed that the Wanderguard alarm and the Fire Door alarm were both going off. Registered Nurse B reported hearing the door alarm but did not get up and check to see who was going through the door. The following interventions were implemented in response to the incident:</p> <ul style="list-style-type: none"> -Education was immediately provided to staff on 4/12 to ensure staff knew the whereabouts of Resident 1 at all times and to report to the manager when leaving to ensure a staff member would monitor and ensure another staff member was designated. -30-minute checks being done on Resident 1 -An in-service was scheduled for 5/1/25 regarding responding to all alarms and monitoring of wandering residents as well as documentation. -Registered Nurse B was placed on suspension during the investigation and employment would be terminated. <p>In an interview on 4/16/25 at 8:20 AM, the Administrator reported Registered Nurse B had been in the TV area near the second floor nurses station and had heard the alarm go off from the double doors which enter into the assisted living area. Registered Nurse B had called out asking who was going through the double doors but did not check to see who had gone through the doors when no one replied to Registered Nurse B's question. The Administrator reported that Resident 1 went down the empty assisted living hallway, opened the door to the stairway and fell down two flights of stairs. According to the Administrator, Resident 1 had been in the Merry [NAME] at the time and the Merry [NAME] was found on the first landing and Resident 1 on the lower landing.</p> <p>A review of Resident 1's Progress Note dated 4/13/25 at 4:33 AM revealed Resident 1 had multiple bruises all over including black and blue right eye, bruising to forehead, pain to right knee and head.</p> <p>Observations on 4/16/25 at 8:25 AM revealed the double doors between the nurses' station and the elevator on the second floor north unit was equipped with a doorbell alarm that sounds each time the door is opened. The hallway on the other side of the double doors is licensed as assist living and has no residents residing on it. The hallway in the assisted living leads to the main entrance of the facility.</p> <p>On 4/16/25 between 11:25-11:39 AM, Maintenance Director activated stairway alarm near room [ROOM NUMBER]/260. The Administrator confirmed that stairway door alarm near room [ROOM NUMBER]/260 could not be heard from second floor nurses station located on other side of the double doors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 1:03 PM, Maintenance Director activated Wanderguard alarm on wall near room [ROOM NUMBER] in the assisted living section of second floor. The Administrator confirmed the Wanderguard alarm could not be heard past the nurses' station located by the TV area on second floor.</p> <p>A review of Intervention Education dated 4/12/25 revealed staff were educated to be aware of Resident 1's location at all times. Signature paper for education also stated Wanderguard alarm box to be placed outside of 2 North double doors going to assisted living.</p> <p>In an interview on 4/16/25 at 3:35 PM, the Administrator reported that the notation on the education about placing a Wanderguard Alarm by second floor double doors had been identified by the staff providing the education and was not currently being implemented but could be considered.</p> <p>B. A review of Resident 6's Face Sheet revealed Resident 6 was admitted to the facility on [DATE] with a diagnosis of dementia. A review of Face Sheet revealed Resident 6 resided on the first floor of the facility.</p> <p>A review of Resident 6's quarterly MDS dated [DATE] revealed the following</p> <ul style="list-style-type: none"> -Resident 6 had a BIMS score of 7. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment -Resident 6 required supervision or touching assistance for walking -Resident 6 used wander/elopement alarm daily <p>A review of Resident 6's Care Plan revealed intervention dated 4/3/25 to monitor for any episodes of wandering, document in progress notes, complete an updated wandering assessment and place wander guard indicated.</p> <p>Observations on 4/17/25 at 12:35 PM revealed Resident 6 had a wander guard bracelet on walker and left wrist.</p> <p>A review of Resident 6's Progress Notes did not reveal any documentation of wandering behaviors between 1/1/25 to 4/16/25.</p> <p>C. A review of Resident 4's Face Sheet revealed Resident 4 was admitted to the facility on [DATE] and resided on the first floor of the facility. Further review of Resident 4's Face Sheet revealed a diagnosis of dementia.</p> <p>A review of Resident 4's quarterly MDS dated [DATE] revealed the following:</p> <ul style="list-style-type: none"> -Resident 4 had a BIMS score of 3. A review of the MDS manual revealed a score of 0-7 indicates severe cognitive impairment -Resident 4 required supervision or touching assistance for wheeling manual wheelchair -Resident 4 used bed alarm, motion sensor alarm and wander/elopement alarm daily <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 4's Care Plan revealed a problem dated 10/14/22 of Resident 4 exhibiting wandering behaviors with interventions for checking alarms on exit doors and utilizing motion detector. The use of a Wanderguard bracelet was not listed on Resident 4's Care Plan.</p> <p>Observations on 4/16/25 at 4 PM revealed a Wanderguard bracelet in place on Resident 4's wrist.</p> <p>A review of Resident 4's Progress Notes dated 3/23/25 revealed Resident 4 trying to go through doors to the long term care unit on the other side.</p> <p>In an interview on 4/17/25 at 9:22 AM, Nurse Aide C reported Resident 4 only wanders around the side of the building that Resident 4 lives on and doesn't go to the other side of the floor.</p> <p>D. Observations on 4/16/25 between 11:25 AM-12:08 PM revealed the Wanderguard did not alarm near rooms [ROOM NUMBERS] [opposite ends of the hallway on the first floor] when tested by Maintenance Director. Observations revealed the Wanderguard near 161 was near a stairway door that was also alarmed. Further observations revealed double doors near room [ROOM NUMBER] was equipped with a doorbell and opened to a landing area with 3 doors. One door in the landing opened to a stairway and is equipped with a Wanderguard alarm. The second door was open and led to the administrative offices and a third set of doors exited to the outside. There is a doorbell on the door exited outside of the facility.</p> <p>A review of Wanderguard Door Monitoring for months 1/25-3/25 revealed the following:</p> <ul style="list-style-type: none"> -Wanderguard wall unit near administrative offices was not working during checks completed 1/1/25, 2/4/25, and 3/17/25 with a note on each month that a white alarm had been installed and Wanderguard company called. -Wanderguard wall unit on first North [NAME] Hall North was not working during checks on 2/4/25 and 3/17/25 with note that white alarm was installed and Wanderguard company called. <p>In an interview on 4/16/25 between 11:25 AM and 12:08 PM, the Administrator reported that the doorbell was added to the door by room [ROOM NUMBER] as the Wanderguard was not working.</p> <p>In an interview on 4/16/25 between 11:25 AM and 12:08 PM, Maintenance Director reported the new Wanderguard units needed to be installed as replacement parts can no longer be obtained for the current units.</p> <p>In an interview on 4/16/25 at 2:29 PM, Maintenance Director reported the Wanderguard on one end of the first floor hallway was not working since January and the other end since March. Doorbell alarms were placed in January by the Administrative offices due to the Wanderguard alarm not working.</p> <p>A review of In-service education dated 1/9/25 and 3/19/25 revealed staff education that first North Wanderguard units were not working.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/25 at 4:25 PM, the door near room [ROOM NUMBER] was opened by the Administrator causing the doorbell to sound. At 4:28 PM the exit door to the outside from the first floor landing by the administrative office was opened causing the doorbell to sound. Observations on 4/16/25 at 4:31 PM revealed no staff member had come to check the reason for the doorbell sounding and no staff were observed in the hallway.</p> <p>In an interview on 4/16/25 between 4:25-4:31 PM, the Administrator acknowledged no staff member had come to check the door. The Administrator reported new Wandergard units had been ordered to replace the current Wanderguard units.</p> <p>Observations on 4/17/25 at 7:17 AM revealed motion detector alarms had been installed on the doors near room [ROOM NUMBER] that opened into the area by the administrative offices.</p>		