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	09/04/2024

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 12-006.05(S) Based on observation, record review, and interview the facility failed to ensure that the rights of facility residents were maintained for 14 residents (14, 2, 27, 30, 22, 19, 15, 1, 18, 9, 134, 26, 8, and 3). The facility census was 32. Findings are: A. Record review of the undated facility Admission Agreement revealed the section titled Rules and Regulations. The section revealed that the resident agrees to follow the rules, regulations and guidelines for residents which are included in the Resident Policies. The resident has the right to voice concerns (grievances) about the care or treatment to the administrator and to expect a response. Resident acknowledges receipt of the Resident Rights. The section titled Facility's Grievance Procedure revealed that if a resident or resident representative believes that the resident is being mistreated in any way or resident rights have been or are being violated by staff or another resident, the resident or resident representative shall make a complaint to the facility's Director of Nursing, Administrator, or Director of Social Services. The facility will review and investigate the complaint and provide a response to the resident and/or resident representative. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Resident Rights dated 2023 revealed that state and federal law define rights within a nursing facility to protect the potentially vulnerable people who live in a nursing facility. The resident has the right to be treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The nursing facility must protect and promote the rights of the resident. The resident has the right to receive visitors of his or her choosing, subject to the resident's right to deny visitation, and in a manner that does not impose on the rights of another resident. The resident has the right to personal privacy including accommodations. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The nursing facility must provide a safe, clean, comfortable, and homelike environment. The nursing facility must exercise reasonable care for the protection of the resident's property from theft or loss. The nursing facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, establish policies and procedures to investigate any such allegations, and include training. Record review of the Admission Record dated 8/29/24 for Resident 6 revealed that Resident 6 admitted into the facility on [DATE]. Diagnoses included Vascular Dementia with behavioral disturbance (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain); Unspecified Dementia with other behavioral disturbance (a non-specific dementia with behaviors that can include impaired concentration, apathy (lack of feeling or emotion), anxiety, and agitation); and Anxiety. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 6/19/24 for Resident 6 revealed that the Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) could not be completed for Resident 6. The MDS revealed that Resident 6 is rarely or never understood. Resident 6's cognitive skills for daily decision making are moderately impaired. The behavior section of the MDS assessment revealed that Resident 6 has a behavior of wandering. The assessment revealed that Resident 6's wandering significantly intrudes on the privacy or activities of others. Record review of the Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for Resident 6 dated 8/28/24 revealed that Resident 6 is able to transfer and walk independently. The care plan revealed that Resident 6 has impaired cognitive function and decision making skills due to dementia and has behaviors of wandering and exit seeking. Interventions included: -Be aware of Resident 6's whereabouts. Resident 6 may wander any time of the day or night but tends to wander more in the afternoon or evening. Distract Resident 6 from wandering by offering toileting, food/fluid, rest, TV show in family room. Initiated 12/29/2014 with revision on 7/15/24. -Document behaviors and attempted diversional interventions in the behavioral book along with a progress note. Initiated 7/15/24. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 6 requires approaches that limit choices. Present just one thought, idea, question, or command at a time. If Resident 6 becomes agitated, leave Resident 6 alone if safe to do so and attempt interaction at a later time. Switch out staff if needed. Initiated 12/29/2014 with revision on 7/15/24. -Staff to monitor for possible interactions between Resident 6 and Residents 2 and 15. (discharged residents from room [ROOM NUMBER] and room [ROOM NUMBER] were also listed in the intervention). Staff to provide early interventions as soon as possible including redirection, distraction and/or remove Resident 6 from the situation and take to an alternate location. Intervene as necessary to protect the rights and safety of both Resident 6 and other residents. Approach Resident 6 from the front and speak in a calm manner. Initiated 7/15/24. Record review of the progress note for Resident 6 dated 12/5/23 at 7:09 PM revealed that Resident 6 was repeatedly entering other resident's rooms. Staff attempted to redirect Resident 6 out of resident rooms and Resident 6 continued to roam. Resident 6 entered the room of Resident 14 and took decorations from the room. Record review of the progress note for Resident 6 dated 12/5/23 at 8:21 PM revealed that a staff member saw Resident 6 take down the stop sign outside the room door of Resident 2. Resident 6 entered the room of Resident 2. The room door was locked and staff was unable to get Resident 6 out of the room. The staff member ran to get the charge nurse. The charge nurse unlocked the door and entered the room of Resident 2. The charge nurse saw Resident 2 standing by the bed in the room facing Resident 6. Resident 2 was hitting Resident 6 across the arms and chest, screaming at Resident 6 to get out of here. The charge nurse removed Resident 6 from the room and placed the stop sign back across the door to the room of Resident 2. Resident 6 was redirected to another area to do activities, 1 on 1, and have a snack. Record review of the progress note for Resident 6 dated 12/5/23 at 8:52 PM revealed that Resident 6 continued to enter other resident's rooms that were now sleeping. The nurse tried to have Resident 6 sit and watch the television with the nurse. Resident 6 sits but gets back up right away and continues to wander. Resident 6 was opening exit doors and then walking away. Record review of the progress note for Resident 6 dated 12/9/23 at 2:49 PM revealed that Resident 6 was wandering the halls and frequently entering other resident's rooms. Record review of the progress note for Resident 6 dated 12/9/23 at 8:43 PM revealed that Resident 6 was in and out of other resident rooms throughout the shift. Resident 6 started taking other resident's walkers and wheelchairs from their rooms and walking with them down the hallway. Staff tried 1 on 1, giving snacks, activities, watching tv in the living room. All interventions were ineffective. Record review of the progress note for Resident 6 dated 12/10/23 at 9:30 PM revealed that the nurse received complaints from 3 different residents about Resident 6 coming into their rooms and touching things. The nurse did remove Resident 6 from 2 of the rooms as the residents were yelling at Resident 6 loudly enough that the nurse could hear them. Resident 6 had been wandering throughout the facility as per their usual. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress note for Resident 6 dated 12/10/23 at 9:32 PM revealed that the nurse did attempt to redirect Resident 6 from wandering in and out of rooms this evening as residents are wanting their doors locked to keep Resident 6 out. Record review of the progress note for Resident 6 dated 12/26/23 at 7:30 PM revealed that Resident 6 wandered into the room of Resident 2. Resident 2 yelled at Resident 6 and Resident 6 did not leave the room. Resident 2 cornered Resident 6 and started punching Resident 6 in the chest. Staff separated the residents and Resident 6 was removed from the room of Resident 2. Record review of the progress note for Resident 6 dated 12/30/23 at 1:34 AM revealed that Resident 6 wandered into other resident rooms until Resident 6 went to bed around 10:00 PM. Several residents yelled at Resident 6. The nurse tried to redirect Resident 6 but Resident 6 was very hard to redirect. Record review of the progress note for Resident 6 dated 12/31/23 at 8:48 PM revealed that Resident 6 has continued to roam the building. Resident 6 continued to go into resident's rooms that have their doors shut and are sleeping. Staff has tried several attempts to redirect Resident 6 to anther activity. Resident 6 will not redirect. Staff have tried television shows, food, and having Resident 6 sit with them and Resident 6 would not do so. Record review of the progress note for Resident 6 dated 1/14/24 at 7:28 PM revealed that Resident 6 was in and out of resident rooms moving things and startling people. Resident 6 removed a family quilt from the room of Resident 27. Resident 27 was upset and the nurse tried to remove Resident 6 from the room of Resident 27 three times in the past 1.5 hours. Interview on 8/29/24 at 10:00 AM with Resident 27 revealed that Resident 27 gets irritated with Resident 6 coming into their room. Resident 27 revealed that staff have to remove Resident 6 from the room. Resident 27 revealed that Resident 6 keeps coming into their room and Resident 27 does not like it. Record review of the progress note for Resident 6 dated 1/17/24 at 8:05 PM revealed that Resident 6 was wandering into other resident rooms constantly this evening and was unable to be redirected. Resident 6 had been removed from rooms 15, 13, 18, 19, 20, 21, 4, 6, and 8 in the last 2 hours. That did not count the rooms on the other side ([NAME] Hills unit) or the other staff removing Resident 6 from rooms. The residents are very frustrated and some yell at Resident 6. Resident 6 does not redirect. Record review of the progress note for Resident 6 dated 2/3/24 at 2:16 PM revealed that Resident 6 had entered several other resident rooms and had been picking up their mail. Staff has redirected Resident 6 several times. Record review of the progress note for Resident 6 dated 2/6/24 at 7:52 PM revealed that Resident 6 entered the room of Resident 30 and took that resident's personal folding chair. Resident 6 drug the chair out of the room and placed it in the hallway. Resident 30 was very upset and said we shouldn't have people like Resident 6 in here. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress note for Resident 6 dated 2/7/24 at 8:32 PM revealed that Resident 6 entered the room of Resident 30 and pushed a dining room chair into the room of Resident 30. Resident 30 was greatly upset. Resident 30 called and complained saying this is not the place for Resident 6. Interview on 8/29/24 at 9:30 AM with Resident 30 revealed that Resident 6 comes into their private room unannounced. Resident 30 explained that when Resident 6 came into their room one evening, Resident 6 threw their chair into the hallway, threw their pillows on the floor, then stood in their shower. Resident 30 revealed that they are not comfortable when Resident 6 enters their room. Resident 30 revealed that they must yell for a staff person to come in and get Resident 6 when it occurs. Record review of the progress note for Resident 6 dated 2/13/24 at 8:58 PM revealed that Resident 6 wandered in and out of resident rooms tonight. Two residents yelled at Resident 6 before staff were able to remove Resident 6 from their rooms. Resident 6 is becoming harder to redirect and gets visibly agitated when staff try to remove Resident 6 from other rooms. Resident 6 was in rooms 21, 20, 19, 14, 13, and 4 that the nurse had noticed tonight so far. Record review of the progress note for Resident 6 dated 3/10/24 at 8:20 PM revealed that Resident 6 had wandered the halls this evening entering multiple rooms. Resident 6 entered the room of Resident 22. Resident 22 is almost blind. Resident 6 took Resident 22 by the hand and was literally pulling Resident 22 down the hallway as Resident 22 tried to resist. The nurse intervened and took Resident 22 back to their room. The nurse tried to redirect Resident 6. Record review of the progress note for Resident 6 dated 3/16/24 at 8:35 PM revealed that Resident 6 was having increased behaviors. Resident 6 walked the halls taking off their top and then continued to get naked. Staff intervened. Resident 6 went into another resident's room several times setting of the resident's motion alarm and scaring the resident. Resident 6 went into another resident's room. The other resident was sleeping. Resident 6 walked over to the recliner and pulled their pants down and tried to urinate on the recliner. Staff removed Resident 6 from the room. Record review of the progress note for Resident 6 dated 3/28/24 at 9:35 PM revealed that Resident 6 had been wandering throughout the facility and in and out of multiple resident rooms walking in on residents in various stages of undress, upsetting them. Resident 6 is unable to be redirected and the behavior continues throughout the shift. Record review of the progress note for Resident 6 dated 4/3/24 at 6:30 PM revealed that Resident 6 entered the room of Resident 2. A nurse aide heard Resident 2 yelling. The nurse aide entered the room of Resident 2 to find Resident 2 with one hand around Resident 6's throat and slapping Resident 6 across the face with the other hand while yelling at Resident 6. Resident 6 backed up into the closet door in an attempt to get away. The nurse aide told Resident 2 to let Resident 6 go. Resident 2 let go of Resident 6 and grabbed onto the nurse aide. The nurse aide pried themselves away from Resident 2 and left the area with Resident 6. The nurse aide placed the stop sign over the door to the room of Resident 2 to deter Resident 6 from reentering the room. Record review of the progress note for Resident 6 dated 4/7/24 at 9:30 PM revealed that Resident 6 wandered the facility this past evening and entered rooms 8, 12 (the room of Resident 27), 13, 15, 19, 20, and 29 that the nurse had witnessed. Resident 6 sat off motion alarms in the room, picked up items, and sat on other resident's beds that upsets them. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress note for Resident 6 dated 4/15/24 at 12:31 PM revealed that Resident 6 was found entering other resident's rooms 3 times this morning. Staff were able to redirect Resident 6 out of the other resident's rooms. Record review of the progress note for Resident 6 dated 4/25/24 at 8:03 PM revealed that the nurse heard Resident 19 screaming get out of here. The nurse entered the room of Resident 19 and found Resident 6 in the room. The nurse escorted Resident 6 from the room and redirected Resident 6. Record review of the progress note for Resident 6 dated 4/26/24 at 10:22 PM revealed that Resident 6 had been going in and out of rooms all evening. Resident 6 was taking things out of resident rooms like pillows and water pitchers. Resident 6 entered the room of Resident 19 and broke off leaves from Resident 19's plant and took Resident 19's candy. Record review of the progress note for Resident 6 dated 5/11/24 at 3:00 PM revealed that Resident 6 was in and out of other resident's rooms continually today. At one point, Resident 6 could not be found, and Resident 6 was sitting in another resident's recliner. Resident 6 was continually redirected out of rooms. Attempted to distract Resident 6 with TV and 1 on 1 interaction. Record review of the progress note for Resident 6 dated 5/19/24 at 10:05 PM revealed that Resident 6 wandered the halls with their walker this evening. Resident 6 entered various resident's rooms and was difficult to redirect. Resident 6 was ramming their walker into staff as they attempted to direct Resident 6 out of the room. It took various staff to redirect Resident 6 out of rooms. Record review of the progress note for Resident 6 dated 6/8/24 at 2:53 PM revealed that staff found Resident 6 sitting on the bed of another resident in room [ROOM NUMBER]. Resident 6 had knocked the phone off the hook. Record review of the progress note for Resident 30 dated 6/8/24 at 6:19 PM revealed that Resident 30 requested that their door remain locked throughout the evening as Resident 6 had entered their room. Resident 6 had squeezed themselves between the bed and the window of Resident 30's room. Resident 30 explained to the nurse at the time that Resident 6 entered the room and shut the door behind them, so when Resident 30 yelled for help, no one could hear. Resident 30 stated I was pretty scared. Record review of the progress note for Resident 6 dated 6/17/24 at 4:44 PM revealed that Resident 6 was entering other resident's rooms and taking items. Resident 6 was hard to redirect out of rooms and to give other resident's items back to the owners. Record review of the progress note for Resident 6 dated 7/14/24 at 10:31 PM revealed that Resident 6 wandered the halls this evening. Resident 6 had been taking the stop signs from resident room doors and attempting to enter other resident's rooms. When staff tried to intervene and redirect, Resident 6 pushed their walker into staff. Staff heard the alarm sound in the room of Resident 15. Staff entered the room and observed Resident 6 sitting on Resident 15's bed on top of Resident 15's legs. Staff was able to get Resident up and off of Resident 15. Record review of the progress note for Resident 6 dated 7/20/24 at 3:00 PM revealed that Resident 6 entered the room of Resident 1 without permission. Resident 1 started yelling at Resident 6 to get out. Staff redirected Resident 6 from the room and locked the door to the room of Resident 1 at the request of Resident 1. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress note for Resident 6 dated 7/30/24 at 9:13 PM revealed that Resident 6 had been wandering about the facility this evening. Resident 6 was removed from rooms [ROOM NUMBER]. Resident 6 had been redirected from entering other rooms as well. Record review of the progress note for Resident 6 dated 8/10/24 at 4:02 PM revealed that Resident 6 had entered several other resident's rooms and has been difficult to redirect. Staff have offered Resident 6 food and fluids. Record review of the progress note for Resident 6 dated 8/18/24 at 5:03 PM revealed that Resident 6 wandered the hallways this afternoon. Resident 6 was banging on the exit door and staff was able to redirect the resident. Resident 6 entered several resident's rooms. Resident 6 opened the closet in one room. Resident 6 pushed a folding chair out of another room. Observation on 8/28/24 at 1:35 PM revealed that Resident 6 walked from the Palm Springs unit down the north hall past room [ROOM NUMBER]. Resident 6 continued through the north hall and continued to the exit door at the west end of the north hall. Resident 6 went to the door keypad and rubbed the left hand over the keypad 4 times. Resident 6 then turned around and walked down the west hallway past rooms 35 through 38. Resident 6 turned around and walked through the [NAME] Hills unit living room and stopped at the kitchen. Licensed Practical Nurse-C (LPN-C) approached Resident 6 and asked Resident 6 to follow LPN-C. Resident 6 followed LPN-C past rooms 28 through 23 and entered the Palm Springs unit. Resident 6 went to the door of the room of Resident 2. Resident 6 grabbed the door handle to open the door. LPN-C was approximately 10 feet past the room door. LPN-C turned around and redirected Resident 6 away from the room of Resident 2. LPN-C continued to have Resident 6 follow LPN-C to the Palm Springs unit living room. Record review of the progress note for Resident 6 dated 8/28/24 at 3:16 PM revealed that Resident 6 had wandered the hallways with their walker this morning. Interview on 8/29/24 at 9:58 AM with Resident 18 revealed that there are two residents that enter their private room. Resident 18 revealed the two residents either don't realize it or they just enter when no one lets them in. Resident 18 revealed it is Resident 6 and Resident 28, explaining, I told the head authority about the situation; however, it continues to happen. Resident 18 explained that they are afraid that those two residents might get COVID, because Resident 18 currently has it. Observation on 8/29/24 at 12:35 PM on the Palm Springs unit revealed that Resident 6 walked down the east hall. Resident 6 stopped at the room of Resident 134. Resident 6 walked past rooms [ROOM NUMBERS]. Licensed Practical Nurse-E (LPN-E) and the facility Director of Nursing (DON) redirected Resident 6 towards the Palm Springs unit living room. Resident 6 stopped at a chair in the living room and picked up a blanket from the chair. Resident 6 put the blanket back on the chair and then walked into the dining room. Record review of the progress note for Resident 6 dated 8/31/24 at 4:39 PM revealed that Resident 6 had been wandering in the hallways this afternoon and had entered several other resident's rooms. Staff has toileted, offered fluids and foods, and done 1 on 1 to redirect the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/4/24 at 11:46 AM with Nurse Aide-I (NA-I) confirmed that resident complain about Resident 6 going into their rooms. NA-I revealed that Resident 6 usually just wants to look out a window in the rooms. NA-I revealed that all staff are to keep an eye on Resident 6. NA-I confirmed that staff can not keep an eye on Resident 6 at all times. Interview on 9/4/24 at 12:45 PM with the facility Assistant Administrator (ADMIN-B) confirmed that the facility expectation is for resident rights to be upheld. ADMIN-B confirmed that resident rights include privacy and safety. ADMIN-B revealed that the facility has tried interventions to protect the rights of residents including stop signs, locked doors, redirecting, and 1 on 1 activities to keep wandering residents out of other resident's rooms. ADMIN-B confirmed that Resident 6 continues to go into other resident's rooms. ADMIN-B confirmed that it is a concern and that there is a potential for injury with resident to resident confrontations. ADMIN-B confirmed that Resident 6 wandering into other resident's rooms is a violation of their rights. Observation on 9/4/24 at 12:55 PM outside the [NAME] Hills unit dining room revealed that Resident 6 walked past the dining room into the Palm Springs unit. Resident 6 walked to the door of Resident 2. Resident 6 rubbed the door of the room and then turned and walked back to the [NAME] Hills unit. Resident 6 walked down the north hall of the [NAME] Hills unit past the dining room. Resident 6 continued to walk to the west exit door. Resident 6 touched the door and ran their hand along the edge and along the press bar of the door. Resident 6 then turned and walked back down the north hall of the [NAME] Hills unit past the dining room and into the Palm Springs unit. Resident 6 turned and went to the family room on the Palm Springs unit. Resident 6 left the family room and walked into the Palm Springs unit living room. The time was now 1:01 PM. No staff were in the area supervising Resident 6. B. Record review of the Admission Record dated 8/29/24 for Resident 28 revealed that Resident 28 admitted into the facility on [DATE]. Diagnoses included Vascular Dementia and Anxiety. Record review of the MDS assessment dated [DATE] for Resident 28 revealed that Resident 28 was unable to complete the Brief Interview for Mental Status. Resident 28 has a problem with short-term and long-term memory. The MDS revealed that Resident 28 has a behavior of wandering. The assessment revealed that Resident 28's wandering significantly intrudes on the privacy or activities of others. Record review of the care plan dated 8/28/24 for Resident 28 revealed that Resident 28 is independent with transfers. The care plan revealed that Resident 28 has a behavior problem with wandering and resisting cares. Interventions included: -Resident 28 sometimes wanders into other resident's rooms or personal space. Intervene as soon as possible to protect the rights and safety of others. Divert attention. Remove Resident 28 from the situation and take to an alternate location as needed. Initiated 8/5/24 with revision on 8/6/24. -Resident 28 wanders throughout the facility. Identify pattern of wandering. Intervene as appropriate. Distract Resident 28 from wandering by offering food, drink, talking with the resident, TV shows (especially sports shows), toileting, or walking with the resident inside or outside the facility. Initiated 8/5/24 with revision on 8/6/24. (continued on next page)

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	28E173	A. Building B. Wing	09/04/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress note for Resident 28 dated 7/22/24 at 8:53 PM revealed that Resident 28 wandered the facility and staff was unable to settle the resident with multiple attempts to get the resident ready for bed and show the resident their room. All interventions were ineffective. Resident 28 continued to wander and check the exits. Record review of the progress note for Resident 28 dated 7/23/24 at 9:10 PM revealed that Resident 28 had wandered in and out of other resident's rooms tonight. Resident 28 went to the doors and tried to open the outside doors. Resident 28 began to walk faster as Resident 26 yelled at Resident 28. Record review of the progress note for Resident 28 dated 7/24/24 at 7:11 PM revealed that Resident 28 entered the room of Resident 8 (a room on the [NAME] Hills unit). Staff went to remove Resident 28 from the room. Staff told Resident 28 that was not their room. About 2 minutes later, Resident 28 again went into the room of Resident 8. Staff found Resident 28 on the toilet in the room. Staff assisted Resident 28 from the bathroom and back to the Park Place unit where Resident 28's room is located so aides could assist Resident 28 with using the bathroom. Record review of the progress note for Resident 28 dated 7/24/24 at 7:20 PM revealed that Resident 28 had just been toileted successfully by the nurse aide. Resident 28 walked into the room of Resident 15 and had to be led out by staff. Staff found Resident 6's shoehorn in Resident 28's back pocket. Resident 28 has wandered the halls tonight and was redirected multiple times as they wandered. Record review of the progress note for Resident 28 dated 8/6/24 at 4:33 PM revealed that Resident 28 had been redirected out of other resident's rooms. Resident 28 will open the door and enter even if doors are closed. Resident 28 will redirect with encouragement but then repeats the behavior. Record review of the progress note for Resident 28 dated 8/6/24 at 8:25 PM revealed that Resident 28 wandered the halls and was in and out of resident's rooms. Resident 28 was redirected easily but then goes right back in. Resident 28 went and started wandering the [NAME] Hills unit hallway. The fire alarm was activated. Medication Aide-K (MA-K) saw Resident 28 walk to the east exit door and pull the fire alarm. Record review of the progress note for Resident 28 dated 8/7/24 at 8:18 PM revealed that Resident 8 wandered the halls going in and out of other resident's rooms. Resident 28 went into room [ROOM NUMBER] and turned on all the lights, putting tennis shoes in the bathroom, and then setting off the motion alarm. Staff got Resident 28 and took Resident 28 back to their room. Record review of the progress note for Resident 28 dated 8/12/24 at 9:17 PM revealed that Resident 28 had been wandering into the room of Resident 27 multiple times this shift. Record review of the progress note for Resident 28 dated 8/17/24 at 4:54 AM revealed that Resident 28 was found in the room of Resident 27. Resident 28 had set off Resident 27's motion alarm. Resident 28 was wearing Resident 27's hat and sitting on Resident 27's toilet. Resident 28 had turned on th [TRUNCATED]

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 License Reference Number 175 NAC 12-006.10(D) Based on record review, observations, and interviews the facility failed to ensure that the medication error rate was less than 5% for 3 (Resident 3, 14, and 24) of 9 sampled residents. There were 6 errors during the administration of 31 medications which resulted in an error rate of 19.35%. The facility census was 32. Findings are: A. Record Review of Sanofi Kwikpen Instructions for administration of Lantus revised December 2020 while using an injection pen revealed the following: After priming the needle and dialing the correct dosage of insulin: -Insert the needle into the skin. -Deliver the dose by pressing the injection button in all the way until you reach the zero it is injected. - Keep the injection button pressed all the way in. Slowly count to 10 before withdrawing the needle from the skin to ensure the full dose is delivered. -https://products.sanofi.us/lantus/lantus.html Record Review of [NAME] Lilly Instructions for administration of Humalog revised August 2023 while using an injection pen revealed the following: After priming the needle and dialing the correct dosage of insulin: -Insert the Needle into your skin. -Push the Dose Knob (Injection Button) all the way in. -Continue to hold the Dose Knob in and slowly count to 5 before removing the needle from the skin. - https://uspl.lilly.com/humalog/humalog.html#ug4 Record Review of Novo-Nordisk instructions for the administration of Ozempic (semiglutide) revised October 2023 for using the injection pen revealed the following: After priming and dialing the correct dose of Ozempic: (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Press and hold down the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. You may then hear or feel a click. Continue pressing the dose button while keeping the needle in your skin. -Count 6 seconds while keeping the dose button pressed. -If the needle is removed earlier, you may see a stream of OZEMPIC(R) coming from the needle tip. If this happens, the full dose will not be delivered. -https://www.novo-pi.com/ozempic.pdf#guide Record Review of the undated Facility Insulin Pen Administration Policy and procedure revealed insulin will be administered per the package instructions. Should the package instructions not be available the procedure will be followed. In paragraph 3, sentence 4 of the procedures to administer insulin it is stated hold the needle in place for 5 to 10 seconds. Record Review of Resident 3 Physician orders revealed the following orders: 1. Glargine (Lantus) subcutaneously (SQ) (under the skin) insulin pen injector. Give 30 units SQ twice a day. Start date 04/04/2024. 2. Humalog Kwikpen 14 units SQ three times daily. Start date 07/02/2024. 3. Semiglutide Pen Injector inject 0.5 milligrams (mg) SQ every Tuesday morning. Start date 08/19/2024. 4. Artificial Tears Ophthalmic Solution instill one drop in right eye two times a day. Start date 03/29/2024. Observed on 09/03/2024 at 8:20 AM Registered Nurse J (RN-J) administered Lantus insulin to Resident 3 using an insulin pen and did not hold the pen in the skin after pushing the injector button a minimum of 10 seconds. Next RN J gave Resident 3 Humalog insulin and did not leave this needle in the skin for a minimum of 5 seconds after pushing the injector button. Finally, RN J gave Resident 3 semiglutide with an injection pen and did not hold the need in the skin for a minimum of 6 seconds. After completing the injections, RN J gave Resident 3 the Artificial Tears Ophthalmic Solution in both eyes of Resident 3 instead of only in the Right eye as ordered. RN J then charted all the medications in the Electronic Medical Record for Resident 3 onto the September 2024 Medication Administration Record as given. RN J then proceeded to the next resident. Interview on 09/03/2024 at 2:30 PM with RN-J who confirmed that RN-J always just push the injection button of the injection pens and when I reach the zero on the dial, I pull the needle out. RN-J confirmed that is how the injections were given to Resident 3. RN-J admitted not knowing that the pen had to be held in place for a certain length of time when the injection button was pushed. RN-J then confirmed that the eye drops were given to Resident 3 in both eyes, and it was at that time that RN-J rechecked the orders for Resident 3 RN-J confirmed the eye drops were only ordered for the Right eye and not both. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed on 09/03/2024 at 2:37 PM of RN-J who reviewed the medication insert from Glargine (lantus) insulin that belonged to Resident 3 and read the instructions for use of the Sanofi (a brand name) Insulin injection pen. RN-J pointed out that the Glargine insulin needle must be held in the skin for a total of 10 seconds. B. Record Review of Resident 14 Physician orders revealed the following order: 1. Lantus insulin 12 units SQ each morning. Observed on 09/03/2024 at 9:05 AM RN-J administered Lantus insulin via an insulin pen to Resident 14 and did not hold the insulin pen needle in the skin for a minimum of 10 seconds before removing the needle. Interview on 09/03/2024 at 2:30 PM with RN-J who confirmed the needle was not held in place for a minimum of 10 seconds. C. Record Review of National Eye Institute and the National Institute of Health website instructions for administering eye drops. Eye drops prescribed to treat glaucoma or another eye condition must be given correctly so all the medicine gets into your eye. If not used correctly, one could lose ones vision. Follow these steps to put in eye drops: 1. Tilt head back and look up. 2. With 1 hand, pull the lower eyelid down and away from the eyeball - to make a pocket for the eye drop. 3. With the other hand, hold the eye drop bottle upside down with the tip just above the pocket. Squeeze the prescribed number of eye drops into the pocket. For at least 1 minute, ask the resident to their close eye and press a finger lightly on the tear duct (small hole in the inner corner of your eye) - this keeps the eye drop from draining into your nose. 4. https://www.[NAME].nih.gov/Glaucoma/glaucoma-medicines/how-put-eye-drops updated: July 23, 2021 Record Review of Resident 24 Physician orders revealed the following order: 1. Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8 MG/ML (Dorzolamide HCl-Timolol Maleate) Instill 1 drop in both eyes two times a day Observed on 09/03/2024 at 9:32 AM Licensed Practical Nurse E (LPN-E) administered Dorzolamide eye drops to Resident 24. The eye drops were administered in the inner canthus of the eye (Area of the eye nearest the nose and tear duct) and then immediately wiped Resident14 eye with a Kleenex and did not hold pressure at the tear duct. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/2024 2:57 PM Minimum Data Set Coordinator (MDS) confirmed the errors in administration of the medications as described.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 License Reference number 175 NAC 12-006.10 Based on record review, observations and interviews, the facility failed to ensure that residents were free of significant medication errors while administering insulins for 3 (Residents 3 and Resident 14) of 9 sampleted residents. Facility Census was 32. Findings are: A. Record Review of Sanofi Kwikpen Instructions for administration of Lantus revised December 2020 while using an injection pen revealed the following: After priming the needle and dialing the correct dosage of insulin: -Insert the needle into the skin. -Deliver the dose by pressing the injection button in all the way until you reach the zero it is injected. -Keep the injection button pressed all the way in. Slowly count to 10 before withdrawing the needle from the skin to ensure the full dose is delivered. -https://products.sanofi.us/lantus/lantus.html Record Review of [NAME] Lilly Instructions for administration of Humalog revised August 2023 while using an injection pen revealed the following: After priming the needle and dialing the correct dosage of insulin: -Insert the Needle into your skin. -Push the Dose Knob (Injection Button) all the way in. -Continue to hold the Dose Knob in and slowly count to 5 before removing the needle from the skin. -https://uspl.lilly.com/humalog/humalog.html#ug4 Record Review of Novo-Nordisk instructions for the administration of Ozempic (semiglutide) revised October 2023 for using the injection pen revealed the following: After priming and dialing the correct dose of Ozempic: -Press and hold down the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. You may then hear or feel a click. Continue pressing the dose button while keeping the needle in your skin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Count 6 seconds while keeping the dose button pressed. -If the needle is removed earlier, you may see a stream of OZEMPIC(R) coming from the needle tip. If this happens, the full dose will not be delivered. -https://www.novo-pi.com/ozempic.pdf#guide Record Review of the undated Facility Insulin Pen Administration Policy and procedure revealed insulin will be administered per the package instructions. Should the package instructions not be available the procedure will be followed. In paragraph 3, sentence 4 of the procedures to administer insulin it is stated hold the needle in place for 5 to 10 seconds. Record Review of Resident 3 Physician orders revealed the following orders: 1. Insulin Glargine (Lantus) subcutaneously (SQ) (under the skin) insulin pen injector. Give 30 units SQ twice a day. Start date 04/04/2024. 2. Humalog Kwikpen 14 units SQ three times daily. Start date 07/02/2024. 3. Semiglutide Pen Injector inject 0.5 milligrams (mg) SQ every Tuesday morning. Start date 08/19/2024. Observed on 09/03/2024 at 8:20 AM Registered Nurse J (RN-J administered Lantus insulin to Resident 3 using an insulin pen and did not hold the pen in the skin after pushing the injector button a minimum of 10 seconds. Next RN J gave Resident 3 Humalog insulin and did not leave this needle in the skin for a minimum of 5 seconds after pushing the injector button. Finally, RN J gave Resident 3 semiglutide with an injection pen and did not hold the need in the skin for a minimum of 6 seconds. Interview on 09/03/2024 at 2:30 PM with RN-J who confirmed that RN-J always just push the injection button of the injection pens and when I reach the zero on the dial, I pull the needle out. RN-J confirmed that is how the injections were given to Resident 3. RN-J admitted not knowing that the pen had to be held in place for a certain length of time when the injection button was pushed. Observed on 09/03/2024 at 2:37 PM of RN-J who reviewed the medication insert from Glargine (lantus) insulin that belonged to Resident 3 and read the instructions for use of the Sanofi (a brand name) Insulin injection pen. RN-J pointed out that the Glargine insulin needle must be held in the skin for a total of 10 seconds. B. Record Review of Resident 14 Physician orders revealed the following order: 1. Lantus insulin 12 units SQ each morning. Observed on 09/03/2024 at 9:05 AM RN-J administered Lantus insulin via an insulin pen to Resident 14 and did not hold the insulin pen needle in the skin for a minimum of 10 seconds before removing the needle. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/2024 at 2:30 PM with RN-J who confirmed the needle was not held in place for a minimum of 10 seconds.