STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285267	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisville Care Center	410 West 5th Street Louisville, NE 68037

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 - 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 178 NAC 12-006.09(I) Based on interview, observation, and record review, the facility staff failed to evaluate and implement interventions to prevent elopement for 2 (Resident 1 and 4) of 4 residents sampled. The facility identified a census of 44. Findings are: Record review of Facility policy dated 10/2024 revealed the following: -Elopement is a situation where an unsupervised resident is found outside of the facility. Staff is unaware of the resident's departure (did not visually see the resident leave). -Policy -It is the policy of the facility to take proper preventative measures to prevent episodes of resident wandering from the facility and to locate resident in an expedient and timely manner. -Procedure-Elopement I. Preventative measures will be taken by the facility to prevent residents from elopement. A. Assessing all residents upon admission for the potential of exit seeking. An Elopement Risk Assessment will be completed on each resident on pre-admission/admission, quarterly and on change of condition if they display behavior changes that may indicate a risk for exit seeking. B. Interventions are placed on the Resident's Care Plan. C. Wander guard bracelets (a device worn by residents who wander that will, if too close to an exit door, will lock the exit door and sound an alarm to alert facility staff) will be placed on Resident that are identified as Exit Seekers. D. Ongoing documentation by the night charge nurse that the wander bracelets on residents are functioning and documenting such on the Medical Administration Record (MAR). (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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NAME OF PROVIDER OR SUPPLIER Louisville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 410 West 5th Street Louisville, NE 68037	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	E. Ongoing documentation by the Maintenance Director that the wander guard door signaling devices are tested on e time a week and the door alarms are tested on a weekly basis. F. Family will be instructed upon admission about the need to sign in and out at the nurse's station when taking the resident out of the facility. G. A photograph will be taken of each resident upon admission and updated as resident's physical appearance changes. H. Doors will be alarmed at all times with the exception of the Front Door during normal visiting hours. II. If an employee observes a resident leaving the premises, he/she should: A. Attempt to prevent the departure in a courteous manner. B. Get help from other staff members in the immediate vicinity. C. Instruct another staff member to inform the Charge Nurse of Director of Nursing that resident has left the premises. III. When an employee discovers that a resident is missing from the facility: A. Notify the Charge Nurse B. Initiate a search of the building and the premises. C. Notify Director of Nursing and/or Administrator or their designees. D. Initiate an extensive search of the surrounding area. IV. When a departing individual returns to the facility: A. In case of an Elopement the Charge Nurse or designated staff member will complete the Incident Report Form. B. Notify the attending Physician. C. Notify the resident's legal representative of the incident. D. Notify Director of Nursing and/or Administrator or designees. E. On direction of above notify Health and Human Services/Adult Protective Services. F. All pertinent information will be charted in departmental notes. G. Administration may discuss additional safety measures such as wander guard placement; room move or alternative facility placement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A. Record review of Resident 1's 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 9/3/2024 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) with a score of 1. A BIMS score of 1 indicated the resident was severely cognitively impaired. The functional status of Resident 1 was assessed as eating required set-up or clean up assist, toileting and bed mobility required partial/moderate assistance, and transfers required substantial/maximum assist. The mobility devices used by Resident 1 was identified as using a wheelchair. Resident 1's active diagnosis included: Progressive neurological conditions, diabetes, respiratory failure, altered mental status, and atrial fibrillation. Resident 1 also received Hospice Care (an interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and terminal illnesses). Record review of Resident 1 Care Plan (CP) dated 10/14/2024 identified a focus of The resident has impaired cognitive function/dementia or impaired thought processes related to dementia. The goal of the focus is Resident will remain safe in the facility despite wandering behaviors secondary to dementia diagnosis by next review on 10/16/2024. The interventions were identified as the following: 1. Ask yes/no questions to determine the resident's needs. 2. Cue, reorient and supervise as needed. 3. Discuss concerns about confusion, disease process, nursing home placement with resident/family/caregivers). 4. Give resident puzzles, crafts, and activities to keep his hands busy to help prevent him from fiddling with his dentures. 5. The resident is able to: self-propel around the unit. Resident prefers not to wear the Wander guard on wrist. Placed on the wheelchair due to irritation and discomfort. Record review of Resident 1's Elopement Risk Tool (ERT) dated 5/21/24 revealed Resident 1 had been found to be at risk for elopement. According to the ERT dated 5/21/2024 Resident 1 cognition had declined since being on hospice and a wander guard was placed. Record review of a facility Investigation report (IR) dated 9/05/2024 revealed Resident 1 was found in the facility parking lot by staff as they were leaving on 8/30/2024. According to the IR dated 9/05/2024 a Wander guard was in place and did not alarm when Resident 1 left. The intervention put into place to prevent re-occurrence was to place the Wander guard in a new location on Resident 1's wheelchair. In addition staff were to check the whereabouts of Resident 1 at shift change and to re-direct the resident into the commons area. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Record review of a IR dated 10/16/2024 revealed on 10/13/2024 the Assisted Living staff notified the facility Charge Nurse Resident 1 was lying on the ground in the driveway. According to the IR dated 10/16/2024 Resident 1 required medical attention and was transported to the hospital. Further review of the IR dated 10/16/2024 Resident 1 sustained multiple small subdural brain bleeds, right sided rib fracture and a pelvis fracture and there was no witnesses.

Record review of Resident 1's Hospital admission records dated 10/13/2024 revealed under the Consult orders section of the report revealed Resident 1 had a small subdural hematoma (a collection of blood between the covering of the brain and its outermost covering).

Record review of a information sheet from the hospital printed on 10/14/2024 for Resident 1 identifed the reason Resident 1 hospitalization was a fracture of Pubic Rami (pelvis area), Head injury and multiple rib fractures.

Record review of Resident 1's Progress note dated 10/14/2024 revealed Resident 1 returned to the facility with the diagnosis of a closed fracture of multiple of Pubic Rami, Right Head injury and multiple right side rib fractures.

On 10/17/2024 at 11:24 AM an interview was conducted with the facility Administrator. During the interview the facility Administrator reported Resident 1 did not have have the wander guard on the wheelchair or their person when Resident 1 was found. The Administrator further reported hospice personal brought in a new wheelchair on 10/12/2024 and the Wander guard was not transferred to the new wheelchair.

A interview with Assistant Director of Nursing (ADON) at 3:10 PM revealed the ADON reported Resident 1 wasn't getting up out of bed currently, staff were to keep Resident 1 comfortable due to their injuries.

17285

B. Record review of Resident 4's quarterly MDS dated [DATE] revealed an admitted [DATE] and diagnoses that included Alzheimer's Disease, Non - Alzheimer's Dementia, Anxiety and Depression. The MDS identified that Resident 3 had a BIMS score of 4, which indicated severe cognitive impairment, no wandering behaviors exhibited, manual wheelchair use, no impairment in range of motion of upper or lower extremities and independence with locomotion once in the wheelchair.

Record review of Resident 4's Care Plan dated 1/8/24 revealed a concern related to the risk of elopement as evidenced by exit seeking behaviors, disorientation to surroundings, agitation, anxiety, wandering and verbalizing intent to leave. The care plan included no updates or revisions to the care plan related to elopement risk until 10/14/24. Interventions included:

- 1/8/24: Elopement risk assessment quarterly and PRN [as needed]

- 1/8/24: Place a wander guard on me, please check to make sure it is functioning correctly per facility protocol.

- 10/14/24: Check wander guard for proper functioning.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 4's Elopement Risk Tool dated 1/24/24 revealed that the resident had been found to be at risk for elopement. Record review of a facility investigation dated 6/25/24 revealed that Resident 4 had eloped from the facility on 6/19/24 to the assisted living side of the building. The investigative report revealed that the alarms were intact and functional and going off at the time of the elopement. The facility investigation revealed that the residents care plan was updated to include walking rounds to be completed at each shift change due to wandering behaviors and resident was to be escorted by staff to every meal by wheelchair. Record review of Resident 4's Electronic Medical Record revealed no elopement risk assessments had been completed quarterly after 1/24/24 and a risk assessment had not been completed after the elopement on 6/19/24 as per the facility policy. Record review of Resident 4's CP revealed no new interventions related to elopement had been identified in the care plan for Resident 4 after the elopement on 6/19/24. Record review of Resident 4's TAR dated June 2024 revealed an order to check the wander guard for proper functioning (on wheelchair) was started on 5/28/24. Record review of Resident 4's TAR's dated June 2024, August 2024, [DATE] and October 2024 revealed missing documentation of the monitoring of the wander guard on the following dates: - June 2024: 6/1, 6/2, 6/3 - August 2024: 8/1, 8/2, 8/18, 8/19, 8/23, 8/27, 8/28, 8/30 - September 2024: 9/8, 9/9, 9/20, 9/28, 9/29 - October 2024: 10/8 Observation on 10/17/24 at 8:25 AM: revealed Resident 4 seated in a wheelchair in the main dining room. A wander guard was attached to the left leg of the wheelchair with a replacement date of 11/15/ 25 written on the wander guard. Interview on 10/17/24 at 1:30 PM with the ADON confirmed that documentation on the TAR for checking of the wander guards was missing on the above cited dates. The ADON was unable to confirm that monitoring had been completed on those dates. The ADON confirmed that no elopement risk assessment had been completed after the elopement on 6/19/24 in accordance with the policy. The ADON confirmed that no quarterly elopement assessments had been completed since 1/24/24.