STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285238	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm 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** 50106 Licensure Reference Number 175 NAC 12-006.09D(l) Based on record review, interviews, and observations, the facility failed to implement assessed interventions to prevent potential injuries for 3 of 3 residents (Residents 1, 4, and 5). The facility identified a census of 65. Findings are: A. Record review of Resident 1 Census Sheet revealed the resident was admitted to the facility on [DATE]. Record review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 6/11/24 revealed the resident had a Brief Interview for Mental Status (BIMS, is a brief screener that aids in detecting cognitive impairment) with a score of 10. According to the MDS [NAME] a BIMS score of 10 identified the resident is moderately cognitively impaired. Resident 1 required set up or clean up assist with eating. The resident required substantial/maximum assist with toileting, bed mobility and transfers. Resident 1 is frequently incontinent of urine and occasionally incontinent of bowel. Record review of Resident 1's Fall assessment dated [DATE] revealed the resident had a score of 13. A score of 13 on the fall assessment dated [DATE] revealed the resident to be at high risk for falls. Record review of Resident 1's Care Plan dated 2/17/22 revealed the resident is at risk for falls related to deconditioning, gait/balance problems, unaware of safety needs, preference to be independent and forgetfulness. The following intervention with dates had been put into place for fall preventions: -03/17/24 Frequent checks by staff. Date Initiated: 03/18/2024 -03/17/24 Offer activities outside of room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 03/18/2024 -6/3/24 Offer assistance to bed and/or toileting after evening smoke time. Date Initiated: 06/03/2024 -Be sure the call light is within reach and encourage to use it to call for assistance as needed. Date Initiated: 02/17/2022 -Ensure resident is wearing appropriate footwear when transferring, ambulating or wheeling in wheelchair. Date Initiated: 11/20/2022 -Low bed Date Initiated: 02/17/2022 -Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders Date Initiated: 03/10/2022 -Resident prefers to get up and ready for the day before breakfast. Staff will offer assistance with rising and activities of daily living and ensure resident gets to dining room for breakfast by 8 am as is her preference. (3/26/24) Date Initiated: 03/26/2024 -Staff to offer toileting assistance after meals (3/4/2022) Date Initiated: 03/04/2022 -Wheelchair next to bed. Date Initiated: 02/17/2022 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285238	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Adult Protective Services (APS) report dated 6/4/24 revealed on 6/3/24 at 7:30 PM Resident 1 was observed lying on their back on the floor of Resident 1's room next to the bed. When inquired about what happened, Resident 1 reported I was trying to get from my chair to my bed and just fell down. Resident 1 reported hit their head but had no loss of consciousness. Resident 1 was alert and oriented to person, place, time, and situation. Resident 1 complained of head pain, sharp neck and sharp, radiating back pain and was rated a 10/10. A call was made to the on-call physician and an order was received to send the resident to the emergency room (ER) for evaluation. Director of Nursing (DON) and Executive Director (ED) were notified of fall and transport of Resident 1 to the ER. Observation on 7/2/24 at 6:45 AM revealed Resident 1 was laying in bed with their eyes closed. The right side of Resident 1's bed was pushed up against the wall and the call light was hanging down the side with the call light button on the floor and out of reach of Resident 1. A interview on 7/2/24 at 6:57 AM was conducted with the Assistant Director of Nursing (ADON). During the interview the ADON confirmed Resident 1's call light was out of the resident's reach. B. Record review of Resident 4's Census Sheet revealed the resident was admitted to the facility on [DATE]. Record review of Resident 4's MDS dated [DATE] revealed the resident had a BIMS score of 15. According to the MDS [NAME] a score of 13 to 15 indicates a person is cognitively intact. According to Resident 4's MDS dated [DATE] Resident 4 was dependent for assistance with toileting, bed mobility, and transfer and was frequently incontinent of bowel and bladder. Record review of Resident 4's Fall assessment dated [DATE] revealed a score of 12. A score of 12 on the Fall Assessment revealed the resident to be at high risk for falls. Record review of Resident 4's Care Plan dated 5/26/15 revealed Resident 4 was at risk for fall related to activities of daily living and mobility deficits, seizure disorder, psychoactive drug use, use of narcotic medication, incontinence of bowel and bladder, and weakness. Resident 4 had a history of behaviors as evidenced by sliding out of wheelchair for attention and pretending (gender) was having a seizure. The goal of the care plan was to prevent serious injury. To meet the goal interventions with dates were identified as follows on Resident 4's Care Plan: -08/22/23 Add non-skid mat to seat of wheelchair to prevent sliding down. Date Initiated: 08/23/2023 -5/8/24- placed on 1:1 until transferred to hospital related to psychosis and intentionally sliding out of wheelchair. Date Initiated: 05/08/2024 -5/8/24- When up in wheelchair provide 1:1 with staff during moments of psychosis, yelling, paranoia, accusatory remarks until resident can be transferred into low bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 05/08/2024 -Anticipate and meet needs as able. Date Initiated: 05/26/2015 -Be sure the call light is within reach and encourage to use it to call for assistance as needed. Date Initiated: 05/26/2015 -Bed will placed in lowest position while in it. (12/17/2023); lock bed control to prevent resident from raising height. (5/3/24) Date Initiated: 12/17/2023 -Ensure proper positioning in wheelchair as needed. Date Initiated: 05/26/2015 -Fall risk assessment quarterly, and as needed. Date Initiated: 05/26/2015 -Foam placed on foot rests to prevent injury when sliding out of chair. (2/5/24) Date Initiated: 02/05/2024 -Grab bars to both sides of bed to assist with repositioning. Date Initiated: 05/26/2015 -Keep needed items, water, etc, in reach. Date Initiated: 05/26/2015 - Observe for seizure activity and notify MD as needed if noted. Date Initiated: 05/26/2015 -Patient to be placed on 1:1 activities ongoing 1-2 times weekly per patient preference. (5/2/24) Date Initiated: 05/03/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	-Resident will have side pillow to assist with positioning while in wheelchair. Date Initiated 11/21/2023 -Wheelchair lap belt to wheelchair. Resident 4 is able to release it. Date Initiated: 02/05/2024 Record review of the facility APS report dated 5/14/24 revealed the following information: -Resident 4 was found on the floor in the dining room sitting on the footrest of wheelchair with legs extended out straight and arms crossed over chest. -Resident was last seen shortly before when (gender) had asked to go sit in the dining room with a safety belt was in place at that time. -When questioned about what happened and how (gender) slid out of wheelchair, Resident 4 replied (gender) did it intentionally because (gender) likes to cause trouble. -When staff approached Resident 4 to reposition the resident off the foot pedals to prevent injury, Resident 4 became physically combative, cursing at staff, and stated (gender) wanted to kill (gender). -Resident 4 was placed in a low bed to prevent injury should (gender) continue behaviors or throw (gender) out of bed. -Nurse Practitioner for Resident 4 was called and Resident 4 was placed on 15-minute checks for safety. -Resident 4 continued to have aggressive behavior with Resident 4 being sent to the ER for evaluation of mental/behavioral status. -Resident 4 returned to the facility at 5:45 P.M. via a ambulance with no new orders. -Resident 4 continued to be combative with staff, refusing assessment, vital signs, and neuro checks the remainder of the evening. -Immediate steps taken to protect the resident were staff to remain with Resident 4 on a 1:1 until Resident 4 could be relocated in bed with the bed placed in low position and locked to prevent injury as a consequence of ongoing behaviors, - Resident 4 was placed on 15-minute checks and all potentially harmful objects removed from the Resident's room following harm statement. A observation on 7/2/24 at 6:53 AM revealed Resident 4 in bed with the bed in the high position. A interview with the ADON on 7/2/24 at 6:57 AM confirmed Resident 4's bed was in the high position and should be in low position. ADON demonstrated during the interview that Resident 4's bed control cannot be locked as indicated on Resident 4's Care Plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER: Keystone Ridge Post Acute Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 7501 Keystone Drive Omaha, NE 68134	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nursing Assistant-A (NA-A) on 7/2/24 at 9:37 AM, NA-A confirmed (gender) was not aware of how to find the Care Plan interventions for the resident under (gender) care. C. Record review of Resident 5's Census Sheet revealed Resident 5 was admitted to the facility on [DATE]. Record review of Resident 5's MDS dated [DATE] revealed Resident 5 had a BIMS score of 14. The MDS also revealed Resident 5 required set-up/clean-up assist with eating, substantial/maximum assist with transfers and toileting. Resident 5 required partial/moderate assist with bed mobility and was frequently incontinent of urine and always continent of bowel. Record review of Resident 5's Fall assessment dated [DATE] revealed a score of 10. A score of 10 was considered medium risk for falls. Record review of report dated 6/03/24 to APS revealed the following: -Resident was found sitting on the side of low bed when staff entered the room and noticed swelling a developing bruise of (gender) nose and left orbital (eye) area. -Resident 5 reported Resident 5 had been lying in bed and reached for something and rolled out onto the floor and hit (gender) nose. -Area examined by the nurse, no blood present, vision unaffected, but resident complains of pain. Resident 5's Nurse Practitioner was contacted and gave telephone order for nasal X-ray, OK for mobile X-ray per resident preference. -The X-ray was completed at approximately with the results diagnosed as a nasal fracture received at 1:59 PM. Record review of Resident 5's Care Plan dated 3/31/22 revealed Resident 5 was at risk for falls related to disease process, antidepressant use, decreased vision, and cognitive deficits. The goal for Resident 5's was not to sustain serious injury. To meet this goal the following interventions with dates were on Resident 5's Care Plan: -1/07/2023: Offer resident extra pillow to help define perimeter of bed and decrease chance of rolling off. Date Initiated: 01/07/2023 -5/22/24: Fall mat placed next to bed to prevent injury. Date Initiated: 05/22/2024 -Avoid rearranging furniture. Date Initiated: 03/31/2022 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Keystone Ridge Post Acute Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 Keystone Drive Omaha, NE 68134	

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 - Minimal harm or potential for actual harm Residents Affected - Few	-Be sure the call light is within reach and encourage to use it to call for assistance as needed. Date Initiated: 03/31/2022 -Ensure resident is wearing appropriate footwear when ambulating or wheeling in wheelchair. Date Initiated: 03/31/2022 -Maintain a clear pathway, free of obstacles. Date Initiated: 03/31/2022 -Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders Date Initiated: 03/31/2022 -Place sign in room for a remind to use call light for assistance. (3/9/23) Date Initiated: 03/09/2023 -Reminder to use call light for assistance Date Initiated: 03/09/2023 -Resident self-transfers from floor to recliner per therapy. Resident is aware to call for assistance but refuses to at times because resident wants to get in dresser and get out clothes and look through her items. Date Initiated: 10/17/2022 -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/Interdisciplinary Team as to causes. Date Initiated: 03/31/2022 -Staff will ensure residents bed is in lowest position while in bed (3/4/23) Date Initiated: 03/04/2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/2/24 at 6:38 AM of Resident 5 revealed no floor mat on the floor beside the bed. Interview with Resident 5 on 7/2/24 at 6:39 AM revealed Resident 5 reported a staff member took the floor mat about a week ago for another resident. Interview with the ADON on 7/2/24 at 6:47 AM, ADON confirmed a floor mat should be on the floor next to Resident 5's bed. Record review of the Policy/Procedure for Fall Management System dated 6/2022 revealed the following: -Standards This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs as appropriate to prevent accidents. -Policy: It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Procedures: 1 On admission, the Fall Risk evaluation will be completed to determine his/her risk for sustaining a fall. 2 Residents with high risk factors identified on the Fall Risk evaluation will have an individualized care plan developed that includes measurable objectives and time frames. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. 3 When a resident sustains a fall, an assessment will be completed by a licensed nurse, with results documented in the medical record. Unwitnessed falls and witnessed falls with impact to head will also include the initiation of neurological assessment. The Attending physician and Resident rep shall be notified of the fall and the resident status. Follow-up documentation will be completed for a minimum of 72 hours following the incident. A Fall Risk Evaluation will be completed post fall incident. 4 Review of the fall incident will include investigation to determine probable causal factors. 5 The investigation will be reviewed by the Interdisciplinary Team. A Summary of the investigation and recommendations will be documented in the Risk Management system. 6 Resident's care plan will be updated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 - Minimal harm or potential for actual harm Residents Affected - Few	7 The Quality Assurance committee will analyze trends related to falls and will determine if further intervention is needed.