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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285275 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>05/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Emerald Nursing & Rehab Lancaster LLC |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1001 South Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0689</p> <p>Level of Harm - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45641</p> <p>Licensure Reference Number 175 NAC 12-006.09D7</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 1) of 3 sampled residents was assessed for the ability to safely use the resident's recliner/chair lift to prevent a fall with major injury. The facility census was 203.</p> <p>Findings are:</p> <p>A record review of the facility's Accidents and Incidents policy with a last revised date of 1/2024 revealed Accident/Incidents may include a fall or suspected fall. Should an accident/incident occur, the facility strived to prevent such occurrence from happening again. The facility's procedure should be to protect resident from further immediate harm or potential harm.</p> <p>A record review of Resident 1's Clinical Census sheet dated 05/07/2024 revealed Resident 1 was admitted to the facility 05/05/2022.</p> <p>A record review of Resident 1's Electronic Medical Record Medical Diagnosis list dated 05/07/2024 revealed the resident had diagnoses of History of Falling, Unspecified, Initial Encounter, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (confusion), Cerebrovascular Disease, Unspecified (problem with blood flow to the brain)Unspecified Sequelae of Nontraumatic Subarachnoid Hemorrhage (altered sensation following a stroke), Other Speech And Language Deficits Following Other Cerebrovascular Disease, Memory Deficit Following Cerebral Infarction (poor memory following a stroke), Insomnia (sleep disorder), Anxiety Disorder, Depression, and Pain.</p> <p>A record review of Resident 1's Minimum Data Set (MDS),a comprehensive assessment used to develop a resident's care plan) dated 02/02/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) 9 of 15 that indicated the resident was moderately cognitively impaired. The resident was dependent on staff for mobility and all activities of daily living (ADL) except eating and oral hygiene and did not have impairment to the upper or lower extremities.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 08/25/2022 at 6:42 AM revealed Resident 1 was found to have slid out of the recliner to the floor. The root cause was the resident was repositioning self. The intervention put in place to prevent this fall from happening again was [NAME] (a sticky pad) in place. The conclusion of the investigation was Resident 1 was impulsive.</p> <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 01/12/2023 at 4:48 PM revealed Resident 1 was found on the floor in front of the recliner while the NA performed rounds. The root cause was impulsiveness. The intervention put in place to prevent this fall from happening again was to encourage the resident to call for help before trying to get out of the chair. The conclusion of the investigation was Resident 1 attempted to get out of the recliner unassisted without calling for help.</p> <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 01/12/2023 at 5:06 PM revealed Resident 1 was found sitting in front of the recliner. The root cause was the resident was wanting to lay down. The intervention put in place to prevent this fall from happening again was to lay the resident down after supper. The conclusion of the investigation was Resident 1 was tired and wanted to lay down.</p> <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 10/31/2023 at 8:54 PM revealed Resident 1 was found with the recliner lifted and tilted forward. The resident was laying on the floor with the pillow from the recliner under the resident's head. The root cause was impulsiveness and needing to use the bathroom. The intervention put in place to prevent this fall from happening again was to toilet after supper and gripper socks on while in the recliner. The conclusion of the investigation was toilet after supper and gripper socks or shoes on while in the recliner.</p> <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 03/26/2024 at 5:22 PM revealed Resident 1 was found sitting on the floor in front of the recliner. The root cause was confusion and the resident slid out of the recliner. The intervention put in place to prevent this fall from happening again was the resident was transferred to the wheelchair and took out of the resident's room. The conclusion of the investigation was Resident 1 slid out of the recliner and needed to toilet.</p> <p>A of record review of Resident 1's Progress Note dated 04/28/2024 revealed a NA called for the nurse and the nurse entered the resident's room to find the resident lying on the floor on the resident's right side in a pool of blood under the head. Resident 1's power recliner was in the lifted position and tilted forward. The remote to the recliner was laying on the floor. There was a laceration above the right eyebrow measuring 2 centimeters (cm) by 1 cm. The resident also had a laceration on the bridge of the nose measuring 0.5 cm by 0.5 cm. Pressure was applied to the lacerations until Emergency Medical Services (EMS) arrived.</p> <p>A record review of the facility's Fall Scene Investigation Report V 2 dated 04/28/2024 at 6:40 PM revealed Resident 1 was found with the recliner tilted in the air and the tray table was pushed to the side. The resident was laying on the resident's right side and had a medium pool of blood under the resident's head. The root cause was the recliner remote. The intervention put in place to prevent this fall from happening again was to place the remote out of reach so that the resident was not able to tilt self. The conclusion of the investigation was to keep remote out of reach due to the resident's cognition.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>   | <p>A record review of the [NAME] Trauma History &amp; (and) Physical dated 04/28/2024 revealed the resident fell out of the recliner striking the front of the head. Upon arrival at the Emergency Department (ED) Resident 1 was found to have a large supraorbital (above the eye) laceration on the right side and imaging showed a likely frontal brain contusion. A wound over the left eye was closed in the ED. The principal problem was a subdural hematoma (pool of blood between the brain and it's outermost covering). The resident was admitted to the Intensive Care Unit. The resident was discharged [DATE].</p> <p>A record review of the facility's Nursing Readmission Data Collection dated 05/01/2024 revealed Resident 1 had a 4 cm in length above the right eye that had approximately 8 sutures and bruising around both eyes.</p> <p>A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident had a Focus area of at risk for falls related to dementia, impulsive, and incontinence (inability to control bowels or bladder). The Care Plan revealed the resident had interventions of:</p> <ul style="list-style-type: none"> <li>-08/01/2021 - Recliner after lunch</li> <li>-08/05/2023 - Encourage frequent toileting</li> <li>-10/31/2023 - Toilet after supper</li> <li>-03/24/2024 - Signage placed in room to remind resident to use call light if needing assistance</li> <li>-03/27/2024 - Encourage with staff to toileting schedule approximately 3:00 PM</li> <li>-Date Initiated 03/27/2024 - Encourage use of call light</li> <li>-Date Initiated 04/28/2024 - Transfer: Dependent</li> </ul> <p>-05/01/2024 - Per POA (Power of Attorney) please keep remote of recliner in the side pocket of chair out of reach when the resident is in the chair to prevent future falls. Discussed with gender and declined manual recliner at this time.</p> <p>A record review of Resident 1's Electronic Medical Record that included progress notes, care plan entries, Practitioners orders, therapy notes and fall scene investigation sheets revealed the facility staff had not assessed the ability of Resident 1 to safely use a recliner/lift chair.</p> <p>An observation on 05/06/2024 at 1:43 PM revealed Resident 1 was sitting in the lift chair with the legs elevated and the lift chair control in the chair's pocket on the right side of the chair. The resident's right eye was bruised all the way around. The resident had a sutured laceration (cut with stitches) along the right brow that had 2 steri strips (a wound closure) on it and a golf ball sized hematoma (a raised area from blood leaks). The resident also had a sutured laceration on the bridge of the nose.</p> <p>An observation on 05/07/2024 at 10:55 AM revealed Resident 1 was sitting in the wheelchair and was transferred to the lift chair by Nursing Assistant (NA)-A and NA-B. NA-A elevated Resident 1's legs with the lift chair control and placed the lift chair control in the chair's pocket on the right side of the chair.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 05/06/2024 at 2:57 M, Resident 1's POA confirmed the facility notified the POA by telephone of the resident's fall on 04/28/2024 and the POA met the resident at the hospital. The POA confirmed Resident 1 told the POA that he thought the lift chair control was the television controller and pressed the up arrow. The daughter confirmed the resident had a history of sliding out of both manual and lift chair style recliners at the facility. The POA stated the resident is most comfortable in this chair, so the decision was made to let the resident keep the lift chair and hide the controller. The POA confirmed the POA has seen the controller next to the resident on at least 1 occasion since the fall on 04/28/2024 and has had to put it in the recliner's pocket.</p> <p>In an interview on 05/07/2024 at 11:08 AM, NA-C confirmed that NA-C had assisted Resident 1 with a meal in the recliner on 4/28/2024 due to the resident refused to go to the dining room. NA-C confirmed NA-C left the resident to go downstairs to the kitchen to get a tray for another resident. NA-C was off the floor for 30-40 minutes. When NA-C returned to the unit, NA-C was doing rounds when NA-C found Resident 1 lying on the floor and called for the nurse. NA-C confirmed Resident 1 was alert and was easy to have a conversation with when NA-C assisted the resident with the meal but was appeared confused following the fall. NA-C confirmed NA-C was unaware that the other staff would place the controller for the recliner in the side pocket and not near the resident so the resident would not play with the buttons until after the fall.</p> <p>In an interview on 05/07/2022 at 10:22 AM, the Director of Nursing (DON) confirmed the facility did not have a recliner or mechanical lift chair policy and they do not assess the ability of the resident to use a mechanical lift chair or recliner.</p> <p>In an interview on 05/07/2024 at 2:13 PM, Resident 1's POA confirmed the facility had not discussed with the family the resident's ability to safely use a recliners or mechanical lift chair until after the resident fell on [DATE].</p> <p>In an interview on 05/07/2024 at 2:20 PM, the DON confirmed the facility did not assess Resident 1 for the ability to safely use a recliner or mechanical lift chair.</p> |