STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Cheney Rehabilitation	5431 South 16th Street Lincoln, NE 68512

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271 Licensure Reference Number 175 NAC 12-006.04C3a(6) Based on record review and interviews; the facility failed to notify the resident's physician of discharge to another facility for 1 (Resident 1) of 1 resident sampled. The facility census was 30. Findings are: A record review of Resident 1's Admission Record revealed that Resident 1 was admitted on [DATE] with diagnoses of Sepsis (a serious condition in which the body responds improperly to an infection), Dysphagia(difficulty swallowing), Gastro-esophageal Reflux Disease(A digestive disease in which stomach acid or bile irritates the food pipe lining), Pulmonary embolism(A condition in which one or more arteries in the lungs become blocked by a blood clot), Depression(It involves a depressed mood or loss of pleasure or interest in activities for long periods of time), Acute respiratory failure with hypoxia(a condition where you don't have enough oxygen in the tissues in your body). A record review of Resident 1's Progress Note indicated that Resident 1 was discharged to another facility on 9/22/23. A record review on 4/17/24 of Physician Orders on 9/22/23 revealed that there had been no order to discharge Resident 1 to another facility. An interview on 4/17/24 at 12:30 PM with LPN- A confirms that there was no physician order to discharge Resident 1. LPN-A further confirmed Resident 1 was discharged . LPN-A also confirmed and order should have been recieved prior to Resident 1's discharge. An interview on 4/17/24 at 2:00 PM with the Director of Nursing and Administrator confirmed that Resident 1 was discharged to another facility and a discharge order from the Physican for Resident 1 could not be located, and a discharge order from the Physican should of been done. Administrator confirms that the facility is unable to locate a policy on physican's orders at this time.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview; the facility failed to notify APS (Adult Protective Services) within 2 hours of serious bodily injury from a fall for 1 (Resident 3) of 3 sampled residents and failed to submit an investigation to the State Agency within 5 working days of a serious bodily injury from a fall for 1 (Resident 3) of 3 sampled residents and an investigation for an injury of Unknown Origin for 1 (Resident 2) of 3 sampled residents. The facility census was 30. Findings are: A. A record review of Resident 3's Medical Diagnosis revealed Resident 3 was admitted on [DATE] with the diagnoses of end stage renal disease (the kidneys no longer work requiring dialysis), chronic pancreatitis (inflammation of the pancreas), severe protein-calorie malnutrition, and weakness. A record review of Resident 3's Progress Note dated 4/7/2024 revealed the resident was sent to the emergency room at 6:15 AM following a fall in [gender] bathroom. The resident returned to the facility at 9:45 AM with 4 staples to a head laceration from the fall. A record review of Resident 3's Fall with an Injury report indicated APS was notified of the fall with injury on 4/8/2024 at 9:24 AM by the Administrator (ADM) by phone. A record review of a Fax Cover Sheet dated 4/15/2024 at 2:39 PM indicated that was the date time the report was submitted by the facility to the State Agency for Resident 3. An interview on 4/16/2024 at 12:05 PM with the ADM confirmed that APS was not notified within 2 hours of known injury from a fall and should have been reported to the State Agency by 4/12/2024. B. A record review of Resident 2's Medical Diagnosis revealed Resident 2 was admitted on [DATE] with diagnoses of alcohol abuse, cellulitis (infection of the skin) to lower legs, severe protein-calorie malnutrition , and pressure ulcer to the sacrum (open wound to lower spine). A record review of Resident 2's Injury of Unknown Origin report dated 3/31/2024 indicated the resident was sent to the emergency room at 1:30 AM for symptoms of pain, cold fingertips and cyanotic (blue) nailbed, cold and purple toes and gray skin to face. While in the emergency room it was discovered that the resident had an orbital (bones around the eye) fracture. The report further indicated the resident had slid out of her recliner onto the floor on 3/28/2024. The resident had denied hitting their head. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a Fax Cover Sheet dated 4/8/2024 at 2:28 PM indicated that was the date time the report was submitted by the facility to the State Agency for Resident 2. An interview on 4/16/2024 at 12:05 PM with the ADM confirmed that the State Agency should have been notified of the injury by 4/5/2024. An interview on 4/16/2024 at 1:15 PM with LPN-A regarding falls with injury revealed that the nurse calls the ADM so [gender] can call it in to APS. LPN-A stated the nurses do not call in the injuries to the State Agency. LPN-A stated a fall with a serious injury must be called within 2 hours. An interview on 4/16/2024 at 1:20 PM with LPN-B regarding falls with injury revealed that [gender] would call the DON (Director of Nursing) or the ADM so they could call APS. LPN-B thought this should be done within 24 hours. A record review of the facility policy Abuse, Neglect and Exploitation dated 9/22/22 stated: VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, APS and to all other required agencies within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The administrator will follow up w/ government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271 Licensure Reference Number 175 NAC 12-006.05(5) Based on record review and interviews the facility failed to complete a discharge summary for 1 (Resident 1) of 3 sampled residents. The facility census was 30. Findings are: A record review of Resident 1's Admission record revealed Resident 1 was admitted on [DATE] with the admitting diagnosis of sepsis(a serious condition in which the body responds improperly to an infection). A record review of Resident 1 Progress notes dated 9/24/23 revealed that Resident 1 was discharged on [DATE] to another Nursing home. A record review of Nursing Assessments revealed that there was no discharge summary initiated on or before 9/22/23. An interview on 4/17/24 at 1:30 PM with Social Services (SS)-C confirmed that [gender] starts a discharge plan on admission which consist of goals for Resident 1 wanting to return home. SS-C confirmed that a discharge summary had not been done on discharge for Resident 1 and that a discharge summary should of been done. An interview on 4/17/24 at 2:00 PM with Director of Nursing (DON) and Administrator confirmed that Resident 1 was discharged to another facility and that the DON or Administrator could not locate a Discharge Summary for Resident 1 and that a Discharge Summary should of been done. A record review of the undated Discharge Summary Policy revealed that: Compliance Guidelines: 1) Upon discharge of a resident (other than in emergency to hospital or death) a discharge summary will be provided to the receiving care provider at the time the resident leaves the facility. The discharge summary should include: A) A recapitulation of the residents stay that includes, but is not limited to diagnoses, course of illness/treatment or therapy, and include any pending lab results. B) A final summary of the residents status which includes items from the resident's most recent comprehensive assessment which would include cognitive pattern, nutritional status, communication, skin conditions, medications and documentation of participation in assessment.