STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285262	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	909 17th Street Fairbury, NE 68352

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)(i)(4)Based on observations, record review, and interviews, the facility failed to reevaluate and update interventions to prevent elopement on two residents (Resident 1 and Resident 4) of the four sampled residents, and the facility failed to revise interventions to prevent falls on one resident (Resident 7) of three sampled residents. The facility census was 48. A.A record review of Resident 1's Clinical Census revealed an admission date of 5/13/2025.A record review of Resident 1's Minimum Data Set (MDS)(this comprehensive assessment evaluates each resident's functional capabilities) dated 05/19/2025 revealed a brief interview for mental status (BIMS) score of one which indicated the resident had severe cognitive impairment. A record review of Resident 1's Care Plan with an admission date of 5/13/2025 revealed a diagnosis of Alzheimer's Disease (A progressive disease that destroys memory and other important functions). A record review of Resident 1's Care Plan with an admission date of 5/13/2025 revealed interventions for elopement to include alerting staff to wandering behavior, testing security system, completing an elopement risk per schedule, and intervening as soon as anxious behavior is noted to prevent escalating behavior.A record review of Resident 1's Care Plan with an admission date of 5/13/2025 and a revision date of 7/18/2025 revealed an intervention was added to offer music or activity of resident's choice and assisting resident to sit in another area other than the front lobby.A record review of Resident 1's Care Plan with an admission date of 5/13/2025 and a revision date of 8/4/2025 revealed interventions relating to elopement risk included redirect to visit with husband, educating families about possible elopements and its risks, and relocating the signage at the front door to a pedestal holder by the door.A record review of Resident 1's Progress Notes dated 6/30/2025 at 6:29 PM revealed Resident 1 was found out of the facility, just off the front porch to the south. The resident went out the front door with a visitor that was leaving. A record review of the Facility's Incident By Incident report dated 8/5/2025 revealed Resident 1 had an Attempted Elopement on 6/30/2025 at 5:00 PM.A record review of the Facility's Elopement Prevention Management policy dated 3/20/2024 revealed the definition of Attempted Elopement means that the resident takes action to leave the facility structure, but the facility alarm systems activate, and team members respond immediately and appropriately. Elopement means a resident takes action to leave the facility and manages to leave the facility without team member knowledge, intervention, or the exit security system fails to activate. A record review of Resident 1's Progress Notes dated 7/18/2025 at 2:45 PM revealed that another resident reported Resident 1 was outside. The nurse immediately went outside and found Resident 1 walking in the front parking lot of the facility. A record review of the Facility's Incident By Incident report dated 8/5/2025 revealed Resident 1 had an Elopement on 7/18/2025 at 2:45 PM. A record review of Resident 1's Progress Notes dated 8/3/2025 at 5:17 PM revealed Resident 1 was located outside of the facility in the parking lot. There were multiple visitors at the time of the occurrence and no door alarm sounded.A record review of the Facility's Incident By Incident report dated 8/5/2025 revealed Resident 1 had an Elopement on 8/03/2025 at 4:45 PM. B.A record review of Resident 4's Clinical Census revealed an admission date of 4/15/2025.A record review of Resident 4's MDS dated [DATE] revealed a BIMS score of seven which indicated the resident had severe cognitive impairment.A record review of Resident 4's Care Plan with an admission date of 4/15/2025 revealed a diagnosis of unspecified Dementia (A condition characterized by a progressive decline in cognitive function, such as memory, thinking, language, judgement, and behavior), severe, with anxiety.A record review of Resident 4's Care Plan with an admission date of 4/15/2025 revealed interventions for elopement to include alerting staff to wandering behavior, testing security system, completing an elopement risk per schedule, and intervening as soon as anxious behavior is noted to prevent behavior escalating.A record review of Resident 4's Progress Notes dated 5/20/2025 at 4:40 PM revealed Resident 4 wondered this shift setting off the alarm on the 400-exit door.A record review of Resident 4's Care Plan with an admission date of 4/15/2025 and a revision date of 7/02/2025, interventions were added to offer activity of resident's choice, 500 hall exit door locked with egress locking system, and to offer pain meds.A record review of Resident 4's Progress Notes dated 7/01/2025 at 4:47 PM revealed that Resident 4 was outside in the parking lot headed towards the street.A record review of the Facility's Incident By Incident report dated 8/5/2025 revealed Resident 4 had an Elopement on 7/1/2025 at 4:25 PM.A record review of Resident 4's Progress Notes dated 7/02/2025 at 2:31 AM revealed Resident 4 was located outside of the facility by the charge nurse at 6:15 PM.A record review of the Facility's Incident By Incident report dated