STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E173	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Square	1621 Front Street Henderson, NE 68371

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 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** Licensure Reference Number 175 NAC 12-006.02(H)Based on interviews and record review, the facility failed to report an incident related to elopement to Adult Protective Services (APS) and to the Department of Health and Human Services (DHHS) within the required timeframe for 1 (Resident 1) of 3 sampled residents. The facility census was 37.Findings are:Record review of the facility's undated algorithm titled Elopements, revealed to complete an incident report, a detailed notation in the resident's medical records after the resident is found and then to send the complete investigation to DHHS Investigations.Record review of Resident 1's progress notes dated 10/13/2025 revealed the Resident was found outside the building.Record review of the facility's reportable investigations for the past 12 months did not reveal any elopements.Record review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 7/23/2025 revealed that the resident originally admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function score of 4), which indicated severe cognitive impairment, and a history of wandering.During an interview on 10/20/25 at 2:53 PM the Assistant Administrator confirmed that the elopement was not investigated or reported because (gender) did not think it was an elopement and there was no assessment completed on the resident because there was no visible injury.During an interview on 10/20/25 at 3:11 PM the Director of Nursing was unaware of how long the resident was outside unattended, it was also confirmed that the resident should not be outside unattended.During an interview on 10/20/2025 at 5:01 PM the Administrator confirmed that the elopement was not reported to the State Agencies and it should have been.

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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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** Licensure Reference Number 175 NAC 12-006.02(H)Based on interviews and record reviews, the facility failed to thoroughly investigate an incident related to elopement for 1 (Resident 1) of 3 residents sampled. This had the potential to affect 6 residents identified as at risk for elopement. The facility census was 37 at the time of the survey.Findings are:Record review of the facility's undated policy titled Elopement Facility Wide revealed the definition of elopement as any resident who has left the campus without informing a member of the staff or a resident who is found in a location off campus that is not planned.Record review of the facility's undated algorithm titled Elopements, revealed to complete an incident report and a detailed notation in the resident's medical records after the resident is found.Record review of the facility's reportable investigations for the past 12 months did not reveal any elopements.Record review of Resident 1's progress notes dated 10/13/2025 revealed the Resident was found outside the building.Record review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 7/23/2025 revealed that the resident originally admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 4, which indicated severe cognitive impairment, and a history of wandering.Record review of Resident 1's Comprehensive Care Plan (CCP - written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) revealed:-Focus dated last revision on 12/3/2021 that the resident has impaired cognitive function related to a diagnosis of dementia.-Intervention with a date initiated of 4/15/2024 that the resident has a Wanderguard (an alarm system that allows facilities to monitor exit doors to prevent wandering or high risk residents from leaving the facility without assistance). Record review of Resident 1's Wandering Risk Scale dated 7/25/25 revealed the resident has a diagnosis of dementia, is ambulatory, and has verbalized wanting to go home or to leave the facility. This Wandering Risk Scale also revealed a score of 14, which indicated a High Risk to wander.During an interview on 10/20/025 at 9:10 AM the Activities Coordinator confirmed that on the morning of 10/13/2025 Resident 1 was walking down the sidewalk next to the building and (gender) redirected the resident back inside. It was also confirmed that the resident should not be outside unattended.During an interview on 10/20/25 at 10:55 AM the Plant Operations Director confirmed that if the WanderGuard malfunctions, there is no way to keep the resident safe from elopement, and if a resident got outside unattended the doors would lock and they could not get back in.During an interview on 10/20/25 at 2:53 PM the Assistant Administrator confirmed that the elopement was not investigated because (gender) did not think it was an elopement and there was no assessment completed on the resident because there was no visible injury.During an interview on 10/20/25 at 3:11 PM the Director of Nursing was unaware of how long the resident was outside unattended, it was also confirmed that the resident should not be outside unattended.During an interview on 10/20/2025 at 5:01 PM the Administrator confirmed that the elopement was not investigated and it should have been.

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)Based on record review and interview, the facility failed to prevent an elopement which had the potential to cause harm on one resident (Resident 1) out of three residents sampled. This had the potential to affect six residents identified at risk for elopement. The facility census was 37. Findings:The facility was notified on 10/20/2025 at 5:02 PM of an Immediate Jeopardy (IJ represents a situation in which noncompliance by the facility has placed the health and safety of the residents in its care at risk for serious injury, serious harm, serious impairment, or death) which began on 10/13/2025. The IJ was removed on 10/20/2025 at 8:00 PM, as confirmed by the surveyor's onsite verification.A record review of the facility's undated Elopement Facility Wide policy revealed:- -Elopement is defined as any resident/patient who has left the campus without informing a member of the healthcare staff or a resident/patient who is found off campus that is not indicated or planned for. - -Staff will be knowledgeable regarding elopement procedures. A record review of the undated Facility's WanderGuard System Policy (an electronic system used in nursing homes to prevent residents with dementia [a syndrome characterized by a progressive decline in cognitive functions], Alzheimer's [a progressive and fatal brain disorder that causes gradual decline in cognitive abilities], or other cognitive impairments from wandering off and becoming lost or injured) revealed:- - Elopement defined as a resident who is cognitively impaired or otherwise at risk leaves a safe area or the facility without staff awareness and/or without necessary supervision. - - Documentation must include the elopement risk results, date and number on WanderGuard bracelet issued, system testing and results, and any incident, malfunctions, or corrective actions taken. A record review of the facility's Clinical Census revealed Resident 1 was admitted on [DATE]. A record review of the facility's Medical Diagnosis form with a print date of 10/20/2025 revealed Resident 1 had a diagnosis of Dementia with mood disturbance. A record review of Resident 1's Minimum Data Set (MDS, this comprehensive assessment evaluates each resident's functional capabilities) dated 7/23/2025 revealed a brief interview for mental status (BIMS a brief screener that aids in detecting cognitive impairment) score of four which indicated the resident had severe cognitive impairment. A record review of Resident 1's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) with an admission date of 10/18/2021 and a revision date of 12/3/2021, included a focus area of impaired cognitive function relating to a diagnosis of Dementia. An intervention included checking WanderGuard function every shift. This intervention was last updated on 1/17/2025. No other interventions relating to exit seeking or elopement risk were identified. A record review of the facility's Wandering Risk Scale dated 7/25/2025 revealed Resident 1 was identified as a high risk to wander (the act of a resident moving from place to place with or without a specific direction or purpose, that may or may not be aimless and could be a safety concern), and had wandered/exit seeking behaviors in the past month. A record review of the facility's Wandering Risk Scale dated 10/17/2025 revealed Resident 1 was identified as a high risk to wander. A record review of the facility's Incident Report Summary dated October 2025, revealed Resident 1 had an equipment failure on 10/13/2025 at 8:03 AM. The description of the event included: - - Staff member observed Resident 1 exiting the building and then immediately notified the Activity Coordinator (AC) who assisted Resident 1 back into the building. - - Resident 1 remained on facility property. - - Resident 1's WanderGuard checked at 7:04 AM and was working. - - Resident 1's WanderGuard checked at 8:30 AM and was no longer working. - - Registered Nurse- A (RN-A) replaced Resident 1's WanderGuard at 8:30 AM. - - Resident 1 was safely maintained. A record review of the facility's 24-Hour Report Sheet dated 10/13/2025 between the hours of 5:30 AM and 2:00 PM revealed no information regarding Resident 1 attempting to leave the facility or of equipment malfunction. A record review of the facility's 24-Hour Report Sheet dated 10/20/2025 revealed Resident 1 had an increase of exit seeking and trying to get out all night. A record review of the facility's undated Aide Care Plan (an informational document used by the nurse aides to assist in the care of the residents) revealed Resident 1 had a WanderGuard. No information regarding attempting to leave the facility or of equipment failure. A record review of a facility email dated 10/13/2025 at 1:06 PM revealed the Director of Nursing (DON) communicated information regarding charging the WanderGuard checking device (a handheld device used to test the WanderGaurd bracelets and door monitors). No information regarding Resident 1 attempting to leave the facility or equipment malfunction was located. During an interview on 10/20/2025 at 9:10 AM

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Licensure Reference Number 175 NAC 12-006.07ABased on interviews and record review, the facility administrator failed to ensure the Quality Assessment and Assurance (QAA) committee included all of the required members. This had the potential to affect all of the residents in the facility. The facility census was 37 at the time of the survey.Findings are:Record review of the facility's Quality Assurance (QA) meeting records revealed no evidence of the facility's Medical Director had participated in the quarterly QA meetings in the facility for the past 4 quarters on December 17, 2024, March 18, 2025, June 17, 2025, and September 16, 2025.During an interview on 10/23/2025 at 10:28 AM the Assistant Administrator confirmed there was no documentation that the facility's Medical Director had participated in the quarterly QA meetings in the long term care facility and it was further confirmed that on March 18, 2025 the facility Director of Nursing services and the Administrator were not in attendance of the QA meeting. During an interview on 10/23/2025 at 10:58 AM the facility's Administrator confirmed that (gender) and the facility's Medical Director did not attend the quarterly QA meetings in the long term care facility and should have.