STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285306	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemingford Care Center	605 Donald Avenue Hemingford, NE 69348

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. License Reference Number 175 NAC 12-006.02(H) Based on interviews and record review, the facility failed to report alleged misappropriation of resident property to a state agency within 24 hours and submit an investigation within 5 working days of the incident as required for 1(Resident 12) of 1 sampled resident. The facility identified a census of 27. Findings are: Record review of a facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last revised September 2022, revealed if misappropriation of resident property is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy also indicated that immediately was defined as within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Record review of an undated facility document titled, Investigation report, Misappropriation, revealed the following: -On 8/7/24 at 10:30AM, the dialysis center called the facility to report that (Resident 12) had alleged that someone stole 4 million dollars from them. -The notification to the administrator/director of nursing was at 8/7/24 at 10:30AM. -Adult Protective Services (APS) was notified on 8/13/24 at 2:12 PM by the facility. -The facility submitted an investigation report to the state agency on 8/19/2024. An interview on 12/5/24 at 10:32 AM with the Director of Nursing (DON) confirmed that the dialysis facility notified the nursing home that Resident 12 alleged that someone had stolen 4 million dollars. The interview also confirmed the allegation was reported to the state agency on 8/13/24. An interview on 12/05/24 at 10:35 AM with the Nursing Home Administrator (NHA) confirmed they did not notify the State Agency within 24 hours or submit an investigation within 5 working days as required.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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. Licensure Reference 175 NAC 12- 006.09(I) Based on record reviews and interview, the facility failed to protect 4 (Residents 9, 16, 17, and 20) from Resident 15's adverse behaviors. The facility identified a census of 27. Findings are: A record review of a facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revised date of April 2021 indicated the facility would protect residents from abuse including from other residents. A record review of a facility policy, Abuse and Neglect - Clinical Protocol with a revise date of March 2018 indicated the physician and staff will address appropriately causes of problematic resident behavior where possible. A. A record review of an admission Record indicated the facility admitted Resident 15 on 2/21/2024 with diagnoses of Alzheimer's disease, agitation, mood disorder, wandering, and chronic pain. A record review of Resident 15's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), revealed Resident 15 had a Brief Interview for Mental Status score of 2/15, which indicated Resident 15 had severe cognitive impairment. The MDS also revealed Resident 15 had wandering behaviors 4-6 days of the 7 day look back period and required supervision with walking. A record review of Resident 15's undated Care Plan revealed the following: -Resident 15 was admitted to the memory care unit due to diagnoses of Dementia, Alzheimer's disease, and a mood disorder. -Resident 15 was at risk for elopement due to frequent wandering without purpose, verbal aggression, refusal of care, and physical aggression, requiring increased monitoring. -Resident 15 had the tendency to enter other resident's rooms. -Resident 15 had been involved in resident-to-resident altercations on the following dates: 4/18/2024, 5/5/2024, 6/28/2024, and 7/15/2024. -On 3/6/2024, the following interventions were implemented: approach with ease; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book; and identify patterns of wandering. -On 4/18/2024, interventions to attempt to redirect the resident when they attempt to enter other resident's room, if Resident 15 is constantly following staff around to assist Resident 15 to the bathroom and attempt to figure out any other needs they may have, monitor Resident 15 for signs of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being tired and assist to room/bed if agreeable; and monitor resident when in close proximity to Resident 17. -On 6/28/2024, a duplicate intervention to supervise Resident 15 when they were ambulating in the hall and attempt to redirect if Resident 15 attempted to enter another resident's room was added. -On 6/29/2024, an additional duplicate intervention was added to include to attempt to distract Resident 15 from entering other resident's room by gently holding their hand and leading them away. Additionally, to use a calm and soothing voice, use a calm and soothing voice, attempt to engage Resident 15 in conversation, and do not tell Resident 15 they can't do something as this could increase Resident 15's agitation. -On 7/15/2024, a duplicate intervention to not tell Resident 15 they can't do something and to redirect was added. -On 7/16/2024, an intervention of a medication review completed by the pharmacist and 15-minute safety checks was added. The 15-minute safety checks were discontinued on 7/22/2024. No additional interventions were placed. B. A record review of Resident 17's Progress Notes from 4/18/2024 at 8:00 PM revealed the nurse heard loud yelling from Resident 17's room. The nurse found Resident 15 standing directly in front of Resident 17. Resident 17 stated to the nurse to get him out. The nurse was unsuccessful in getting Resident 15 out of Resident 17's room and left to get assistance from the charge nurse. Resident 17 stated that Resident 15 had opened the door to their room and laid down on their bed. When Resident 17 told Resident 15 to get out of his room, Resident 17 felt Resident 15 hit them in the back of them head. Resident 17 was assessed for injuries and none were noted. Resident 17 denied any pain related to the altercation. C. A record review of Resident 9's Progress Notes from 5/5/2024 at 12:49 PM revealed the Medication Aide (MA) on duty overheard yelling to get out of their room coming from Resident 9's room. Resident 15 had entered Resident 9's bathroom and pushed Resident 9 to the ground. Resident 9 sustained a bruise to their outer left wrist from the altercation. D. A record review of Resident 16's Progress Notes from 6/28/2024 at 10:56 PM revealed Resident 15 had entered Resident 16's room and an altercation occurred. Resident 16 reported Resident 15 had hit them in the torso. Resident 16 sustained no injuries due to the altercation. E. A record review of Resident 20's Progress Notes from 7/16/2024 at 12:00 AM revealed Resident 20 had been pushed down to the floor by Resident 15 outside their bedroom door. Resident 20 sustained a skin tear to their right upper arm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 12/9/2024 at 10:55 AM with the Director of Nursing (DON) confirmed no interventions were placed on the care plan after Resident 15's altercation with another resident on 5/5/2024. The DON also confirmed the intervention from 6/29/2024 for Resident 15's altercation with another resident was a duplicate and no intervention to prevent Resident 15 from entering other resident's room was placed. Additionally, the DON also confirmed that no other non-pharmacological intervention to prevent Resident 15 from wandering into other resident's rooms for Resident 15's resident to resident altercation on 7/16/2024 was placed.