STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OMAHA	6032 VILLE DE SANTE DRIVE OMAHA, NE 68104

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 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, document review and staff interview, the facility failed to make the most recent certification and licensure survey results available for staff, residents and visitors to review. The facility failure to ensure survey results were available has the potential to affect all residents, staff and visitors. The facility reported a census of 64 residents. Findings are: The lower shelf of a table in the main entry into the facility held a binder labeled, Facility Surveys. Observation of the facility binder on 09/09/20 at 9:30 AM revealed a dark, sticky piece of debris (appeared to be candy) stuck on the first page of the documents. The survey results contained in the binder were dated 06/03/19, 12/12/18, 03/19/18 and 01/11/17. An interview with the Administrator on 09/09/20 at 9:35 AM revealed awareness the most recent survey results were not placed in the binder. The Administrator stated the binder was checked semi-regularly to ensure the binder contained the required documents and ensure the documents were readable but was unable to identify the date the binder was last checked. Observation of the binder on 09/10/20 at 10:00 AM confirmed the facility had failed to place the survey results from 03/16/20, 05/21/20, 07/15/20 and 08/04/20 into the binder for staff, resident and visitor review.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].05(4) Based on record reviews and interviews, the facility failed to ensure that Advance Directives for cardiopulmonary resuscitation reflected the residents' wishes in the Medical Chart and the Electronic Medical Record for 1 of 24 (Resident 18) residents sampled. The facility identified a census of 64 at the time of survey. Findings Are: A record review of the facility policy titled Advance Directives dated [DATE] revealed: Residents may revise an advance directive either orally or in writing. With an oral reversal, charting is due immediately, the physician is notified immediately, an immediate notation is made on the care plan, and an immediate entry is made in the medical record. With written reversals, the physician is notified and the plan is permanently adjusted. The physician must give an order for [REDACTED]. Representative on [DATE]. The paper chart contained a Face sheet indicating Resident 18 as a DNR. The paper medical chart contained orange stickers on the inside divider indicating Resident 18 as a DNR. A review of Resident 18's electronic medical Record (EMR) revealed Resident 18 identified as a DNR on the banner of the EMR. A Review of the current physician orders of Resident 18 revealed an order dated [DATE] indicating OK to intubate. A Review of Resident 18's progress notes dated [DATE] at 14:42 reads: COMMUNICATION - with Family/NOK/POA Note Text: Call placed to POA, Verified Do not intubate, and the order was received by Social Services. A Review of Resident 18's care plan dated [DATE] revealed Resident 18 was indicated as a CPR, Full Code and Code Status would be reviewed on a quarterly and on a as needed basis. The following interviews were conducted between 11:20 and 11:24 on [DATE]; The question asked was; where do you find the code status for a resident? Certified Medication Aide (CMA) B -On the Banner in PCC and in the chart, Code sticker in chart and on Face sheet. CMA B also verified Resident 18 was identified as a DNR on all 3 places. Licensed Practical Nurse (LPN) A -Advanced Directives in chart. CMA C -I guess in the chart, they never told me that. Director of Nursing (DON) -Code Status is in the paper chart. Interview with DON- [DATE] at 12:30 confirmed EMR banner, Paper chart, care plan and physician orders do not match, and should match.
F 0610 **Level of harm** - 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(8) Based on observations, record reviews, interviews and facility policy review, the facility failed to thoroughly investigate an incident where a resident fell out of a mechanical lift requiring an ER visit and resulting in a laceration. This affected 1 of 3 (Resident 117) resident files reviewed for facility reported incidents and had the potential to affect all residents requiring an investigation. The facility census was 64. Findings are: The facility Clinical Services Manual titled, Event Management and Emergency Procedures, in effect at the time of the resident's fall was dated February 2018. The procedure included in part: Neglect - means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Possible indicators of abuse/neglect may include but are not limited to: An injury that is suspicious because the source of injury is not observed, or the extent or location of the injury is unusual. It is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The written summary of the investigation should include, but is not limited to: - A review of the Incident Report - An interview with person(s) reporting the incident - Interviews with any witnesses to the incident - An interview with the resident if appropriate - A review of the resident's medical record - An interview with employee(s), as needed - A review of the employee's file, as needed - Interviews with staff members on all shifts having contact with the resident at the time of the incident - Interviews with the resident's roommate, family, and/or visitors who may have information regarding the incident - Interviews (with) other residents who received care or services from the alleged perpetrator - A review (of) all circumstances surrounding the incident The Event Management and Emergency Procedures, document also indicated a report of abuse/neglect should be submitted to the State Agency within 24 hours of the incident, and the results of the investigation should be submitted within five working days from the date of the incident. Resident 117 was admitted with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment, dated 10/24/19, indicated Resident 117 was moderately cognitively impaired, and required limited to extensive assistance with transfers. The care plan, most recently updated on 12/21/19, revealed the resident was at risk for falls. On 12/21/19, a report was submitted to the State agency by the Director of Nursing (DON) and indicated Resident 117 had fallen from a mechanical lift on 12/21/19 at 6:45 PM. A second report dated 12/30/19, was submitted to the State Agency related to the facility's investigation of a fall with injury for Resident 117. The, Detailed Description of Event, stated that on 12/21/19 at approximately 6:45 PM, Resident 117 was transferred from wheelchair to bed via a mechanical lift with two staff assisting. While being lifted, one corner strap of the sling became disconnected from the lift causing the resident to slide head-first out of the sling. The resident's head hit the floor leg of the lift and the resident sustained [REDACTED]. The family and physician were notified

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

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F 0610 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) of the fall with injury. New orders were received to send the resident to the emergency room (ER) for evaluation and treatment. The resident returned to the facility at approximately 11:30 PM on 12/21/19 with no further injuries noted. A computed tomography (CT) scan was negative for any acute trauma to the brain. The Immediate Interventions, observed in the report indicated the resident was assessed by the charge nurse, noted to have a laceration to the back of the head, and was sent to the ER for further evaluation. The mechanical lift was taken out of service for evaluation, and the facility determined the lift was in proper working order. The mechanical lift's sling (which held the resident during transfer) was evaluated and determined to be in good condition with no fraying or tears. The sling straps (which would be attached to the lift bars) were all intact. Staff were educated prior to next shift on the proper use of mechanical lifts and they completed a return demonstration. The Outcome of Investigation, stated that upon investigation, the facility determined staff did not correctly secure the mechanical lift's sling to the lift bars prior to lifting the resident. It concluded the fall was determined to be accidental. The facility was unable to substantiate abuse or neglect, and then listed the names of the Director of Nursing (DON) and Executive Director (ED). The documents submitted in the report consisted of Resident 117's identifying information, diagnoses, a statement from the Maintenance Supervisor attesting the mechanical lift was in working order, the hospital's ER discharge summary and five pages of staff education acknowledgement signatures. The report did not include the names or interviews from the staff members involved in the transfer and did not include the incident report or statement from the nurse who assessed the resident after the fall. An interview was conducted with the facility ED and DON on 09/08/20 at 6:25 PM. The ED stated the investigation had been left up to the DON. The DON was unable to provide interviews from the staff involved and when asked about the names of the Certified Nursing Assistants (CNAs) who did the transfer, the DON could not remember but was able to refer to the staffing on 12/21/19 to provide the names. During an interview on 09/09/20 at 8:50 AM, the DON provided the names of CNA-G and CNA-H but didn't know which CNA had failed to secure the right shoulder strap to the mechanical lift. The DON said, I interviewed them, and they didn't know what happened. On 09/09/20 at 1:40 PM, CNA-G was interviewed by phone about Resident 117's fall from the mechanical lift and was asked to describe the incident. CNA-G said, Yes, that was terrible. The other CNA didn't hook the strap properly. CNA-G went on to describe the incident saying, I put the strap on the lift by the head and the leg on one side and (CNA-H) put the straps on the right side. I went to the back of the machine to work the controls. (CNA-H) removed the wheelchair, and then the strap on the right, by the head came off the lift and (the resident) fell backwards out of the sling. (Resident 117's) head hit the leg of the lift. There was blood everywhere. When asked about training received on the mechanical lift, CNA-G said, Let's see .I don't remember a date or anything, but we had training all the time. I'm sure I had training on the (mechanical lift) at least once a year. CNA-H did not respond to multiple attempts for a phone interview. The facility was asked when CNA-G and CNA-H had received training for transfers with the mechanical lift. The DON provided an orientation checklist that specified CNA-H had mechanical lift transfer education on 10/07/19 as a new hire. The Administrator provided mechanical lift training dated November 2017, but it did not include CNA-G. The facility was unable to provide documentation of CNA-G's training for the mechanical lift. The mechanical lift used to transfer Resident 117, was observed on 09/14/20 at 12:59 PM. The lift had six hooks where sling straps could be attached. The DON was unsure if the sling used for Resident 117 had four 4-point straps to attach to the lift or 6-point straps. The Maintenance Director said he had checked with the mechanical lift company and was told it was okay to use a 4-point sling on a 6-point mechanical lift. The manual for the mechanical lift was reviewed but did not address the number of hooks to be used. The ED was interviewed on 09/14/20 at 3:09 PM, about what was expected regarding the content of reports to the State agency. The ED indicated interviews should be included in the investigations and staff were expected to be trained.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1a Based on interview and record review the facility failed to ensure a baseline care plan was completed upon admission for 1 of 1 (Resident 317) residents sampled. The facility identified a census of 64 at the time of survey. Findings Are: A review of Resident 317's medical chart revealed an admission date of [DATE]. A review of Resident 317's medical chart on 09/08/2020 revealed the baseline care plan uncompleted. Interview with the Director of Nursing on 09/09/2020 confirmed the baseline care plan was uncompleted and should have been completed within 48 hours.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D1c Based on observations, record reviews and staff interviews, the facility failed to provide nail care for 1 of 3 (Resident 60) sampled residents reviewed that were dependent on staff for activities of daily living (ADLs). This had the potential to affect 38 residents currently in the facility that were dependent on staff for activities of daily living. The facility census was 64. Findings are: Resident 60 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact, did not resist care and required extensive to total assistance with activities of daily living. Record review revealed the resident had been seen at the facility for podiatry care in 2018. A podiatry list dated January 2019 indicated the resident was not seen because of a need for an insurance authorization. There were no podiatry notes or lists provided from the facility for February 2019 to September 2019 for Resident 60. The facility provided evidence of one podiatry list of residents seen in October in 2019 but Resident 60 was not on that list. A Social Services note in Resident 60's clinical record revealed a note dated 12/16/19 when Resident 60 refused to be seen by the podiatrist. There were no podiatry notes or lists for 2020. Review of the clinical record revealed the resident was discharged to the hospital on [DATE] and returned to the facility on [DATE]. Resident 60 was readmitted to the facility with additional [DIAGNOSES REDACTED]. The re-entry 5-day MDS indicated the resident was cognitively intact, did not resist care, and required extensive to total assistance with activities of daily living. The care plan, most recently updated on 09/10/20, revealed no documentation Resident 60 refused care and did not contain any specific interventions for Resident 60. During an interview on 09/11/20 at 4:30 PM, Resident 60's family member said the family had seen the resident's toenails and the condition of the feet while the resident was in the hospital for COVID-19. The family member brought it to the facility's attention on 08/12/20, after the resident had returned to the facility. Record review revealed Resident 60 went out to a Podiatry appointment on 09/03/20 The podiatrist's note included, there is severe neglect of foot hygiene noted. (Resident 60's) nails are extremely elongated. They are curving into (the) skin in multiple places. The note stated Resident 60 had not been seen in over 2 years for podiatry and had not been brought for routine foot care during any of the podiatrist's visits to the facility. The podiatry notes further stated, There is opening of the skin here but no signs of infection or exposed bone. The podiatrist's plan specified Resident 60's feet should be soaked daily and a good moisturizing cream should be applied to the feet. On 09/14/20 at 7:54 AM, LPN-W reviewed Resident 60's Treatment Administration Record (TAR) and did not an order to soak and lotion the resident's feet. LPN-W said the CNA tasks were found on the Kardex. Review of Resident 60's Kardex revealed it did not have directions to soak and lotion the resident's feet daily. The DON was interviewed on 09/14/20 at 9:31 AM, about the podiatrist's order to soak and lotion Resident 60's feet, not being carried over to the TAR or Kardex. The DON said, That may have been a transcription error. We'll make sure the soak gets in there and the lotion too. Resident 60's feet were observed on 09/10/20 at 10:07 AM. Resident 60 had several mycotic toenails (toenails that have been infected by a fungus), but the nails were trimmed. Resident 60's nails had recently been trimmed because there were still impressions visible where the nails had pressed into the underside of the toes. There was a scabbed area on the left third toe approximately one centimeter in diameter. Resident 60's feet were very dry and scaly. On 09/10/20 at 4:08 PM, Certified Nursing Assistant (CNA)-D said it was usually the responsibility of the Bath Aides to trim residents' nails. CNA-D also said if the resident was diabetic or the nails were thick, then I tell the nurse and there is a pink paper at the desk, and we can put the name there. Resident 60 was not on CNA-D's list of residents to care for that day. On 09/10/20 at 04:48 PM, Licensed Practical Nurse (LPN)-M was interviewed about residents who needed to see the podiatrist. LPN-M said, If they need to see a podiatrist, we call social services and they put the name on a list. The podiatrist comes about once a month. The

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) nurse was unsure how the residents' received nail care during the limited visitation required due to COVID-19. When asked about nursing assessments, the nurse said, Yes, they should make a note of it and make sure (a resident) is on the podiatry list. On 09/14/20 at 2:56 PM, the DON was asked who was responsible for documentation of communication from the podiatrist. The DON said the nurse had documented no information had come back with the resident but, Whoever the nurse is when (the resident) returns should call and get clarification. When asked if staff should have made the DON aware of the condition of Resident 60's toenails, the DON indicated the resident's toenails had been neglected and staff should have made administration aware before the nails got so long.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure care for 1 (Resident 4) of 1 resident with hospice care was provided in a coordinated effort between the hospice agency and the facility. The facility reported 2 residents were receiving hospice services. The census was 64. Finding are: Resident 4's [DIAGNOSES REDACTED]. Resident 4 elected the hospice benefit on 06/09/20 with the terminal [DIAGNOSES REDACTED]. Review of Resident 4's clinical record revealed hospice visits twice a week. The clinical record revealed no documentation of the hospice plan of care for the resident which would include, in part, orders for medications, visit frequency, and goals of care. Review of Resident 4's facility plan of care, last reviewed 09/11/20, revealed facility staff and the resident's representative participated in the meeting. The Care Plan Conference Record revealed no documentation hospice participated in the care plan review. Review of the care plan meeting and attendance notes in Resident 4's clinical record revealed a care plan meeting was held. Social Services Designee (SSD)-U was only attendee of the scheduled care plan meeting on 09/08/20. Interview with SSD-U on 09/10/20 at 9:28 AM confirmed there were no other attendees at the scheduled care plan meeting and confirmed no documentation hospice was invited to participate in the meeting. Interview with the Administrator, DON and Corporate Nurse on 09/11/20 at 3:39 PM confirmed the facility failed to develop, implement and revise, as needed, a coordinated plan of care with the hospice provider to ensure resident care was provided in a coordinated and effective manner. Interview with the Director of Nursing (DON) on 09/11/20 at 2:11 PM confirmed the clinical record revealed no documentation the hospice and facility coordinated Resident 4's care to provide the care as the resident preferred and according to the resident's goals for care. Review of the facility's contract for services with the hospice provider dated 06/15/18 directed services would be provided with the following agreements between the facility and the hospice provider: 1.5 Hospice Plan of Care- means a written care plan established, maintained, reviewed and modified, if necessary, at intervals established by the interdisciplinary group. 3.2 Communication Protocol: Prior to admission of any Facility resident to Hospice, Hospice and facility shall work together to develop a written communication protocol governing how they will communicate all information needed for the Hospice Patients' care (such as physician orders [REDACTED]. The facility's failure to provide care in coordination with hospice places the resident at risk for duplicative care or failure to provide care as the resident/responsible party wishes.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].09D7 Based on observation, record review, interviews and facility policy review, the facility failed to prevent an accident when a resident fell backwards out of a mechanical lift onto the resident's head requiring an ER visit and resulting in a laceration The facility failed to ensure all staff had documented training and education on the use of the mechanical lifts. This affected 1 of 1 residents (Resident 117) in the sample reviewed for mechanical lift transfers and had the potential to affect 15 residents currently in the facility being transferred with the mechanical lift. The resident sustained [REDACTED]. The facility census was 64. Findings are: Resident 117 was admitted with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident 117 was moderately cognitively impaired, and required limited to extensive assistance with transfers. The care plan, most recently updated on [DATE], revealed the resident was at risk for falls. On [DATE], a report was submitted to the State Agency by the Director of Nursing (DON) and indicated Resident 117 had fallen from a mechanical lift on [DATE] at 6:45 PM. A second report dated [DATE] submitted to the State Agency related to the facility's investigation of a fall with injury for Resident 117. The Detailed Description of Event, stated on [DATE] at approximately 6:45 PM, Resident 117 was transferred from wheelchair to bed via a mechanical lift with two staff assisting. While being lifted, one corner strap of the sling near the resident's right shoulder became disconnected from the lift causing the resident to slide head-first out of the sling. The resident's head hit the base leg of the lift and the resident sustained [REDACTED]. The family and Personal Care Physician were notified of the fall with injury. New orders were received to send the resident to the emergency room (ER) for evaluation and treatment. The resident returned to the facility at approximately 11:30 PM on [DATE] with no further injuries noted. A computed tomography (CT) scan was negative for any acute trauma to the brain. Immediate Interventions, observed in the report indicated the resident was assessed by the charge nurse, noted to have a laceration to the back of the head, and was sent to the ER for further evaluation. The mechanical lift was taken out of service for evaluation, and the facility determined the lift was in proper working order. The mechanical lift's sling (which held the resident during transfer) was evaluated and determined to be in good condition with no fraying or tears. The sling straps (which would be attached to the lift bars) were all intact. Staff were educated prior to next shift on the proper use of mechanical lifts and they completed a return demonstration. The Outcome of Investigation, stated upon investigation, the facility determined staff did not correctly secure the mechanical lift's sling to the lift bars prior to lifting the resident. It concluded the fall was determined to be accidental. The facility was unable to substantiate abuse or neglect, and then listed the names of the Director of Nursing (DON) and Executive Director (ED). Review of the hospital ER summary dated [DATE], CT scan revealed: There is no [MEDICAL CONDITION] or mass effect. There is no hemorrhage, mass or cortical infarct. There is no [DIAGNOSES REDACTED] or shift of midline. There is no extra-axial fluid collection. The skull is normal. No acute trauma to the brain. The resident was not admitted to the hospital and returned to the nursing facility. Due to ongoing pain after the fall, a leg x-ray was ordered on [DATE]. The x-ray was negative- no fractures noted. A nursing note dated [DATE], stated Resident 117 was alert and oriented to familiar surrounding, a small hematoma with scab on the right side of the head and the resident denied pain. Nursing notes revealed between [DATE] and [DATE], the resident was treated with Tylenol and [MEDICATION NAME] for hip and back pain. Nursing notes on [DATE] indicated the resident complained of a severe headache that was unrelieved despite being given [MEDICATION NAME] for pain. The clinical record specified the resident's pain was no longer relieved by [MEDICATION NAME] on [DATE], and [MEDICATION NAME] was ordered at 10 milligrams (mg) every hour as needed for pain. [MEDICATION NAME] 1mg was also ordered for agitation and could be given every hour as needed. Due to ongoing complaints of unrelieved pain, a [MEDICATION NAME] spine x-ray was ordered and obtained on [DATE]. The results were negative for any injury. [MEDICATION NAME] and [MEDICATION NAME] continued to be given through [DATE] until on [DATE] at 9:50 AM when documentation included, Patient appears comfortable this shift, has not been yelling out for staff and remains calm. On [DATE] at 1:15 PM, the resident expired. A Health Status Late Entry note for [DATE] dated [DATE] included Resident followed due to weight loss. Resident had a recent decline, not getting out of bed, fall and decreased intake often. Received order for hospice consult on [DATE] and resident passed on [DATE]. An interview with the facility's ED and DON on [DATE] at 6:25 PM. The ED stated the investigation had been left up to the DON. The DON was unable to provide interviews from the staff involved and when asked about the names of the Certified Nursing Assistants (CNAs) who did the transfer, the DON could not remember but would be able to refer to the staffing on [DATE] for the names. The DON also could not provide documentation of any monitoring done to ensure staff were using the lift according to instructions. The DON stated there had not been any falls from the mechanical lift since Resident 117's fall. During an interview on [DATE] at 8:50 AM, the DON provided the names of CNA-G and CNA-H but didn't know which CNA had failed to secure the strap to the mechanical lift. The DON said, I interviewed them, and they didn't know what happened. On [DATE] at 1:40 PM, CNA-G was interviewed by phone about Resident 117's fall from the mechanical lift and was asked to describe the incident. CNA-G said, Yes, that was terrible. The other CNA didn't hook the strap properly. CNA-G went on to describe the incident saying, I put the strap on the lift by the head and the leg on one side and (CNA-H) put the straps on the right side. I went to the back of the

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) machine to work the controls. (CNA-H) removed the wheelchair, and then the strap on the right, by the head came off the lift and (the resident) fell backwards out of the sling. (Resident 117's) head hit the leg of the lift. There was blood everywhere. CNA-H did not respond to multiple attempts for a phone interview. The facility was asked when CNA-G and CNA-H had received training for transfers with the mechanical lift. The DON provided an orientation checklist that specified CNA-H had mechanical lift transfer education on [DATE] as a new hire. The Administrator provided mechanical lift training dated [DATE], but it did not include CNA-G. The facility was unable to provide documentation of CNA-G's training for the mechanical lift. On [DATE] at 11:30 AM, Resident 117's primary care physician was interviewed. The physician stated the resident had also been losing some weight and refusing meals before the fall. The physician said, (Resident 117's) decline is more attributed to the dementia rather than the fall. The mechanical lift used to transfer Resident 117, was observed on [DATE] at 12:59 PM. The DON stated they currently used this kind of lift for 15 residents in the facility. The lift had six hooks where sling straps could be attached. The DON was unsure if the sling used for Resident 117 had 4-point straps to attach to the lift or 6-point straps. The Maintenance Director said he had checked with the mechanical lift company and was told it was okay to use a 4-point sling on a 6-point mechanical lift. The manual for the mechanical lift was reviewed but did not address the number of hooks to be used. The ED was interviewed on [DATE] at 3:09 PM, about what would be expected regarding training, monitoring and safe transfers. The ED said, My expectation is that staff would transfer according to how they are trained. The ED also said, I expect the training to be monitored and the training was monitored. Every day in our stand up we reviewed falls and we had no further issues with the (mechanical lift).
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.04B Based on interview and record review; the facility failed to ensure staff had been educated on care and management of Laryngectomy tubes for 1 of 1 (Resident 317) residents sampled. The facility census was 64. Findings Are: A review of Resident 317's face sheet found an admission date of [DATE] with a [DIAGNOSES REDACTED]. An interview with the Staff Development Coordinator Registered Nurse (RN) L, on 09/09/2020 at 17:33 found no education had been provided to staff related to care and management of a resident with a [MEDICAL CONDITION]. An interview with the Director of Nursing (DON) on 09/10/2020 at 13:35 confirmed no education had been provided to the staff related to the care and management of a resident with a [MEDICAL CONDITION].
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on document review, facility policy review and staff interview, the facility failed to update the staff posting with the actual hours worked each shift for registered nurses, licensed practical nurses and certified nurse aides for 8 of 12 days reviewed for staff posting. The facility's failure to post actual hours worked and update the posting at the beginning of each shift has the potential to inaccurately inform residents and visitors of the facility's staffing. The facility reported a census of 64 residents. Findings are: Review of the staff posting from 08/28/20 to 09/08/20 revealed 8 of the 12 days reviewed lacked the required posting of actual hours worked by each staff type. An interview with Staff Scheduler-B on 09/09/20 at 10:33 AM confirmed the actual hours worked were missing from many of the daily staff postings and confirmed the actual hours worked was not updated at the beginning of each shift. Review of the facility policy titled, Staffing, directed the facility, 483.35(g)(2) Posting Requirements, (i) The facility must post the nurse staffing data .on a daily basis at the beginning of each shift.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D5 Based on observation, record review, resident and staff interviews, the facility failed to reassess and provide an individualized, interdisciplinary approach to a supportive psychosocial environment for 1 of 1 sampled resident (Resident 60) who expressed hopelessness and frustration. The facility census was 64. Findings are: Resident 60 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE], revealed the resident was cognitively intact, did not resist care and required extensive to total assistance with activities of daily living. The Patient Health Questionnaire (PHQ-9), a validated interview that screens for symptoms of depression, indicated the resident had no signs of depression. An activity note dated 09/30/19 indicated the resident enjoyed church services, 1:1 visits, socializing with fell ow residents, and attended music socials and meals in the dining room. An activity note dated 05/02/20 stated the resident was provided 1:1 visits and family calls. The most recent progress note related to activities was dated 07/24/20. It stated the resident received 1:1 visits, weekly calls with a volunteer and offers to call family. Review of the clinical record revealed the resident was discharged to the hospital on [DATE] and returned to the facility on [DATE]. Resident 60 was readmitted to the facility with additional [DIAGNOSES REDACTED]. The resident was also in a precautionary quarantine period. The re-entry 5-day MDS, dated [DATE] indicated the resident was cognitively intact, did not resist care, and required extensive to total assistance with activities of daily living. The PHQ-9 indicated the resident had no signs of depression. The Social Worker note by the Social Services Director (SSD-U), dated 08/16/20, indicated the resident was cognitively intact and scored 00 on the PHQ-9, showing no signs of depression. A nursing note dated 08/17/20, specified the resident was frustrated and wanted to die. The note said, the resident was put on a watch. It further stated the resident reported improved mood after having visitors. A nursing note dated 08/23/20 stated, refuses and rejects cares, not cooperative at times. A nursing note dated 08/31/20 specified a skilled therapist had reported, when asked if there was anything else the resident might want, the resident responded that the therapist could get the resident a bullet. The note indicated Social Services was notified. A social services note dated 09/02/20 said, family was notified about the room change. The next social services note was 09/03/20 and stated, notified the Resident about COVID-19 updates. A nursing note dated 09/05/20, stated the resident had been yelling out at staff and screaming most of the shift for help and staff had been in the room frequently throughout the shift. There were two more social services notes revealed no documentation of conversation with the resident about the statements documented on 08/17/20 and 08/31/20. Resident 60's care plan updated on 09/10/20, did not indicate the resident refused care and did not have any specific interventions for this. The care plan stated the resident enjoyed being read to from the Bible, 1:1 visits, interacting with other residents, and visits with family. The care plan stated, provide psychosocial support if in isolation, but did not have any specific interventions for this. The care plan also stated, observe for increased anxiety or changes in mood/behavior that are related to isolation and notify the physician as appropriate. A nursing note dated 09/13/20, stated, Patient continues to be rude to staff, continues to refuse care and continues to refuse pain medication, and refused offers to get up in (the wheelchair). The note also stated the resident had continued to make statements of 'just kill me' and 'leave me alone so I can die.' There were no other progress notes documented on the weekend (09/12/20 and 09/13/20) in Resident 60's clinical record. Licensed Practical Nurse (LPN)-W interview on 09/14/20 at 11:19 AM. stated the Resident 60 had been agitated over the weekend. LPN-W specified the resident had requested twice that LPN-W put a gun to the resident's head and kill the resident. LPN-W said, (Resident 60) wants to die and the family won't let (Resident 60). When asked how long the resident had been making statements of that nature, the nurse indicated it had been since the resident returned from the hospital in August 2020. LPN-W said, (Resident 60) is immobile and (Resident 60) has a pressure ulcer, (Resident 60) has no quality of life and wants to die. When LPN-W was asked if the resident's remarks about the gun had been documented over the weekend, the nurse said, Yes. When asked if social services, administration, or the physician had been notified, LPN-W said, They are aware. When asked who had been notified of the resident's statement over the weekend, the nurse said, They are aware. (Resident 60) is always like this. The Corporate Consultant was notified on 09/14/20 at 11:25 AM, about Resident 60's statements on the weekend and indicated administration had not been made aware. The DON interview on 09/14/20 at 11:37 AM. The DON had not been aware the resident was making statements about wanting to die until informed by the Corporate Consultant a few minutes earlier. The DON was also unaware of Resident 60's statements on 08/17/20 and 08/31/20. The Social Services Director (SSD-U) interview on 09/14/20 at 12:02 PM. SSD-U had been aware of the resident's statements but had not made any referrals or notified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OMAHA	6032 VILLE DE SANTE DRIVE OMAHA, NE 68104

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 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) physician. SSD-U stated, since returning from the hospital, SSD-U had been told Resident 60 had made some comments about wanting to die. SSD-U reported having spoken to the resident and the resident reported not having a plan and told SSD-U, everyone take things so seriously. The SSD-U said the resident's family member had just been informed about the statements from the weekend. On 09/14/20 at 2:05 PM, and interview with Advanced Practice Registered Nurse (APRN-X) spoke about having done a cognitive assessment on Resident 60 on 09/02/20, and APRN-X had not noted any signs of depression at the time. APRN-X had been unaware the resident had made any statements about wanting to die at the time of the 09/02/20 cognitive assessment and was informed by the DON that morning about Resident 60's weekend statements. After being told, APRN-X went in to see Resident 60 and the resident confirmed wanting to die but would not explain why. After seeing the resident, APRN-X spoke with the family and was told they believed Resident 60 had been depressed since COVID-19 because the resident couldn't have visitors or go outside. On 09/14/20 at 3:53 PM, the DON indicated the expectation was staff would immediately make the DON aware when a resident makes death-wish statements and the physician should have been informed.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].12E4 Based on observations, interviews, record reviews, and review of policy and procedures, it was determined the facility failed to ensure; 1) expired vaccinations were discarded timely for 1 of 1 medication storage room observed; 2) Insulin medication carts were free of discontinued, undated, and expired insulin vials and pens for 3 of 4 medication carts observed for 13 residents with prescribed insulin. 3) a medication care was unspervised and unlocked in a resident care area. The facility census was 64. Findings are: 1. On [DATE] at 11:30 AM, observations and interview with LPN-K of the medication storage room on the South Wing of the facility revealed medication storage refrigerator contained two boxes of [MEDICATION NAME] Quadrivalent influenza vaccine. One unopened vaccine box, with an expiration date of [DATE] contained 10 prefilled syringes of vaccine. One opened vaccine box, with an expiration date of [DATE] contained seven prefilled syringes. LPN-K said, That is expired, and stated the Infection Preventionist Nurse (IPN) was responsible for vaccination storage. On [DATE] at 11:30 AM, the IPN said, The outdated vaccinations are on me. The IPN stated they knew the vaccinations had expired, but they had not had time to dispose of them. On [DATE] at 12:21 PM, the Director of Nurses (DON) stated the expired vaccinations should have been discarded. 2. a. On [DATE] at 11:30 AM, observations of the medication cart on Hall 600 with Certified Medication Aide (CMA)-O revealed the cart contained one multi-dose vial of Admelog for Resident 23 labeled opened on [DATE]. The vial had been open 54 days. CMA-O stated the vial of Admelog should not have been stored on the medication cart but should have been stored in the insulin cart. 2. b. On [DATE] at 11:40 AM, observations of the insulin medication cart on the South Wing of the facility with Licensed Practical Nurse (LPN)-K. The following was identified: 1. Two vials of Admelog for Resident 23 were opened and undated. 2. One opened [MEDICATION NAME] pen for Resident 30, labeled opened on, [DATE]. LPN-K stated the vial had expired as it was only good for, 45 days. The pen had been open for 48 days. 3. One opened [MEDICATION NAME] pen for Resident 30 labeled opened on, [DATE]. The pen had been opened 53 days. 4. One [MEDICATION NAME] pen for Resident 46 opened and undated. One Insulin [MEDICATION NAME] pen for Resident 46 was opened and undated. A Medication Administration Record [REDACTED]. 2. c. On [DATE] at 5:47 PM, observations of the insulin medication cart on the North Wing of the facility with LPN-M. The following was identified: 1. One opened [MEDICATION NAME] vial for Resident 42 dated opened on, [DATE]. LPN-M said, That's old. The vial had been open 40 days. LPN-N stated nurses should dispose of insulin after 28 days. 2. One opened [MEDICATION NAME] vial for Resident 42 dated opened on, [DATE]. The vial had been open 48 days. 3. One [MEDICATION NAME] pen for Resident 65 opened and undated. LPN-M stated the resident no longer resided on the North Wing of the facility. In an interview on [DATE] at 12:21 PM, the Director of Nursing (DON) stated insulin should be dated when it was opened. The DON was asked how long insulin was good after it had been opened, and the DON stated it depended on the type of insulin. The DON stated the facility policy referred to the medication storage guidance provided by the pharmacy to determine how long to keep insulin after it had been opened. The DON stated the nurses on duty were responsible for disposing of expired insulin. When asked how nurses would know when insulin was outdated, the DON stated they would place copies of the guideline on the carts for future reference. The DON provided a document, dated ,[DATE], titled, (Named pharmacy) .Insulin Storage Recommendations, which recommended storage of 28 days for Admelog, [MEDICATION NAME], insulin [MEDICATION NAME] and [MEDICATION NAME] when stored at room temperature. A facility policy, revised [DATE], titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, documented: .Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines .are stored separate from other medications until destroyed or returned to the pharmacy or supplier . .Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened . 3. A review of the facilities policy titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, with a revision date of [DATE] revealed the following: Facility should ensure that all medications and biologicals including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. An observation on [DATE] of the medication cart on 600 hall outside of room [ROOM NUMBER] at 09:05 revealed the cart unattended and unlocked. At 09:10 LPN K went into room [ROOM NUMBER] passed by the unlocked medication cart and entered the room then shut the door. At 09:12 LPN K exited the room and began to work on the computer on top of the medication cart. LPN K was interviewed while at the mediation cart and confirmed the cart was unlocked and had been unlocked when the cart was unattended. LPN K was asked if it was routine to leave the medication cart unlocked when unattended, LPN K responded with No, I typically have it locked but I just came on. An interview with the Director of Nursing (DON) revealed, the expectation is staff keep the medication carts locked when not in line site of the staff working the cart. The DON confirmed the cart should have been locked.