STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(9) Based on interviews and record reviews the facility failed to protect Resident's 219, 220, and 218 from potential misappropriation of medications. The facility census was 14. Findings are: A. Record review of Pharmacy document dated 8/14/19 revealed Resident 218 had [MEDICATION NAME] HCL 50 mg, 30 each delivered, this was underlined written under unable to find. Record review of PO (Physician Order) for Resident 218 dated 8/6/19 revealed an order for [REDACTED]. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed there was not an investigation completed and a reported filed with the state agency. The facility could not locate a report filed with the state. B. Record review of Pharmacy document dated 8/9/19 revealed Resident 219 had [MEDICATION NAME] HCL 50 MG 20 each delivered and was underlined written below unable to find. Record review of a prescription dated 7/17/19 for Resident 219 for [MEDICATION NAME] 50 mg give tablet PO BID (Twice daily) PRN. Record review of Physician order [REDACTED]. an order for [REDACTED]. The facility could not locate a report filed with the state. C. Record review of Physician orders [REDACTED]. Record review of Pharmacy document for Resident 220 dated 8/13/20 revealed [MEDICATION NAME] HCL 50 MG 45 Each was delivered and was underlined written below unable to find. Record review of Abuse, Neglect, and Exploitation Policy dated 1/20/20; Section III B. Identifying, correcting, and intervening in situation in which abuse, neglect, exploitation and/or misappropriation of resident property is more than likely to occur with deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents care needs and behavioral symptoms. G. Addressing features of the physical environment that may make abuse, neglect, exploitation and misappropriation of resident property more likely to occur; VII. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation not involve abuse and do not result in serious bodily injury. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed there was not an investigation completed and a reported filed with the state agency. The facility could not locate a report filed with the state. An interview on 09/03/20 at 10:11 AM with the IDON (Interim Director of Nurses) confirmed if a facility was unable to locate narcotics that it would be reportable, an investigation should take place. An interview 09/03/20 11:09 AM with Nurse D confirmed there were medications missing. The medications came in on day shift- signed in by the day shift nurse. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed there was not an investigation completed and a reported filed with the state agency. The facility could not locate a report filed with the state.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 609 Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview; the facility failed to report incidents of missing narcotics to the State Agency for 3 residents (Resident 218, 219, and 220). The facility census was 14. Findings are: A. Record review of Pharmacy document dated 8/14/19 revealed; Resident 218 had [MEDICATION NAME] HCL 5 mg, 30 each delivered, this was underlined written under unable to find. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed the facility could not locate a report filed with the State Agency related to missing medications. B. Record review of Pharmacy document dated 8/9/19 revealed Resident 219 had [MEDICATION NAME] HCL 50 MG 20 each delivered and was underlined written below unable to find. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed the facility could not locate a report filed with the State Agency related to missing medications. C. Record review of Pharmacy document for Resident 220 dated 8/13/20 revealed; [MEDICATION NAME] HCL 50 MG 45 Each was delivered and was underlined written below unable to find. An interview on 9/3/20 at 7:55 AM with the Administrator confirmed the facility could not locate a report filed with the State Agency related to missing medications. An interview on 09/03/20 at 10:11 AM with the IDON (Interim Director of Nurses) confirmed if a facility was unable to locate narcotics that it would be reportable to the State Agency. An interview 09/03/20 11:09 AM with Nurse D confirmed there were medications that were missing. The medications came in on day shift- signed in by the day shift nurse. Record review of Abuse, Neglect, and Exploitation Policy dated 1/20/20; VII. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation not involve abuse and do not result in serious bodily injury. Record review of Pharmerica for Resident 220 dated 8/13/20 revealed; [MEDICATION NAME] HCL 50 MG 45 Each underlined unable to find. Record review of an Physician order [REDACTED]. Rates back pain 2-3 never higher per Resident 220 Family request PRN order for [MEDICATION NAME]. Orders for PRN [MEDICATION NAME]. Interview An interview on 9/3/20 at 7:55 AM with the Administrator confirmed there was not a reported filed with the state agency. The facility felt that it was more of a medication destruction issue and not a missing narcotic issue.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure an MDS (Minimum Data Set (a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes)) assessment was submitted within 14 days for 1 resident (Resident 2) of 2 residents reviewed. The facility also failed to ensure a discharge MDS assessment was completed for 1 resident (Resident 1) of 2 residents reviewed. The facility census was 14. Findings are: A. Review of Resident 2's EHR (electronic health record) dated 9/1/20 revealed Resident 2 had an MDS assessment dated [DATE] with a description of Discharge Return Not Anticipated. Status of the MDS assessment revealed the assessment was completed. Review of Resident 2's Progress Notes dated 4/21/20 revealed Resident 2 was discharged home with family. Interview on 9/2/20 at 6:17 AM with the MDS-C (MDS Coordinator) confirmed Resident 2's discharge MDS assessment was completed, but not

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

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.

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) submitted. Review of the Validation Report dated 9/2/20 revealed the MDS assessment dated [DATE] was submitted late. A message on the report revealed the record was submitted late. B. Review of Resident 1's EHR revealed an absence of a discharge MDS assessment. A note at the top of the MDS assessment list noted a discharge assessment reference date was 4/7/20, and was 133 days overdue. Review of Resident 1's Progress Note dated 4/7/20 revealed Resident 1 was discharged home on[DATE]. Interview on 9/2/20 at 6:17 with the MDS-C confirmed Resident 1's discharge MDS assessment was missed and was not completed.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 The facility failed to complete a Baseline Care Plan Summary provided to the resident/resident representative that included initial goals, physician orders, dietary orders, therapy orders, and social services for 3 residents (Resident 5, Resident 4, and Resident 13). The facility census was 14. Findings are: A. Record review of Resident 4's Grand Round/Baseline Care Plan dated 6/9/20 revealed; ---Resident 4 lived in an ALF (Assisted Living Facility). Resident 4 had family support Resident 4 used a walker and transferred with one assist. Resident 4 wore glasses and dentures. Resident 4 had a Provider and pharmacy. Resident 4 took medications, felt depressed at times (took medications for depression). Resident 4 did not attend church, did not have hobbies. Resident 4 had no concerns with nursing Resident 4 reported the food had been to their liking. Resident 4 wanted to be awakened after 9:30 AM. Resident 4 was informed that discharge timeline depended on achievement of goals met in therapy and insurance coverage. Resident 4 declined home health Resident 4 had no additional questions. A copy of the med list/orders and current care plan was given to the Resident- was not documented Signatures on the form that had not been completed were Administrator DON (Director of Nurses) DM (Dietary Manager) SS (Social Services) Clinical Staff MDS (Material Data Set) Coordinator The completed signatures were: Other - the MC (Marketing Coordinator)member had signed the form. An interview on 9/1/20 at 4:35 PM with the IDON (Interim Director of Nurses) confirmed the facility had a changeover in staff for Marketing and since that time the Baseline care plan had not been attended, completed and signed by all the team members. B. Record review of Grand Rounds/Initial Baseline Care Plan for Resident 5 revealed; Resident 5 was independent at and ALF. Resident 5 had a POA (Power of Attorney) who provided support. Resident 5 had no durable medical equipment. Resident 5 required 2 assist with transfer and toileting. Resident 5 wore glasses. Resident 5 had a Provider. Resident 5 was not taking medications for anxiety or depression and was not feeling anxious or depressed. Resident 5 had missing teeth. Resident 5 was a DNR (Do Not Resuscitate). Resident 5's hobby was walking. Resident 5 was not concerned about nutrition. Resident 5 was not concerned about staff. Resident 5 agreed to be awakened before 7 AM. Resident 5 was informed a discharge timeline depended on achievement of goals met in therapy and insurance coverage. Resident 5 was given a list of home health providers. Resident 5 had no additional concerns. A copy of the Residents med list/orders and current care plan was not documented. Signatures on the form that had not been completed were Administrator DON DM Therapy Director Social Services Clinical Staff MDS coordinator The completed signatures were: Other was signed by the MC An interview on 9/1/20 at 4:35 PM with the IDON confirmed the facility had a changeover in staff for Marketing and since that time the Baseline care plan had not been attended, completed and signed by all the team members. C. Record review of Grand Round/Initial Baseline Care Plan for Resident 13 revealed: Resident 13 lived at home without stairs. Resident 13 lived with spouse. Resident 13 used a walker. Resident 13 wore glasses, used a [MEDICAL CONDITION] (Continuous Positive Airway Pressure-to assist a person who has sleep apnea breathe more easily during sleep) and an inhaler/nebulizer. Resident 13 had a Provider and a Pharmacy. Resident 13 had dentures and missing teeth. Resident 13 was not taking medication for depression and preferred to speak with staff when anxious or depressed, as well as word search. Resident 13 had a church affiliation. Resident 13 reported the food had been to their liking. Resident 13 had no concerns related to nursing. Resident 13 was okay to be awakened before 7:00 AM. A copy of the Residents med list/orders and current care plan was not documented. Signatures on the form that had not been completed were Administrator DON DM Therapy Director Social Services Clinical Staff MDS coordinator The completed signatures were: Other was signed by the MC Resident and Spouse An interview on 9/2/20 at 12:19 PM with the MC confirmed; they filled out the Grand Round/Initial Baseline Care Plan dated 7/24/20 with Resident 13 and their spouse. MC confirmed; the process had changed from before, prior to COVID-19 1 member from each department would attend Grand Rounds. MC confirmed; they were the only person that had attended Grand Rounds.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER ,[DATE].09C1c Based on record reviews and interview, the facility failed to review and revise the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) related to an update in code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) for 1 resident (Resident 18) of 8 residents reviewed. The facility census was 14. Findings are: Review of Resident 18's [DATE] MAR (Medication Administration Record) revealed the resident's advance directives (a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate) specified Resident 18's code status was CPR (cardiopulmonary resuscitation (an emergency lifesaving procedure performed when the heart stops beating)). Review of Resident 18's Code Status/Comfort Measures Order dated [DATE] revealed Resident 18's POA (Power of Attorney) changed the resident's code status to DNR (Do Not Resuscitate - do not resuscitate by manual, chemical, and/or electrical means with no intubation in the event the heart or breathing stops). Resident 18's health care provider signed the form on [DATE]. Review of Resident 18's Care Plan dated [DATE] revealed the resident's code status was CPR. An intervention dated [DATE] revealed the resident may choose to change code status at any time. No documentation of the care plan being updated after the new code status completed [DATE] was noted. Interview on [DATE] at 11:55 AM with the MDS-C (MDS (a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) Coordinator) confirmed Resident 18's Care Plan was not updated when the resident's POA completed the DNR.
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** LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].09 Based on record review and interview, the facility failed to ensure Advance Directives (a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate) were correct in the EHR (electronic health record) for 1 resident (Resident 18) of 8 residents reviewed. The facility also failed to ensure Advance Directives were followed for 1 resident (Resident 18) of 8 reviewed. The facility census was 14. Findings are: Review of Resident 18's [DATE] MAR (Medication Administration Record) revealed the resident's advance directives specified Resident 18's code status was CPR (cardiopulmonary resuscitation (an emergency lifesaving procedure performed when the heart stops beating)). Review of Resident 18's Code Status/Comfort Measures Order dated [DATE] revealed Resident 18's POA (Power of Attorney) changed the resident's code status to DNR (Do Not Resuscitate - do not resuscitate by manual, chemical, and/or electrical means with no intubation in the event the heart or breathing stops). Resident 18's health care provider signed the form on [DATE]. Review of Resident 18's Care Plan dated [DATE] revealed the resident's code status was CPR. An intervention dated [DATE] revealed the resident may choose to change code status at any time. No documentation of the care plan being updated after the new code status completed [DATE] was noted. Review of Resident 18's Progress Note dated [DATE] revealed Resident 18 became unresponsive when staff were assisting the resident with transferring to a recliner. Staff assisted the resident to bed and the nurse assessed the resident for a pulse and breath sounds, which were present. The nurse checked the resident's blood glucose and it was noted the resident's lips were blue and hands were cold. Resident 18 did not have a pulse and was not breathing, so CPR was started based on the CPR code status in the EHR. Staff called [DATE] and placed AED (Automated External

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Defibrillator - a portable electronic device used to help those experiencing sudden [MEDICAL CONDITION]) on the resident while continuing CPR. When EMS (Emergency Medical Services) arrived they plugged in their AED, and the resident was in asystole (when the heart stops beating, or a flatline) then was pronounced dead. Interview on [DATE] at 2:45 PM with the MDS-C (MDS (a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) Coordinator) revealed staff normally would check the EHR for code status, but the paper charts were accessible in the charting room if nursing staff were not available to look code status up on the computer. Interview on [DATE] at 7:32 AM with the DON (Director of Nursing) confirmed Resident 18 had a DNR signed on [DATE], but documentation on the EHR noted the resident wanted CPR.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 NAC 175 12-006.09D7 Based on interviews and record reviews the facility failed protect residents from injury by allowing the facility van to be unsecured, keys in the ignition and doors open and unlocked. This had the potential to affect all residents in the facility. The facility also failed to protect a resident (Resident 68) from injury by failing to ensure a door alarm was functioning, staff were trained for the Sure Monitor, and the facility failed to implement interventions to monitor 1 resident (Resident 68) to prevent elopement. The facility census was 14. Findings are: A. An observation on 08/31/20 08:16 AM with the DON (Director of Nurses) the facility van unlocked, keys in the ignition, bilateral side doors open and the ramp down from the back of the van. An interview on 08/31/20 at 8:16 AM with the DON confirmed having the keys in the ignition and the van doors open and unlocked was a potential safety risk for residents. B. Record review of Elopement assessment dated [DATE] revealed Resident 68 elopement score indicated a moderate risk was placed on PT(Physical Therapy), OT (Occupational Therapy) and 15 minute checks. Record review of 15 Minute checks dated 4/23/20 revealed the facility was unable to provide documentation of 15 minute checks. Record review of Progress note for Resident 68 dated 7/26/2020 revealed; Resident 68 was found to not be in (genders) room and staff conducted a search in each room and outside. Resident 68 was located sitting in the grass outside the building. No injuries noted. Resident 68 was helped up and brought into the building. Resident 68 wanted to sit in the lounge area and refused to go to (genders) room. This nurse sat with the Resident 68 for an hour and then was able to get Resident 68 to go to (genders) room. Resident 68 appeared to be confused as (gender) was discussing women who were questioning (genders) wholesomeness and that they were saying (gender) was damaged goods Resident 68 was very upset that they were accusing (gender) of having an affair with the help just because (gender) was pleasant to staff and staff was pleasant with (gender). On the way back to the Resident 68's room (gender) turned to this nurse and stated I don't know if I told you, but I'm incontinent. Resident 68 was helped into bed. Record review of Progress note for Resident 68 dated 7/26/2020 with POA (Power of Attorney) regarding incident with Resident 68. POA stated that Resident 68 had a long history of UTI's (Urinary Tract Infections) with confusion. Will call and get order to test urine. Record review of Progress note for Resident 68 dated 7/27/2020 revealed Resident 68 had BIMS (Brief Interview Mental Status- and evaluation for elderly to assess cognition) Score: 12.0 indicated moderate impairment. Record review of Resient 68's care plan revealed; Resident 68 was an elopement risk. On 7/26/20 Resident 68 was found sitting outside the building on the grass in the evening. Goal: Resident 68 would exhibit no exit seeking behaviors through next review date. Interventions: Elopement risk assessment completed upon admission, quarterly, and PRN (as needed). 04/24/20 Follow facility protocol for elopement 07/27/20 Recent U/A for confusion 07/27/20 Request therapy assess mini mental status. Resident placed on 15 minute checks 07/27/20. Record review of Wandering and Elopement Policy statement revealed; 1. If identified as at risk for wandering, elopement, or other safety issues the resident care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should; a. Attempt to prevent the resident from leaving in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary and; c. Instruct another staff member to inform the charge nurse or DON that a resident was attempting to leave or has left the premises. 3. If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building and premises; and c. If the resident is not located, notify the Administrator and the DON, the resident's legal representative, the Attending Physician, law enforcement officials, and volunteer agencies. 4. When the resident returns to the facility, the DON or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Provider and report findings and condition of the resident, c. Notify the resident legal representative; d. Notify search teams that the resident has been located; e. Complete and file an incident report; f. Document relevant information in the residents medical record. Record review of Resident 68 Elopement timeline on 7/26/20 revealed; At 8:20 PM Resident 68 exited room and was in hallway looking around. Resident 68 did not have the walker. Resident 68 stopped at the counter in the hallway and was moving the mouse. At 8:21 PM Resident 68 had looked into an empty room across the hall. At 8:22 PM Resident 68 exited the building out the back door. At 8:47 PM a NA (Nurse Aide) heard the Sure Monitor going off at that time. The NA went in Resident 68's room and noted they were not in the room. The NA notified the Charge Nurse. At 8:48 PM the nurse started looking for Resident 68 in other rooms. The NA went out the front door to the back of the building and looked for Resident 68. At 8:52 PM the 2nd nurse noted the recliner monitor went off, noted Resident 68 was not in the room. The 2nd nurse started to look for Resident 68 around the building, then saw the NA bringing Resident 68 in through the 400 hall door. At approximately 8:50 PM NA reported Resident 68 was observed sitting in the grass outside 400 hall door. Resident came in with the NA. The NA reported Resident 68 had not hesitated. The NA reported Resident 68 was confused. It had been raining earlier in the evening, however, Resident 68 cloths and hair were dry, only the bottom of the gripper socks were wet. Resident 68 had a long sleeved button up shirt, with slacks and slipper socks. At 10:30 PM The nurse assisted Resident 68 back to the room and helped the resident to bed. Every 15 minute checks were started. The Door on the 400 hall was not working and an employee had been placed. Record review of Elopement assessment dated [DATE] revealed Resident 68 elopement score was 5 indicated a moderate risk was placed on 15 minute checks. Record review of Elopement: dated 7/27/20 revealed Resident 68 elopement score was a 5 indicating a moderate risk was placed on 15 minute checks. Record review of Mini Mental State Examination not dated; printed on 7/29/20 revealed Resident 68 had a score of 23 indicated mild cognitive impairment. A record review of Electronic Contracting Company dated 7/27/20 revealed Door buzzer was not working. Found door controller to be bad. Replaced door controller and buzzer started working. An interview on 09/01/20 03:56 PM with the Administrator confirmed; Resident 68 was outside the building unattended reported the sure monitor would go off if the resident wiggles. The administrator reported they have not been trained on the monitor. The alarm on the door alerts staff someone was going out the door. The door alarm was not working so did not sound. The Administrator contacted the company that came to look at the door and had them go check all doors to ensure they were working properly. The Administrator reported the Company that came to fix the door alarms reported this could happen at any time, the door was sending a signal but was not alarming. The person fixed the door and until the door was fixed staff were posted at the doors. An interview on 09/01/20 at 3:58 PM with the IDON (Interim Director of Nurses) confirmed the alarm could have sounded for from 8:22 PM to 8:47 PM (25 minutes) without staff response related to staff being in rooms helping other residents. An interview on 9/2/20 at 6:55 AM with the IDON confirmed the facility could not locate 15 minute checks completed 4/23/20. The staff were instructed to do 15 minute checks on new admits. The staff will have re-education. An interview on 9/2/20 at 7:00 AM with the IDON revealed the Sure Monitor triggers an alarm on a phone carried by staff. There is more than one phone. An interview on 9/2/20 at 4:14 PM with the IDON confirmed staff were not trained on the sure alarm, the facility would need to discontinue its use.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D8b Based on record review and interview, the facility failed to ensure staff were documenting evening meal intakes for a resident experiencing significant weight loss for 1 resident (Resident 11) of 3 residents reviewed. The facility census was 14. Findings are: Review of Resident 11's EHR (electronic health record) revealed on 7/29/20 the resident weighed 118.2 lbs. On 8/27/20 the resident weighed 109.8 lbs, which was a 7.11% weight loss. Review of Resident 11's Order Summary Report dated 8/31/20 revealed Resident 11 was ordered a regular diet with regular texture and thin liquids. Resident 11 was also ordered Ensure [MEDICATION NAME] (a high protein nutrition shake) in the afternoon and if food intake was less than 50%. Review of Resident 11's Care Plan (a written interdisciplinary

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) comprehensive plan detailing how to provide quality care for a resident) dated 7/30/20 revealed the resident had nutritional problem or the potential for a nutritional problem. Interventions included monitoring and recording every meal and offering alternatives if the resident was not eating well. Review of Resident 11's Meals Consumed Task dated 8/2/20 - 8/31/20 revealed evening meal intake not recorded for 8/2/20 - 8/8/20, 8/12/20 - 8/15/20, 8/18/20, 8/19/20, 8/21/20 - 8/24/20, 8/27/20, and 8/30/20. 19 of 29 days were missing documentation for the evening meal intake. Review of Resident 11's August 2020 TAR (Treatment Administration Record) revealed Resident 11 received Ensure [MEDICATION NAME] daily in the afternoon except for 8/24/20 (resident refused) and 8/25/20 (resident was out of facility). Ensure [MEDICATION NAME] was also given as follows: - 8/21/20 - Morning intake was 50% (Ensure was given), evening intake was not documented and Ensure was not given. - 8/22/20 - Morning intake was 50% (Ensure was given), evening intake was not documented and Ensure was not given. - 8/23/20 - Morning intake was 50% (Ensure was given), evening intake was not documented and Ensure was given. - 8/24/20 - Morning intake was 75% (Resident refused Ensure), evening intake was not documented and Ensure was given. - 8/25/20 - Resident was out of the facility in the morning. Evening intake was marked not applicable and Ensure was given. - 8/26/20 - Morning intake was 50% (Ensure was given), evening intake was 25% and Ensure was given. - 8/27/20 - Morning intake was less than 25% (Ensure was given), evening intake was not documented and Ensure was given. - 8/28/20 - Morning intake was 50% (Ensure was given), evening intake was 75% and Ensure was given. - 8/29/20 - Morning intake was 25% (Ensure was given), evening intake was 50% (Resident refused Ensure). - 8/30/20 - Morning intake was 75% (Ensure was given), evening intake was not documented and ensure was given. - 8/31/20 - Morning intake was 25% and Ensure was given. Interview on 09/01/20 at 02:45 PM with the MDS-C (MDS (a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) Coordinator) confirmed Resident 11's evening meal intakes were not consistently documented. The MDS-C revealed the NAs (Nurse Aides) should have recorded intakes via electronic charting and the floor nurses should have reviewed the documentation. Interview on 9/2/20 at 7:32 AM with the DON (Director of Nursing) revealed every meal should have intake documentation completed. The DON confirmed Resident 11 was missing meal intake documentation. Interview on 9/2/20 at 7:57 AM with the DM (Dietary Manager) revealed NAs provide resident meals to the rooms, so the NAs would monitor meal intake in percentage eaten. Interview on 09/02/20 at 09:03 AM with LPN-A (Licensed Practical Nurse) revealed Resident 11 does eat independently, but if intake is less than 50% for morning or evening meals the resident would receive Ensure. LPN-A revealed intakes are monitored through the NA charting in the EHR. Interview on 09/02/20 at 09:19 AM with NA-B revealed all meal intakes should have been recorded and documented in the EHR. NA-B revealed some staff write the intake percentage down on a clipboard or on the meal slips then transcribe the numbers into the computer.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Numbers 175 NAC 12-006.12B Based on record review and interviews, the facility failed to ensure the Consulting Pharmacist identified irregularities during the monthly medication regimen review (review of all medications the resident is currently using to identify any potential adverse effects and drug reactions.) related to Milk of Magnesia for one Resident receiving [MEDICAL TREATMENT] (Resident 168); failed to ensure the attending provider documented rationale for use of multiple diuretics and the risk vs benefit for use for medications identified by the pharmacist for one resident (Resident 4); and failed to identify a special instruction was needed related to scheduled and as needed [MEDICATION NAME] use for one Resident (Resident 11). This had the potential to affect 3 residents of 5 residents reviewed. The facility census was 14. Findings are: Record review of Resident 168 care plan's dated 08/20/20 revealed Resident received [MEDICAL TREATMENT] (process of purifying the blood of a person whose kidneys are not working normally) on Tuesday, Thursday, and Saturdays. Record review of Resident 168 Medication review summary revealed an order for [REDACTED]. Interview on 09/02/20 at 0730 a.m. DON confirmed, [MEDICAL TREATMENT] residents should not receive Milk of Magnesia. DON revealed the facility Consulting Pharmacist reviewed the Medication Regimen with no irregularities or recommendations. Record review on 09/02/20 of Consulting Pharmacist duties revealed: 1) Consulting Pharmacist is to complete monthly chart reviews for all residents including Resident benefit and risk compliance. 2) All Resident's medication regimen reviewed on admission and recommendations sent to Director of Nursing. B. Record review of Pharmacy review sheet dated 6/10/20 revealed recommendations for documentation benefit vs risk for the [MEDICATION NAME], and to document justification for multiple diuretics. Record review of Resident 4's Face sheet revealed resident 4 was admitted on [DATE] DX (Diagnosis): [MEDICAL CONDITION], acute pain due to trauma, [MEDICAL CONDITIONS], liver [MEDICAL CONDITION] Record review of a Referral/Response Letter dated 6/11/20 for Resident 4 revealed; an addendum dated 9/2/20 Patient was admitted on [MEDICATION NAME] for muscle spasms prior to hospitalization . Resident 4 was taking [MEDICATION NAME] for hypertension and [MEDICATION NAME] for fluid overload. The provider was aware of the multiple diuretic treatment. An interview on 09/03/20 08:49 AM with the IDON (Interim Director of Nurses) confirmed the Pharmacy review sheet dated 6/10/20 signed on 6/11/20 by the Provider had not addressed the recommendations from the Pharmacist. The IDON reported that a nursing staff member should review the document to ensure the recommendations have been addressed within 1 week. C. Review of Resident 11's Order Summary Report dated 8/31/20 revealed Resident 11 had orders to receive: - [MEDICATION NAME] 325 mg - 2 tablets by mouth every 6 hours as needed for pain. - Tylenol (brand name for [MEDICATION NAME]) 650 mg by mouth three times daily for pain. No documentation related to an upper limit of [MEDICATION NAME] to be administered to the resident was noted. Review of Resident 11's August 2020 MAR (Medication Administration Record) revealed Resident 11 received Tylenol 650 mg three times daily. The resident also received [MEDICATION NAME] 650 mg as needed one time daily for 15 of 31 days and two times daily for 2 of 31 days. No documentation of a warning to notify staff to monitor amount of [MEDICATION NAME] administered was noted on the MAR. Review of [MEDICATION NAME] Dosage Guide with Precautions from Drugs.com dated 2/28/20 revealed the maximum oral dose for pain in adults would be 4 grams per 24 hours. Review of Resident 11's Progress Notes dated 8/25/20 revealed the resident's chart was reviewed by the pharmacy and no recommendations were noted. Interview on 9/2/20 at 7:23 AM with the DON (Director of Nursing) confirmed residents should not receive more than 4 grams of [MEDICATION NAME] daily. The DON confirmed Resident 11 had orders for Tylenol 650 mg three times daily and for [MEDICATION NAME] 650 mg every 6 hours as needed, and a note or special instruction should be included for staff to monitor the resident did not receive more than 4 grams daily. The DON revealed the pharmacist should have identified a note was needed when completing the monthly medication regiment review
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12.B Based on record reviews and interviews the facility failed to identify a Medication Regimen Review (review of all medications the resident is currently using to identify any potential adverse effects and drug reactions.) was free of unnecessary medications for one resident (Resident 168) of five sampled, with a [DIAGNOSES REDACTED]. The facility census was 14. Findings are: Record review of Resident 168's care plan dated 8/20/20 revealed, resident admitted with a [DIAGNOSES REDACTED]. Record review on 8/31/20 of Interim Medication Regimen Review dated 08/20/20 revealed, Physician orders [REDACTED]. Record review of Resident's 168 Medication Summary report dated 8/20/20 revealed, Resident had an order for [REDACTED]. regimen reviewed on admission and recommendations sent to Director of Nursing. Interview on 9/2/20 at 7:30 am with DON (Director of Nursing) confirmed [MEDICAL TREATMENT] patients should not receive Milk of Magnesia. DON revealed Milk of Magnesia is a standing order that was put on the admission medication sheet. DON revealed, on admission the facility sends a list of the Resident's medications to the consulting Pharmacist for review of irregularities, suggestions or recommendations. DON confirmed the Consutling Pharmacist should of made a note about the Milk of Magnesia order.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12E1 Based on observation, interview and record review the facility failed to ensure liquid stock medications were not expired and available for use. This has the potential to affect all the residents in the facility. The facility census was 14. Findings are: An observation on 09/01/20 at 09:05 AM with the DON (Director of Nurses) of the Medication Storage room. During the observation the following expired medications were located in cupboard for stock medications available for staff use: 2 bottles of Dicto Liquid 50 mg/5 ML with an expiration date of 12/ 2 bottles of Dicto Liquid 50 mg/5 ML with an expiration date of 4/2020 4 bottles of Iron Supplement [MEDICATION NAME] 220 mg with an expiration date 2/2020 4 bottles Geri-[MEDICATION NAME] DM cough suppressant with an expiration date of 4/2020 3 bottles of Antacid Regular Strength liquid with an expiration date of 8/2020 An observation on 9/1/20 at 9:34 AM with RN E of the 500 hall cart revealed; an open bottle of Antacid Regular strength with an Expiration date of 8/2020. An interview on 9/1/20 at 9:34 AM with RN (Registered Nurse) E confirmed; the Antacid in the cart was expired. RN E confirmed; if the medication was empty they would restock the med cart with stock medication from the cupboard in the medication storage room. An observation on 9/1/20 at 9:39 AM with LPN (Licensed Practical Nurse) F confirmed; Advanced Antacid located in the 300 hall medication cart was expired on 2/2020. LPN confirmed; when the medications are empty they would restock the med cart from the stock medications in the cupboards in the medication storage room. Record review of Medication Storage Policy dated 2018 #6 Unused Medications revealed; The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, out dated, defective or deteriorated medications with worn, illegible or missing labels. These medications are destroyed in accordance with out Destruction of Unused Drugs Policy.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.17 and 12-006.17D Based on observation, interview and record review the facility failed to ensure multi use equipment was cleansed between resident uses, and failed to ensure hand hygiene was completed per facility policy to prevent cross contamination during the provision of medication administration. This had the potential to affect all the residents in the facility. The facility census was 14. Findings are: A. An observation on 9/2/20 at 7:13 AM of LPN (Licensed Practical Nurse) G during medication administration, took a wheeled vitals machine into Resident 12's. LPN G took Resident 12's blood pressure and used the pulse oximeter. The wheeled vitals machine was then placed in the hall way for use by others. The wheeled vitals machine was not cleansed prior to use on Resident 12 or after use on Resident 12. An interview on 9/2/20 at 11:20 AM with the IDON (Interim Director of Nurses) revealed the expectation was, staff did not have to clean the wheeled vitals machine between resident use. Record review of Cleaning and Disinfecting of Resident Care Items and Equipment dated 2018 revealed Section 1, c. Reusable items are cleaned and disinfected or sterilized between residents. (Stethoscopes, durable medical equipment, etc). An observation on 9/2/20 at 7:13 AM of LPN G who performed HH (hand hygiene) for 15 seconds after taking Resident 12's vitals. Medications were prepared and given. HH was performed with HS (hand sanitizer). LPN G then performed HH in the sink for 6 seconds (7:20:26 AM - 7:20:20:32 AM). An observation on 9/2/20 at 7:32 AM of LPN G during medication administration for Resident 11 revealed Juice was retrieved from the kitchen the HH was performed with HS. The medications were prepared HS was used and glove were applied. The medications were given. LPN G removed the gloves. HS was used and new gloves applied eye drops given gloves were removed HH with HS and new gloves then nasal spray was given. LPN G removed gloves completed HH for 7 seconds (7:34:16 -7:34:23 AM) Record review of Hand Hygiene Policy dated 2017 revealed; 4. Hand hygiene technique is indicated when using an alcohol based hand rub. a. Apply a palm-full of product in the palm of one hand and rub hands together. b. Cover surfaces with the product until hands feel dry. c. This should take about 20 seconds. #5. Hand Hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water because repeat exposure to hot water may increase the risk of [MEDICAL CONDITION]. b. Apply enough soap to cover all hands surfaces. c. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single towel. f. Use towel to turn off the faucet.