

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  Jefferson Community Health & Life Gardenside		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 North H 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47312</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record review and interview; the facility failed to report an incident related to elopement for 1 (Resident 1) of 3 sampled residents. This had the potential to affect 10 residents identified as at risk for elopement. The facility census was 31.</p> <p>Findings are:</p> <p>A record review of the facility policy Missing Resident revised on 9/19/24, revealed the following:</p> <ul style="list-style-type: none"> <li>-Elopement is defined as an event in which a resident who needs supervision leaves a safe area without supervision.</li> <li>-5. The Director of Nursing (DON) or designee will make the report to the Department of Health &amp; Human Services and to Adult Protective Services per facility policy.</li> </ul> <p>A record review of the facility's December 2024 QA/QI (Quality Assurance/Quality Improvement) log revealed the following entry:</p> <ul style="list-style-type: none"> <li>-12/31/24 at 1555 (3:55 PM) Resident 1 exited dining room door, returned safely.</li> </ul> <p>An interview on 1/8/25 at 9:47 AM with the Registered Nurse (RN) revealed that [gender] was working on 12/31/24 and around 4:00 PM that day Resident 1 went outside through the dining room door facing west, walked around the building to a door on the east side of the building and was let in by a dietary staff member. The RN further revealed that Resident 1 was outside for approximately 2 minutes. The RN confirmed that no one from nursing saw Resident 1 go outside.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 1/8/25 at 11:12 AM with the DON revealed that [gender] had visited with staff after Resident 1 was back in the facility about what had happened. [Gender] stated [gender] was told that someone from dietary had seen Resident 1 exit the facility through the dining room door and had their eyes on Resident 1 while [gender] was outside. The DON revealed that [gender] did not investigate which dietary staff member it was that visualized Resident 1 while [gender] was outside and had not investigated the elopement because [gender] was told that someone had their eyes on Resident 1 the entire time [gender] was outside. The DON confirmed that [gender] should have done a thorough investigation of the elopement, that included which dietary staff member visualized the incident to determine if the elopement needed to be reported. The DON further confirmed that because the elopement was not investigated, it was not reported as required.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47312</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record review and interview; the facility failed to investigate an incident related to elopement for 1 (Resident 1) of 3 sampled residents. This had the potential to affect 10 residents identified as at risk for elopement. The facility census was 31.</p> <p>Findings are:</p> <p>A record review of the facility policy Missing Resident revised 9/19/24, revealed the following:</p> <ul style="list-style-type: none"> <li>-Elopement is defined as an event in which a resident who needs supervision leaves a safe area without supervision.</li> <li>-4. The Charge Nurse will complete an incident report and forward it to the Director of Nursing (DON).</li> <li>-5. The DON or designee will make the report to the Department of Health &amp; Human Services and to Adult Protective Services per facility policy.</li> </ul> <p>A record review of the facility's December 2024 QA/QI (Quality Assurance/Quality Improvement) log revealed the following entry:</p> <ul style="list-style-type: none"> <li>-12/31/24 at 1555 (3:55 PM) Resident 1 exited dining room door, returned safely.</li> </ul> <p>An interview on 1/8/25 at 9:47 AM with the Registered Nurse (RN) revealed that [gender] was working on 12/31/24 and around 4:00 PM that day Resident 1 went outside through the dining room door facing west, walked around the building to a door on the east side of the building and was let in by a dietary staff member. The RN further revealed that Resident 1 was outside for approximately 2 minutes. The RN confirmed that no one from nursing saw Resident 1 go outside.</p> <p>An interview on 1/8/25 at 10:44 AM with the Assistant Director of Nursing (ADON) revealed that [gender] was unsure if there was a complete investigation of the elopement due to it being reported that a member of dietary had visualized Resident 1 the whole time [gender] was outside. The ADON confirmed that [gender] was unaware of what dietary staff member had visualized Resident 1.</p> <p>An interview on 1/8/25 at 11:12 AM with the DON revealed that [gender] had visited with staff after Resident 1 was back in the facility about what had happened. [Gender] stated [gender] was told that someone from dietary had seen Resident 1 exit the facility through the dining room door and had their eyes on Resident 1 while [gender] was outside. The DON revealed that [gender] did not investigate which dietary staff member it was that visualized Resident 1 while [gender] was outside and had not investigated the elopement because [gender] was told that someone had their eyes on Resident 1 the entire time [gender] was outside. The DON confirmed that [gender] should have done a thorough investigation of the elopement, that included which dietary staff member visualized the incident to determine if the elopement needed to be reported.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 1/8/25 at 11:12 AM with the [NAME] revealed that [gender] was working on 12/31/24 at the time Resident 1 went out the dining room door and did not visualize Resident 1 exiting the facility because [gender] was in the kitchen area. The [NAME] revealed that there was only one other dietary staff member present at that time and that was the Dietary Aide (DA).</p> <p>An interview on 1/8/25 at 11:44 AM with the DA confirmed that [gender] was working on 12/31/24 at the time Resident 1 went out the dining room door and that [gender] did not visualize Resident 1 exiting the facility because [gender] was in the dietary breakroom. The DA confirmed that [gender] and the [NAME] were the only two dietary staff members working at that time.</p>		