STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285275	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lancaster LLC	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.02(G) and (H) Based on record review, observation, and interviews; the facility failed to ensure a formal investigation was completed and the State Agency was notified for 2 (Residents 1 and 2) of 3 sampled resident's elopement. The facility census was 198. Findings are: A record review of the facility's undated Missing Resident/Elopement Procedure revealed all nursing staff were responsible for knowing the whereabouts of residents for which they were assigned. Each resident was required to advise the nurse in charge when the resident left the building. Residents were not permitted to leave the building alone unless a physician order was present. Residents identified as cognitively impaired and assessed as an elopement risk were to be provided with an elopement prevention device and all personnel were responsible for promptly going to the location and determining the cause of an activated audible door alarm. In the event a resident cannot be located the charge nurse of the missing resident was to activate the elopement procedure, contact the Administrator and Director of Nursing immediately, and assign staff to search the building and grounds. The Administrator/Designee was responsible for initiating (starting) detailed documentation of all actions taken and efforts made to locate the resident immediately after or at the time of the event and contacting the State Department of Public Health. A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident had impaired cognitive function or impaired decision making. The resident was at risk for elopement related to cognition and wandering with a goal of the resident would not exit the facility unaccompanied by staff or family through the next review date. The risk for elopement intervention was the resident was currently wearing a wandering device on the left wrist. A record review of Resident 2's Care Plan with an admitted [DATE] revealed the resident had the following focus areas: functional deficit with current ADL's, at risk for falls, impaired visual function, appropriate for long term care related to the need for 24/7 (24 hours per day, 7 days per week) supervision/care and the potential for a mood problem related to depression. A record review of the facility's Waunderguard Master Resident List dated 06/28/2024 revealed Resident 1 was in room [ROOM NUMBER]B and was on the list for having a wanderguard. (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: 285275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Community Access Pass Master List dated 06/21/2024 revealed Resident 2 was on the list and was approved to sit out front only. A record review of Resident 1's Progress Note dated 06/29/2024 at 12:07 PM revealed the resident had increased confusion and constantly seemed lost. The resident had been packing belongings all night and the staff was not able to redirect. The resident was constantly wandering in the hallways without direction or purpose. The management was notified, and the resident was being moved to Station 5 (the locked memory care unit) for safety related to increased confusion and wandering. A record review of the facility's Incidents By Incident Type dated 01/02/2024 to 07/02/2024 did not reveal Resident 1 or Resident 2 had an Elopement Incident. A record review of the unnamed reportable incidents list dated 04/03/2024 through 07/01/2024 did not reveal Resident 1 or Resident 2 had an elopement. A record review of the facility's undated Elopement list for the previous 6 months did not reveal Resident 1 or Resident 2 had eloped. A record review of Resident 1's Progress Notes dated 06/17/2024 to 7/1/2024 did not reveal the resident had eloped from the facility. A record review of the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 did not reveal Resident 1 signed out of the facility with Resident 2 on 06/29/2024 at 9:47 AM. A record review of the Emerald Nursing & (and) Rehab [NAME] document signed by Receptionist (Rec)-A on 06/22/2024 revealed: I agree to stop all residents from going out the front door and having them sign out before leaving the facility. If the resident does not have a community pass (a pre-determined authorization to leave the building), the resident must always have a family member or staff member with them. A review on 07/02/2024 at 1:44 PM of the facility's security system Emerald [NAME] Video of Resident 1 and 2 Elopement from 06/29/2024 revealed Resident 1 pushed Resident 2 in a wheelchair to the reception desk located by the front door. Resident 1 was wearing long sleeves and did not reveal Resident 1 had a wanderguard safety device on. It appeared that Resident 2 signed the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 but did not reveal Resident 1 did. Resident 1 then pushed Resident 2 toward the front door and the green light on the facility's waunderguard alarm system started flashing at 3 minutes 26 seconds into the video. Rec-A approached the waunderguard alarm system keypad and entered the code to clear the alarm at 3 minutes 39 seconds into the video. Resident 1 then pushed Resident 2 out of the front door of the facility at 4 minutes and 6 seconds into the video and the camera lost sight of the residents. The video did not reveal that Resident 1 was accompanied by staff or family when the resident exited the facility through the front door. The video revealed multiple people dressed in the facility's dark green scrubs entering and exiting the facility and Resident 1 pushed Resident 2 back in the facility through the front door at 31 minutes 58 seconds into the video. The waunderguard alarm system light begins to flash again as Resident 1 entered the facility 32 minutes and 03 seconds into the video. Rec-A approached the waunderguard alarm system keypad and entered the code to clear the alarm at 32 minutes 14 seconds into the video. The video did not reveal that Resident 1 or 2 approached the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 to sign back in. (continued on next page)

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 07/08/2024
NAME OF PROVIDER OR SUPPLIER: Emerald Nursing & Rehab Lancaster LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1001 South Street Lincoln, NE 68502	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 07/02/2024 at 7:00 AM revealed the front door to the facility was unlocked and no staff was in sight until entering the administrative offices. In an interview on 07/08/2024 at 3:28 PM, Resident 2 confirmed that Resident 2 did not know that Resident 1 had a wanderguard bracelet on or that Resident 1 was not supposed to leave the facility. Resident 2 confirmed that Resident 2 had gone across the street several times before and it was not an issue. Resident 2 confirmed that Resident 2 was in a wheelchair at the time and Resident 1 was nice to push me across the street. Resident confirmed the only place the residents went was to Zesto's to get ice cream. Resident 2 confirmed Resident 2 signed in and out but don't know if Resident 1 did. Resident 2 confirmed 2 staff members from the facility came to Zesto's to tell the residents to go back to the facility. Resident 2 confirmed Resident 2 had not been told they could not go across the street. In a telephone interview on 07/02/2024 at 11:37 AM, Rec-A confirmed Resident 1 came to the reception desk where Resident 2 withdrew 60 dollars to go across the street to Zesto's to get ice cream. Resident 2 signed self out in the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 and went outside. Resident 2 then came back in the facility and Resident 1 and Resident 2 got together and were leaving the facility. Rec-A confirmed that another resident with a wanderguard set off the alarm. Rec-A then cleared the alarm and a line of people left the facility that included Resident 1 and Resident 2. Rec-A confirmed that Resident 2 was sitting outside smoking and Resident 1 was also there. Rec-A confirmed that Rec-A thought Resident 1 was just a visitor and did not think anything about it. Later, 2 staff entered the building and told Rec-A that Resident 1 was out and had a wanderguard on. The 2 staff went to get the residents and the residents were at Zesto's. Rec-A confirmed there is a list of residents that says where the resident is allowed to go at the receptionist desk and Resident 1 was not on there yet due to Resident 1 was a new resident. Rec-A again confirmed Rec-A thought Resident 1 was just a visitor pushing Resident 2 around. Rec-A confirmed it can get too busy in the lobby and 1 person cannot watch all the people coming and going. Rec-A confirmed there was a master list of residents with wanderguard's in the computer and that the staff has to pull up the resident's Electronic Medical Record to see a picture of a resident. In an interview on 07/02/2024 at 1:35 PM, the facility's Administrator confirmed the facility has the security video of Residents 1 and 2 leaving the facility and the receptionist knew where the residents were going, so the Administrator confirmed that the facility's management group determined it was not an elopement. The Administrator confirmed that it was not until 10:55 AM that the Administrator was contacted by the facility. The Administrator confirmed that the facility's receptionist was the one that made the determination that it was safe for Resident 1 and Resident 2 to leave the grounds to go across South Street to Zesto's. In an interview on 07/02/2024 at 8:01 PM, the Clinical Consultant (CC) confirmed that the receptionist that was working on 06/29/2024 should not have turned off the wanderguard alarm system to let Resident 1 leave the facility. In an interview on 07/02/2024 at 1:35 PM, the Director of Nursing (DON) confirmed there was no a formal investigation completed for the 06/29/2024 incident where Resident 1 and Resident 2 left the facility grounds unattended with the exception of viewing the security video of the event and deeming that it was not an elopement. The DON confirmed a reportable was not submitted to the State Agency due to the facility deemed that it was not an elopement.

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NAME OF PROVIDER OR SUPPLIER Emerald Nursing & Rehab Lancaster LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Street Lincoln, NE 68502	

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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 - Immediate jeopardy to resident health or safety 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** 45641 Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to prevent elopement (when a resident leaves the premises or a safe area without authorization) for 2 (Residents 1 and 2) of 3 sampled residents. The facility census was 198. The facility Administrator for Emerald Nursing and Rehab [NAME] was notified on 07/02/2024 at 5:30 PM of an Immediate Jeopardy (IJ) which began on 06/29/2024. The IJ was removed on 07/02/2024, as confirmed by surveyor onsite verification. Findings are: A record review of the facility's undated Missing Resident/Elopement Procedure revealed all nursing staff were responsible for knowing the whereabouts of residents for which they were assigned. Each resident was required to advise the nurse in charge when the resident left the building. Residents were not permitted to leave the building alone unless a physician order was present. Residents identified as cognitively impaired and assessed as an elopement risk were to be provided with an elopement prevention device and all personnel were responsible for promptly going to the location and determining the cause of an activated audible door alarm. In the event a resident cannot be located the charge nurse of the missing resident was to activate the elopement procedure, contact the Administrator and Director of Nursing immediately, and assign staff to search the building and grounds. The Administrator/Designee was responsible for initiating (starting) detailed documentation of all actions taken and efforts made to locate the resident immediately after or at the time of the event and contacting the State Department of Public Health. A record review of the facility's Elopement Education dated 03/28/2024 revealed that lists were provided at the nurse's stations for residents that were currently at risk for elopement. If the staff had concerns of a resident wandering or wanting to leave, management needed notified. An elopement book at the receptionist desk identified residents as well. For residents that wanted to leave the building, staff was to notify the reception desk to ensure they sign out and were safe to do so. A. A record review of Resident 1's Clinical Census dated 07/02/2024 revealed the resident was admitted to the facility 06/17/2024. A record review of Resident 1's Medical Diagnosis dated 07/02/2024 revealed the resident had diagnoses of: Unspecified Sequelae Of Nontraumatic Subarachnoid Hemorrhage (a brain bleed), Alcohol Dependence, Uncomplicated, Alcoholic Liver Disease, Other Seizures (uncontrolled jerking or shaking events), Unspecified, Type 2 Diabetes Mellitus Without Complications (uncontrolled blood sugar), Depression, and Pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) with a Target Date of 06/24/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) 9 of 15 which indicated the resident was moderately cognitively impaired (difficulty with mental function and skills). The resident was independent with mobility and all activities of daily living (ADL) except eating. The resident had wandered (walked around aimlessly) 1 to 3 days in the lookback period. A record review of Resident 1's Nursing Admission Data Collection - V 2 dated 06/17/2024 revealed the resident had a history of exit seeking, wandering away, or getting lost. The resident had a pertinent diagnosis of Dementia (confusion) Alzheimer's disease, Anxiety disorder, or Delusions and was capable of independent mobility. The resident was a potential elopement risk. A record review of Resident 1's Clinical Physician's Orders dated 07/02/2024 revealed the resident had a wanderguard safety device (device worn that would set off an alarm if the resident got close to an alarmed door). The Clinical Physician's Orders did not reveal the resident had a physician order to leave the building alone. A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident had impaired cognitive function or impaired decision making. The resident was at risk for elopement related to cognition and wandering with a goal of the resident would not exit the facility unaccompanied by staff or family through the next review date. The risk for elopement intervention was the resident was currently wearing a wandering device on the left wrist. A record review of Resident 1's Progress Note dated 06/17/2024 at 12:40 PM revealed Social Services (SS) documented the resident was unaware why he was at the facility, and nobody told the resident anything, they just dropped the resident off. SS did tell the resident there was concerns with memory and cognition. SS encouraged the resident to check out the building and that the resident could not exit the front door alone. The resident was observed checking out various areas of the building and getting familiar with things. SS notified the front desk that the resident may be checking out the building and if the resident was in the lobby unsure which direction to go, help guide Resident 1. A record review of Resident 1's Progress Note dated 06/17/2024 at 5:59 PM revealed Resident 1 was assessed as an elopement risk. A record review of Resident 1's Progress Note dated 06/27/2024 revealed the resident believed the resident had a flight to catch in Omaha and packed up belongings. The resident was not easy to redirect. The resident was confused and unaware what city the resident was in. The resident went to the first floor looking for the main entrance. The resident was assisted back to the 2nd floor by a Nursing Assistant (NA) and was not able to find own way back. A record review of the facility's Waunderguard Master Resident List dated 06/28/2024 revealed Resident 1 was on the list for having a wanderguard. A record review of Resident 1's Progress Note dated 06/29/2024 at 12:07 PM revealed the resident had increased confusion and constantly seemed lost. The resident had been packing belongings all night and the staff was not able to redirect. The resident was constantly wandering in the hallways without direction or purpose. The management was notified, and the resident was being moved to Station 5 (the locked memory care unit) for safety related to increased confusion and wandering. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the facility's Incidents By Incident Type dated 01/02/2024 to 07/02/2024 did not reveal resident 1 had an Elopement Incident. A record review of the facility's unnamed reportable incidents list dated 04/03/2024 through 07/01/2024 did not reveal Resident 1 had an elopement. A record review of the facility's undated Elopement list for the previous 6 months did not reveal Resident 1 had eloped. A record review of Resident 1's Progress Notes dated 06/17/2024 to 7/1/2024 did not reveal the resident had eloped from the facility. A record review of the facility's unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 did not reveal Resident 1 signed out of the facility with Resident 2 on 06/29/2024 at 9:47 AM. An observation on 07/02/2024 at 7:00 AM revealed the front door to the facility was unlocked and no staff was in sight until entering the administrative offices. In an interview on 07/02/2024 at 10:14 AM, Rec-F confirmed there is a book kept in the cabinet at the receptionist's desk that contained a list of residents with wanderguards and a list of residents with Community Access Passes, a photo of the resident, and the resident's demographic information. The book indicated if a resident could leave the facility and where they were allowed to go, and the wanderguard list indicated the resident was not to leave the facility without staff or family. Rec-F confirmed Rec-F does not refer to the binder that contained the wanderguard list, Community Access Passes, resident photos, and resident demographics. In a telephone interview on 07/02/2024 at 11:50 AM, Nursing Assistant (NA)-B that was scheduled to be working Station 4 on 06/29/2024 confirmed NA-B was not working on Station 4, NA-B was transferred to Station 5. NA-B confirmed NA-B knew Resident 1 and the resident had a wanderguard on that should have gone off when the resident attempted to leave the facility. NA-B confirmed the staff on Station 4 was running around looking for the resident on that date after being unable to locate [gender]. NA-B confirmed Resident 2 went in and out of the facility all day. In a telephone interview on 07/02/2024 at 12:07 PM, NA-C that was scheduled to be working Station 4 on 06/29/2024 confirmed that NA-C left for a break and Residents 1 and 2 were outside as NA-C left the facility. NA-C confirmed Resident 1 had a wanderguard and should not have been outside of the facility, but NA-C confirmed NA-C did not notify anyone. When NA-C returned to the facility after the break, NA-C heard Residents 1 and 2 were at Zestos on the other side of South Street. NA-C reported the incident to the charge nurse. NA-C was then instructed to take Resident 1 to station 5 as soon as possible. NA-C confirmed there was supposed to be a list of residents with wanderguards but NA-C doesn't check it and NA-C did not know what residents were on the list. NA-C revealed nobody was checking the wanderguards and NA-C was unsure who was supposed to be checking the wanderguards. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 07/02/2024 at 12:23 PM, NA-D that was scheduled to be working Station 4 on 06/29/2024 confirmed that NA-D was very busy that day and heard that Residents 1 and 2 had gone across the street but was not sure when Resident 1 took Resident 2 across the street. NA-D confirmed that none of the staff realized the residents were gone. NA-D confirmed the staff let Resident 1 and 2 do what they want. NA-D confirmed that after the incident, the staff took Resident 1 directly to Station 5, the locked unit. NA-D confirmed some residents could go out and some could not. NA-D confirmed NA-D was unaware how to determine what each resident was allowed to do. NA-D confirmed the nurse lets the staff know who can go out by themselves. NA-D confirmed the staff is unaware of when the residents leave the floor. In an interview on 07/02/2024 at 12:48 PM, Unit Director (UD)-E confirmed UD-E was on call at the time of the incident, but not at the facility. The Social Worker was at the facility and reported to UD-E. UD-E confirmed that Resident 2 talked Resident 1 into taking Resident 2 across South Street to Zestos. UD-E confirmed that Resident 1 had a wanderguard bracelet on at the time and was not sure why it did not trigger the alarm system. UD-E confirmed that every nurse's station had a list of residents that wear a wanderguard. UD-E confirmed UD-E tested the wanderguard and it worked, but if the wanderguard bracelets get close to expiration, they get glitchy and don't always read correctly. UD-E confirmed that Resident 1 was younger, ambulates without an assistive device unhindered (without being slowed or more difficult), and talked like the resident knew what they were saying. Resident 1 was very deceptive and that may be why the staff allowed the resident to leave the facility. UD-E revealed the Director of Nursing (DON) confirmed [gender] was working on the investigation and report on 06/29/2024. In an interview on 07/02/2024 at 3:56 PM, the DON confirmed that while investigating the Resident 1 and Resident 2 incident on 06/29/2024, the DON reviewed the progress notes for Resident 1 and seen Resident 1 had increased confusion, was exit-seeking more, and was packing the resident's things up to leave, so the DON decided it was best to get Resident 1 to a locked unit. In an interview on 07/08/2024 at 3:28 PM, Resident 2 confirmed that Resident 2 did not know that Resident 1 had a wanderguard bracelet on or that Resident 1 was not supposed to leave the facility. Resident 2 confirmed that Resident 2 had gone across the street several times before and it was not an issue. Resident 2 confirmed that Resident 2 was in a wheelchair at the time and Resident 1 pushed [gender] across the street. Resident 2 confirmed Resident 2 signed in and out but was unaware if Resident 1 did. Resident 2 confirmed 2 staff members from the facility came to Zesto's to tell the residents to go back to the facility. Resident 2 confirmed Resident 2 had not been told they could not go across the street. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 07/02/2024 at 11:37 AM, Rec-A confirmed Resident 1 came to the reception desk where Resident 2 withdrew 60 dollars to go across the street to Zesto's to get ice cream. Resident 2 signed themselves out in the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 and went outside. Resident 2 then came back in the facility and Resident 1 and Resident 2 got together and were leaving the facility. Rec-A confirmed that another resident with a wanderguard set off the alarm. Rec-A then cleared the alarm and a line of people left the facility that included Resident 1 and Resident 2. Rec-A confirmed that Resident 2 was sitting outside smoking and Resident 1 was also there. Rec-A confirmed that Rec-A thought Resident 1 was just a visitor and did not think anything about it. Later, 2 staff entered the building and told Rec-A that Resident 1 was out and had a wanderguard on. The 2 staff went to get the residents and the residents were at Zesto's. Rec-A confirmed there is a list of residents that says where the resident is allowed to go at the receptionist desk and Resident 1 was not on there yet due to Resident 1 was a new resident. Rec-A again confirmed Rec-A thought Resident 1 was just a visitor pushing Resident 2 around. Rec-A confirmed it can get too busy in the lobby and 1 person cannot watch all the people coming and going. Rec-A confirmed there was a master list of residents with wanderguards in the computer and that the staff has to pull up the resident's Electronic Medical Record to see a picture of a resident. In an interview on 07/02/2024 at 1:35 PM, the facility's Administrator confirmed the facility has the security video of Residents 1 and 2 leaving the facility and the receptionist knew where the residents were going, so the Administrator confirmed that the facility's management group determined it was not an elopement. The Administrator confirmed that it was not until 10:55 AM that the Administrator was contacted by the facility. The Administrator confirmed that the facility's receptionist was the one that made the determination that it was safe for Resident 1 and Resident 2 to leave the grounds to go across South Street to Zesto's. In an interview on 07/02/2024 at 8:01 PM, the Clinical Consultant (CC) confirmed that the receptionist that was working on 06/29/2024 should not have turned off the wanderguard alarm system to let Resident 1 leave the facility. B. A record review of Resident 2's Clinical Census dated 07/02/2024 revealed the resident was admitted to the facility 11/10/2023. A record review of Resident 2's Medical Diagnosis dated 07/02/2024 revealed the resident had diagnoses of: Presbyopia (eye disease), Myopia, Unspecified Eye (nearsighted), Nonexudative Age-Related Macular Degeneration, Bilateral, Stage Unspecified (chronic eye disease), Morbid (Severe) Obesity Due To Excess Calories (very overweight), Non-Pressure Chronic Ulcer Of Other Part Of Left Foot Fat Layer Exposed (deep left foot wound), Acquired Absence Of Other Left Toe(s), Chronic Obstructive Pulmonary Disease (COPD), Unspecified, Chronic Combined Systolic (Congestive) And Diastolic (Congestive) Heart Failure (CHF), Unspecified, Type 2 Diabetes Mellitus Without Complications (uncontrolled blood sugar), Depression, and Pain. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident 2's MDS dated of 04/23//2024 revealed the resident had a BIMS score of 13 of 15 that indicated the resident was cognitively aware. The resident was needed partial/moderate staff assistance with most ADL's except eating and oral hygiene (cleaning). The resident needed setup assistance with all areas of mobility. The resident required the use of a walker or wheelchair. The resident had 2 or more falls with injury in the lookback period. The resident did not wander. Resident 2 did have oxygen. A record review of Resident 2's Care Plan with an admitted [DATE] revealed the resident had the following focus areas: functional deficit with current ADL's, at risk for falls, impaired visual function, appropriate for long term care related to the need for 24/7 (24 hours per day, 7 days per week) supervision/care and the potential for a mood problem related to depression. A record review of Resident 2's Nursing Admission Data Collection - V 2 dated 04/23/2024 did not reveal the resident had a history of exit seeking, wandering away, or getting lost. The resident did not have a pertinent diagnosis of Dementia (confusion) Alzheimer's disease, Anxiety disorder, or Delusions and was capable of independent mobility. A record review of Resident 2's Clinical Physician's Orders dated 07/02/2024 revealed a provider order of: May go out of facility with responsible person with all meds (medications) PRN (as needed). A record review of the facility's Incidents By Incident Type dated 01/02/2024 to 07/02/2024 did not reveal resident 2 had an elopement incident. A record review of the facility's unnamed reportable incidents list dated 04/03/2024 through 07/01/2024 did not reveal Resident 2 had an elopement. A record review of the facility's undated Elopement list for the previous 6 months did not reveal Resident 2 had eloped. A record review of the facility's unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 revealed Resident 2 signed out of the facility on 06/29/2024 at 9:47 AM but did not sign back in. A record review of the Community Access Pass Master List dated 06/21/2024 revealed Resident 2 was on the list and was approved to sit out front only. An observation on 07/08/2024 at 3:28 PM revealed Resident 2 was exiting the public restroom walking with a 4 wheeled walker. The resident went to the receptionist desk and got the resident's cigarettes, then continued to the smoking area in the facility's courtyard. The resident walked very slowly and was short of breath. In an interview on 07/02/2024 at 10:14 AM, Rec-F confirmed there is a book kept in the cabinet at the receptionist's desk that contained a list of residents with wanderguards and a list of residents with Community Access Passes, a photo of the resident, and the resident's demographic information. Rec-F confirmed Rec-F does not refer to the binder that contained the wanderguard list, Community Access Passes, resident photos, and resident demographics. The book indicated if a resident could leave the facility and where they were allowed to go, and the wanderguard list indicated the resident was not to leave the facility without staff or family. Rec-F confirmed Resident 2 had a Community Access Pass, but the resident was approved to sit out front only. (continued on next page)

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 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lancaster LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 07/02/2024 at 11:50 AM, Nursing Assistant (NA)-B that was scheduled to be working Station 4 on 06/29/2024 confirmed NA-B was not working on Station 4, NA-B was transferred to Station 5. NA-B confirmed NA-B knew Resident 2. NA-B confirmed the staff on Station 4 was running around looking for the residents (Resident 1 and 2). NA-B confirmed Resident 2 went in and out of the facility all day. In a telephone interview on 07/02/2024 at 12:07 PM, NA-C that was scheduled to be working Station 4 on 06/29/2024 confirmed that NA-C left for a break and Residents 1 and 2 were outside as NA-C left the facility. NA-C confirmed Resident 1 had a wanderguard and should not have been outside of the facility, but NA-C confirmed NA-C did not notify anyone. When NA-C returned to the facility after the break, NA-C heard Residents 1 and 2 were at Zestos on the other side of South Street. NA-C reported the incident to the charge nurse. In a telephone interview on 07/02/2024 at 12:23 PM, NA-D that was scheduled to be working Station 4 on 06/29/2024 confirmed that NA-D was very busy that day and heard that Residents 1 and 2 had gone across the street but was not sure when Resident 1 took Resident 2 across the street. NA-D confirmed that none of the staff realized the residents were gone. NA-D confirmed the staff lets resident 1 and 2 do what they want. NA-D confirmed the nurse lets the staff know who can go out by themselves. NA-D confirmed the staff is unaware of when the residents leave the floor. In an interview on 07/02/2024 at 12:48 PM, Unit Director (UD)-E confirmed UD-E was on call at the time of the incident, but not at the facility. The Social Worker was and reported to UD-E. UD-E confirmed that Resident 2 talked Resident 1 into taking Resident 2 across South Street to Zestos. UD-E confirmed that Resident 1 had a wanderguard bracelet on at the time and was not sure why it did not trigger the alarm system. UD-E confirmed that every nurse's station had a list of residents that wear a wanderguard. UD-E confirmed UD-E tested the wanderguard and it worked, but if the wanderguard bracelets get close to expiration, they get glitchy and don't always read correctly. UD-E confirmed that Resident 1 was younger, ambulates without an assistive device unhindered (without being slowed or more difficult), and talked like the resident knew what the resident was saying. Resident 1 was very deceptive and that may be why the staff allowed the resident to leave the facility. UD-E confirmed that the Director of Nursing (DON) confirmed the DON was working on the investigation and report on 06/29/2024. In an interview on 07/08/2024 at 3:28 PM, Resident 2 confirmed that Resident 2 did not know that Resident 1 had a wanderguard bracelet on or that Resident 1 was not supposed to leave the facility. Resident 2 confirmed that Resident 2 had gone across the street several times before and it was not an issue. Resident 2 confirmed that Resident 2 was in a wheelchair at the time and Resident 1 was nice to push me across the street. Resident confirmed the only place the residents went was to Zesto's to get ice cream. Resident 2 confirmed Resident 2 signed in and out but don't know if Resident 1 did. Resident 2 confirmed 2 staff members from the facility came to Zesto's to tell the residents to go back to the facility. Resident 2 confirmed Resident 2 had not been told they could not go across the street. Resident 2 confirmed the resident has gone across the street several time to the liquor store to get cigarettes, the Mexican restaurant and to Zesto's and has never been told the resident was not supposed to leave the property. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In a telephone interview on 07/02/2024 at 11:37 AM, Rec-A confirmed Resident 1 came to the reception desk where Resident 2 withdrew 60 dollars to go across the street to Zesto's to get ice cream. Resident 2 signed self out in the unnamed resident sign-out list dated 06/27/2024 - 06/28/2024 and went outside. Resident 2 then came back in the facility and Resident 1 and Resident 2 got together and were leaving the facility. Rec-A confirmed that another resident with a wanderguard set off the alarm. Rec-A then cleared the alarm and a line of people left the facility that included Resident 1 and Resident 2. Rec-A confirmed that Resident 2 was sitting outside smoking and Resident 1 was also there. Rec-A confirmed that Rec-A thought Resident 1 was just a visitor and did not think anything about it. Later, 2 staff entered the building and told Rec-A that Resident 1 was out and had a wanderguard on. The 2 staff went to get the residents and the residents were at Zesto's. Rec-A confirmed there is a list of residents that says where the resident is allowed to go at the receptionist desk and Resident 1 was not on there yet due to Resident 1 was a new resident. Rec-A again confirmed Rec-A thought Resident 1 was just a visitor pushing Resident 2 around. Rec-A confirmed it can get too busy in the lobby and 1 person cannot watch all the people coming and going. Rec-A confirmed there was a master list of residents with Community Access Passes and where the residents were allowed to go and there was a master list of wanderguards in the computer and that the staff has to pull up the resident's Electronic Medical Record to see a picture of a resident.

In an interview on 07/02/2024 at 1:35 PM, the facility's Administrator confirmed the facility has the security video of Residents 1 and 2 leaving the facility and the receptionist knew where the residents were going, so the Administrator confirmed that the facility's management group determined it was not an elopement. The Administrator confirmed that it was not until 10:55 AM that the Administrator was contacted by the facility. The Administrator confirmed that the facility's receptionist was the one that made the determination that it was safe for Resident 1 and Resident 2 to leave the grounds to go across South Street to Zesto's.

In an interview on 07/02/2024 at 4:35 PM, the facility's Manager of Operations (MOO) confirmed that when a resident was issued a Community Access Pass, Social Services has a conversation with the UD and the resident's physician to determine the extent to where the resident is allowed to go. The facility's Manager of Operations confirmed that when it was decided that the resident was approved to sit out front only, meant the resident was to stay on the facility grounds.

In an interview on 07/02/2024 at 1:42 PM, the DON confirmed the facility's Community Access Pass Master List dated 06/21/2024 revealed Resident 2 was approved to sit out front only.

C.

Emerald Nursing and Rehab [NAME] was previously cited on 03/28/2024 at the immediate jeopardy level J for an elopement of a resident who walked out the front door and the facility staff were unaware who was at risk for elopements or who wore wanderguards.

Abatement Statement was received 07/02/2024 at 9:50 PM.

Identified Opportunity for Improvement/Deficient Practice:

-Resident 1 currently resides on a locked unit.

-Resident 2 is currently hospitalized . Community Pass has been revoked

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Process/Steps to Identify others having the potential to be impacted by the same deficient practice: -Staff member who shut the Wanderguard system off has been suspended pending investigation related to supporting documentation that (gender) had been educated on facility procedures. -Immediate Education to Receptionist with Competency on 7/2/24. -Community Pass Policy revised as a Best Practice of the facility and not a physician's order. -Current Community Pass residents will be evaluated for prior restrictions to ensure following revised policy by 7/5/24. Measures put into place/systematic changes to ensure the deficient practice does not recur: -Receptionist staff will be re-educated with Competency by the Administrator or designee on resident safety with community passes and wanderguards prior to next immediate shift. -All staff will be re-educated by the Administrator or designee on resident safety with community passes and wanderguards immediately. -Competency will be placed in Orientation for all new hires and agency staff. Plan to monitor performance to ensure solutions are sustained. -Audits to be completed to ensure receptionist are knowledgeable about resident safety with community passes and wanderguards 3 times per week for 1 month and then monthly times 3. -The Plan of correction will be reviewed bu QAPI committee for the next 3 months. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.