

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Emerald Nursing & Rehab Lancaster LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1001 South Street Lincoln, NE 68502	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48271</p> <p>Licensure Reference Number 175 NAC 12-006.09D7</p> <p>Licensure Reference Number 175 NAC 12-006.18B</p> <p>Based on record review and interviews, the facility failed to ensure elopement (unsupervised wandering that leads to the resident leaving the facility without facility staff knowledge) door alarms were functioning, which affected 1 (Resident 3) of 14 sampled residents. The facility failed to ensure all staff were aware of residents who were at risk for elopement which affected 1 (Resident 3) out of 5 sampled residents. This had the potential to affect 14 residents identified at risk for elopement. The facility census was 206.</p> <p>Findings are:</p> <p>A record review of Resident 3's Admission Record dated 3/8/2023 revealed that Resident 3 was admitted to the facility on [DATE] with diagnoses of: Ataxia (have problems coordinating how your muscles work, leading to awkward, unwieldy or clumsy movements) following unspecified cardiovascular disease (conditions that affect blood flow and the blood vessels in the brain), Cerebral infarction ( clot blocks a blood vessel that feeds the brain) due to unspecified occlusion of the left cerebellar artery, Attention and concentration deficit (forgetfulness, problems staying on task, easily distracted, easily bored, easily confused and difficulty following instructions), Metabolic Encephalopathy(chemical imbalance in the blood, when the imbalance affects the brain, it can lead to personality changes), Chronic heart failure, Type 2 diabetes, and Urinary Tract Infection.</p> <p>A record review of the Minimum Data Set (MDS- a comprehensive assessment of each resident's functional capabilities used to develop a residents plan of care) dated 12/ 31/ 2023 revealed Resident 3 had a Brief Interview for Mental Status(BIMS-a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 10 which indicates Resident 3 was moderately cognitively impaired. In Behaviors Section E the question has the resident wandered, was answered no behavior exhibited. In Section GG of the MDS revealed that Resident 3 required some help from another person with all activities of daily living (ADL's).</p> <p>A record review of the Nursing Admission Data Collection form dated 12/15/2023 revealed there was no indication or history of exit seeking, wandering away or getting lost and was the resident was determined not to be an elopement risk.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A record review of the Social Services Admission Data Collection form dated 12/18/2023 revealed that Behavior factors was marked as none above, indicating the resident had no wandering or exit seeking behaviors.</p> <p>A record review of the Comprehensive Care Plan (CCP-written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) dated 12/21/2023 revealed Resident 3 was not an elopement risk.</p> <p>A record review of the Progress Notes dated 3/22/2024 at 2:15 PM revealed Resident 3 had increased confusion and agitation, and was exit seeking. A Wander Guard (A Wander Guard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts the caregivers), bracelet had been placed on Resident 3's wrist per the Unit Manager.</p> <p>A record review of the Progress Notes and the Nursing assessment forms revealed no documentation from 3/22/2024 through 3/27/2024 of an Elopement Assessment after placement of the wander guard on Residents 3's wrist.</p> <p>A record review of the Facility Investigation Report dated 3/28/2024 for Resident 3 revealed that on 3/27/2024 at 7:17 PM Resident 3 had left the facility through the front door without staff supervision or knowledge. At 7:37 PM Resident 3 was returned to the facility after a bystander assisted Resident 3 when Resident 3 tipped over in the wheelchair on South Street while Resident 3 was trying to cross South Street. Resident 3 received a skin tear to left elbow and left arm from the fall. Resident 3 was wearing sweat pants and T-shirt when [gender] left the facility. The weather at the time when the resident left the facility was 45 degrees per channel 10/11 news. The front door Wander Guard system failed to alarm when Resident 3 was close to the front door.</p> <p>A record review of the Maintenance log in the Tel's (technology is designed specifically for Senior Living to create safer environments and increase Life Safety compliance. Boost the efficiency of your maintenance teams and gain control over your operations) system for checking the Wander Guard system on the doors revealed that on 2/29/2024 a test of the doors,locks and alarms was documented as completed. The next due date to check functioning of the doors, locks and alarms was scheduled for 3/31/2024.</p> <p>A record review in the Progress Notes dated 3/27/2024 at 7:45 PM revealed Resident 3's Wander Guard bracelet on the resident's wrist was functioning.</p> <p>An interview on 3/28/2024 at 11:30 AM with the Unit Manager (UM) revealed Resident 3 had never been an elopement risk before, and was able to go down to the bistro or activities, and would always come back up to [gender] room. UM confirmed that [gender] received a call on 3/22/2024 regarding Resident 3 exit seeking and increased agitation and informed the staff to put a Wander Guard bracelet on Resident 3.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 3/28/2024 at 3:30 PM with Maintenance Director (MD) confirmed [gender] got a call on 3/27/2024 at 8:00 PM from the facility regarding the malfunction of the Wander Guard door alarm, which was not alarming when a resident with a Wander Guard went through the front door. MD arrived at the facility at 9:00 PM and reset the Wander Guard system. MD confirmed that [gender] did not know why the wander guard system did not alarm. MD also confirmed the wander guard system on the doors are checked monthly.</p> <p>An interview on 3/28/2024 at 4:45 PM with the Electrical contract company (EC) came out to check the Wander Guard system to make sure the system was functioning properly. EC confirmed that [gender] is not sure why the wander guard system malfunctioned. EC checked the timing and wires and verified set up and tested the system and everything was functioning properly.</p> <p>An interview on 3/29/2024 at 11:30 AM with Medication Aide (MA)-A confirmed that [gender] is not aware of how often the Wander Guards are checked on residents who have a bracelet. MA-A confirmed [gender] is not aware of which residents have a Wander Guard on, or the residents who are at risk for elopement.</p> <p>An interview on 3/29/2024 at 11:45 AM with Licensed Practical Nurse (LPN)-G confirmed that the nurses check the function of the Wander Guard bracelets on the residents who are risk for elopement every shift. LPN -G also confirmed that nursing assistants do not necessarily know which residents are at risk for elopement, but the nurses do know. LPN-G confirmed that the wander guard system had this little device that when put up to the wander guard bracelets it would turn green if the wander guard was working and if it turned red the wander guard bracelet would be replaced. LPN-G confirmed that the wander guard bracelets had expiration dates on them.</p> <p>An interview on 3/29/2024 at 2:30 PM with Nursing Assistant (NA)-D, confirmed that Wander Guards are on the resident's wrist, ankle, or wheelchair. NA-D further confirmed [gender] is not aware if there is a list of residents who have Wander Guard on, and is not aware of the residents who are at risk for elopement. NA-D confirmed that the nurses check the Wander Guards with a machine. If the machine turns green, then its working and if it turns red then the wander guard is not working.</p> <p>An interview on 3/29/2024 at 2:45 PM with MA-B confirmed that [gender] is not aware of which residents are at risk for elopement or which residents are wearing a Wander Guard. MA-B does know that the nurses are checking them on the evening shift but not aware of what other shifts do.</p> <p>An interview on 3/1/20204 at 3:30 PM per phone call with Receptionist who monitors the front desk by the front door revealed, that on 3/27/2024 at 7:17 PM, the Receptionist did not notice Resident 3 in the front lobby, nor did [gender] notice that Resident 3 went out the front door. The Receptionist confirmed that Resident 3 may have went out the front door when [gender] went to the bathroom. The Wander Guard system did not alarm when Resident 3 exited through the front door. The Receptionist further confirmed [gender] is not aware of any residents who are at risk for elopement or which residents have a Wander Guard on. The Receptionist also revealed that [gender] is aware of who the smokers are and the residents who have the Resident community access/pass.</p> <p>An interview on 3/28/2024 at 3:30 PM with the Administrator confirmed that Resident 3 was able to leave the unit that Resident 3 lives on to go to the Bistro, or activities provided in other areas of the building. The Administrator confirmed that Resident 3 has the right to go any where in the building.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 3/28/2024 at 12:30 PM with the Director of Nursing (DON) confirmed that on 3/22/2024 an Elopement Assessment was not done for Resident 3 and should have been done. The DON confirmed that the nurses check that the Wander Guard bracelet is functioning every shift, but they do not check the functioning of the Wander Guard system on the doors. The DON confirmed that Resident 3 was able to attend activities and go to the Bistro but that Resident 3 did not leave Unit 4 by self.</p> <p>An interview on 3/28/2024 at 1:30 PM with the Clinical Consultant (CC) confirmed that on 3/22/2024 an Elopement Assessment should of been completed and was not done for Resident 3. The CC confirmed that after the Elopement of Resident 3, during the Risk Management meeting areas of concern were identified. The CC revealed that there was no Policy and Procedure for Wandering/Behavior or Elopement for residents at risk. The CC confirmed that Nursing Assessments are to be done quarterly and that the Nursing Assessments are not being done quarterly. The CC also confirmed that the Nursing Assessments consisted of; elopement/wandering risk, Lifestyle, cognition, communication, hearing, vision and oral, skin conditions, pain, Braden scale, bowel, and bladder, fall risk, hot liquid safety, Safely/Bed enablers/entrapment, mediation use, and Immunization/TB.</p> <p>A record review of the Abatement Statement to remove the immediacy of the situation on 3/28/2024 revealed the following:</p> <ul style="list-style-type: none"> <li>-Preventative Maintenance checklist will check doors weekly vs monthly due to the malfunction.</li> <li>-Re-education to the DON and Social Worker on the elopement policy by the consultant on 3/28/2024 to include orders, accurate forms, and care plans.</li> <li>-Staff education on 3/28/2024 on residents who are at risk. Provide current list to all stations on residents who are identified at risk.</li> <li>-All new staff will be educated in orientation upon hire.</li> <li>-Agency staff will be educated upon 1st shift in building.</li> <li>-The receptionist in the evening will check the functioning of the wander guard before the end of the shift.</li> </ul>		