

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Hemingford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Donald Avenue Hemingford, NE 69348	
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record review and interview, the facility failed to submit an accurate investigation report to the state agency following an elopement for 1 (Resident 1) of 2 sampled residents. The facility census was 25.</p> <p>The Findings Are:</p> <p>A record review of a facility provided document titled New Investigation Report revealed that the Director of Nursing (DON) submitted an investigation report to the State Agency on 7/11/24 regarding the elopement of Resident 1. The report stated that the facility called the incident in to Adult Protective Services (APS) on 7/6/24 at 9:32 PM, and that the facility administrator was notified of Resident 1's elopement on 7/6/24 at 6:57 PM. In the section labeled Describe the incident, the document stated that Resident 1's elopement occurred on 7/6/24 at 6:57 PM and that the NHA (Nursing Home Administrator) was notified of the incident on 7/5/24 around 5:12 PM. In the Outcome of the Facility Investigation section, the document stated that Resident 1 had been outside the facility from approximately 5:37 PM or 5:39 PM until Resident 1 returned indoors with the DON at around 6:05 PM.</p> <p>An interview on 7/16/24 at 9:00 AM with the DON confirmed that in the report the facility submitted to the State Agency on 7/11/24 regarding Resident 1's elopement on 7/5/24, there were several inconsistencies. The inconsistencies were:</p> <ul style="list-style-type: none"> -Resident 1's elopement occurred on 7/5/24, not on 7/6/24 as documented in the report. -APS was notified of the elopement on 7/5/24, not on 7/6/24 as documented in the report. -The facility administrator was notified of the elopement on 7/5/24 at 7:17 PM, not on 7/6/24 at 6:57 PM or on 7/5/24 at 5:12 PM as documented in the report. -The resident returned to the facility on [DATE] with the DON at 7:05 PM, not at 6:05 PM as documented in the report. 		

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 - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263</p> <p>Licensure Reference Number 175 NAC 12-006.09(l)(i)(3)</p> <p>Based on record review and interview, the facility failed to implement interventions to prevent elopements for 1 (Resident 1) of 2 sampled residents. The facility census was 25.</p> <p>The Findings Are:</p> <p>A record review of facility policy Wandering and Elopements with revision date of March 2019, revealed that if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. The policy did not contain information regarding implementing new interventions after an elopement occurred and did not contain examples of interventions that could be put into place if a resident was at risk for wandering or elopements.</p> <p>A record review of Resident 1's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 3/12/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3/15, which indicated the resident had severe cognitive impairment. The MDS also revealed that the resident wandered daily and had diagnoses of non-Alzheimer's dementia and a personal history of traumatic brain injury.</p> <p>A record review of Resident 1's Elopement Risk Scale assessment dated [DATE], revealed the resident was at risk for elopement/wandering and that the following interventions were implemented:</p> <ul style="list-style-type: none"> -Exit Alarms, -Behavior Logs, -Pharmacy Reviews of Medication, -Activities, -Personalization of room with familiar objects and pictures, and -Photograph in the elopement book <p>The assessment also revealed that the resident's care plan had been updated.</p> <p>A record review of Resident 1's MDS dated [DATE] revealed the resident had a BIMS score of 4/15, which indicated the resident had severe cognitive impairment, and that the resident wandered daily.</p> <p>A record review of Resident 1's Care Plan Conference Summary dated 5/28/24, revealed that the resident would occasionally make statements about leaving the facility due to their spouse not calling or visiting.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 1's progress note dated 5/30/24 revealed the resident was moved to the main side of facility as the resident was not an elopement risk.</p> <p>A record review of Resident 1's census report revealed that the resident was moved from the facility's Memory Care Unit to the 200 hall, which is not a locked unit, on 5/30/24.</p> <p>A record review of Resident 1's progress note dated 6/2/24 revealed that the resident had asked the staff how to leave the facility as Resident 1 was frustrated with staff waking the resident during the night to go to the bathroom. The progress note also stated the resident was re-directed and did not seem to be exit-seeking.</p> <p>A record review of Resident 1's progress note dated 6/3/24 revealed that the resident became agitated toward the end of cares being provided and was asking staff if they would help the resident to leave this place.</p> <p>A record review of Resident 1's MDS dated [DATE] revealed the resident had a BIMS score of 4/15, which indicated the resident had severe cognitive impairment, and that the resident wandered daily.</p> <p>A record review of Resident 1's Treatment Administration Record (TAR) for June 2024 revealed that on 6/10/24 on the 6 AM-6 PM shift, the resident had exhibited behaviors of exit-seeking/trying to get others to leave with them and having delusions.</p> <p>A record review of Resident 1's progress note dated 6/15/24 revealed the resident was wandering in the halls during the night.</p> <p>A record review of Resident 1's progress notes dated 7/5/24 revealed at 6:57 PM, Resident 1 was observed by facility staff sitting in their wheelchair at a park in a gazebo across the street from the facility. When asked why they were outside, Resident 1 stated they felt threatened because I just transferred here from [NAME], and they were trying to give me a lot of pills. The progress note also stated that every 15-minute safety checks were implemented for the resident. At 9:56 PM, the resident's every 15-minute safety checks were decreased to hourly.</p> <p>A record review of a facility document titled 15-minute checks revealed that Resident 1 was on 15-minute checks from 7/5/24 at 7:15 PM until 7/5/24 at 11:45 PM. The resident was on hourly checks from 7/5/24 at 11:45 PM until 7/8/24 at 5:45 PM, when the safety checks were discontinued.</p> <p>A record review of Resident 1's care plan revealed a new focus area was initiated on 7/5/24 for elopement. The goal, also initiated on 7/5/24, stated the resident would not leave the facility unattended through the review date. The following interventions were also initiated on the care plan for this focus area:</p> <p>-7/5/24: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers one on one conversation.</p> <p>-7/5/24: Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7/5/24: Monitor location every 15-minutes for safety while awake. Decrease to every hour while asleep. 7/6/24: If resident makes no attempt to exit seek, may D/C safety checks.</p> <p>-7/11/24: Provide a home like environment.</p> <p>-7/6/24: Resident's picture and face sheet placed in the Elopement Risk Book</p> <p>-7/6/24: Utilize behaviors logs.</p> <p>A record review of Resident 1's Elopement Risk Scale assessment dated [DATE] revealed the resident was at risk for elopement and that the following interventions were in place:</p> <ul style="list-style-type: none"> -Behavior Logs, -Activities, -Personalization of room with familiar objects and pictures, and -Photograph in the elopement book <p>The assessment also revealed that the resident's care plan had been updated.</p> <p>A record review of Resident 1's progress notes dated 7/7/24 revealed that the resident had increased confusion and had wandered toward the front entryway of the facility three times that day but was redirected.</p> <p>An interview on 7/15/24 at 2:50 PM with NA-A revealed that an intervention of 15-minute safety checks, then hourly safety checks had been implemented following Resident 1's elopement from the facility on 7/5/24, but that these had been discontinued. NA-A was not aware of any other interventions that were in place to prevent Resident 1 from eloping from the facility.</p> <p>An interview on 7/16/24 at 9:00 AM with the Director of Nursing (DON) confirmed that Resident 1 had resided within the facility's Memory Care Unit (MCU) until 5/30/24, when the resident was moved to the 200 hallway of the facility. The DON stated Resident 1 was moved off of the MCU because the facility had made the determination, through observations by the nursing staff, that the resident was no longer at risk for elopement. The DON confirmed that the resident would make comments at times about leaving the facility, but that the resident would not actively exit-see, and that the comments were due to the resident feeling their spouse had forgotten about them. The DON revealed that the hourly safety checks were discontinued for Resident 1 on 7/8/24 as it was determined that the resident was no longer actively exit-seeking. The DON confirmed that the elopement focus area of Resident 1's care plan was newly implemented following Resident 1's elopement on 7/5/24, and that besides the safety checks, which were discontinued on 7/8/24, there were no interventions in place that would prevent the resident from being able to elope from the facility.</p>		