STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 Licensure Reference Number 175 NAC 12-006.05(E) Based on record review and interview; the facility staff failed to include the resident/ family member in the quarter care planning process for 1 (Resident 2) of 3 sampled residents. The facility staff identified a census of 90. Findings are: Record review of a Order Summary Report printed on 10-28-2024 revealed Resident 2 admitted to the facility on [DATE]. Record review of Resident 2's Electronic Medical Record (EMR) under the section identified as census revealed Resident 2 discharge from the facility on 8-23-2024. Further review of Resident 2's EMR revealed the last quarter care planning process was completed on 10-24-2023. There was no indication a quarter care planning process was conducted as of 10-29-2024. On 10-28-2024 at 10:10 AM an interview was conducted with a Family Member (FM) of Resident 2's. During the interview Resident 2's FM reported not being invited or being aware of the quarterly care planning process. Resident 2's FM reported being involved in planning care for Resident 2. On 10-28-2024 at 3:42 PM an interview was conducted with the Social Services Director (SSD). During the interview the SSD confirmed Resident 2's record did not reflect the care planning process had been completed for the resident. The SSD reported not being aware that the quarterly care planning process had been completed for Resident 2.

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

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F 0689 Level of Harm - Minimal harm or potential for 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** 21492 Licensure Refernce Number 175 NAC 12-006.09(I) Based on observations, record review and interview; the facility staff failed to implement assessed interventions to prevent accidents/falls for 3 (Resident 1,3 and 4) of 4 sampled residents. The facility staff identified a censu of 90. Findings are: A. Record review of Resident 1's Comprehensive Care Plan (CCP) printed on 10-28-2024 revealed Resident 1 was admitted to the facility on [DATE]. Further review of Resident 1's CCP revealed Resident 1 had a fall initiated on 7-03-2023. According to Resident 1's CCP the goal for Resident 1 was Resident 1 would not sustain a serious injury requiring hospitalization . Interventions to meet this good were as follows: -Anticipate and meet the residents needs. -Call light in reach. -Complate a fall risk assessment. -Fall mate next to the bed. -Parameter mattress to the bed. Observation on 10-28-2024 at 7:26 PM revealed Resident 1 was in bed and did not have a fall mat in place. On 10-28-2024 at 7:28 PM Licensed Practical nurse (LPN) A confirmed Resident 1 did not have a fall mat and should have had one. B. Record review of Resident 3's CCP with an initiated date of 4-23-2020 revealed Resident 3 had a fall. The goal for Resident 3 was Resident 3 wound not sustain any serious injury with falls requiring hospitalization . Interventions identified on Resident 3 CCP included the following: -Educate staff to remove a sling (item used with a mechainal lift transfer) after being positioned in a chair. -Fall mat at bed side when the resident is in bed. -frequent checks when the resident was in bed to ensure bed positioning. Observation on 10-28-2024 at 10:24 AM revealed Resident 3 was in the lobby area seated in a wheelchair and setting on a sling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10-28-2024 at 12:55 PM revealed Resident 3 was setting on a sling. 10-28-2024 at 1:23 PM an interview was conducted with LPN F. During the interview LPN F confirmed Resident 3 was sitting on a sling. Observation on 10-28-2024 at 7:20 PM revealed Resident 3 was in bed and did not have a fall mat in place. A interview was conducted with Registered Nurse (RN) D on 10-28-2024 at 7:22 PM. During the interview RN D confirmed Resident 3 should have had a mat next to their bed and did not. Observation on 10-29-2024 at 4:36 AM revealed Resident 3 was in bed and did not have a mat next to the bed. C. Record review of Resident 4's CCP with an iniiation date of 3-30-2023 revealed Resident 4 was at rsik for falls. The goal identified on Resident 4's CCP was Resident 4 would not sustain serious injury requiring hospitalization . The interventions list on the CCP were as follows: -Anticipate and meet Resident 4's needs. -Call light within reach. -Fall mat at bed side while the resident is in bed. Low bed when Resident 4 is asleep. Observation on 10-28-2024 at 1:17 PM revealed Resident 4 was in bed and did not have a mat next to the bed. Observation on 10-28-2024 at 7:22 PM revealed Resident 4 was in bed and did not have a fall mat next to the bed. On 10-28-2024 at 7:22 PM an interview was conducted with RN D. During the interview RN D confirmed Resident 4 did not have a fall mat and should have had one.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 21492 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review and interview; the facility staff failed to ensure a medication error rate of less than 5%. Observation of 34 medication revealed 4 errors resulting in an error rate of 11.76%. The medication errors effect 3 (Resident 10,11 and 13) of 5 sampled residents. The facility staff identified a census of 90. Findings are: A. Record review of Resident 10's Medication Administration Record (MAR) for October 2024 revealed Resident 10 practitioner had ordered Atorvastation(medication to treat high cholesterol level) 20 milligrams (mg) and Metamucil 4 in 1 fiber oral packet to be given 4 times a day. According to Resident 10's MAR for October 2024, the Atorvastation was schedule to be given at 5:00 PM. Observation on 10-28-2024 at 7:33 PM revealed Licensed Practical Nurse (LPN) A prepared Resident 10 medications that included the Atorvastatin 20 mg. In addition LPN A scooped out 1 scoop of the Metamucil using a plastic spoon and place the medication into a plastic cup. LPN A took the medications and administered them to Resident 10. On 10-28-2024 at 7:40 PM and interview was conducted with LPN A. During the interview LPN A confirmed the Atrovastatin was given late and and the Metamucil was not given as ordered. B. Record review of a Order Summary Report printed on 10-29-2024 revealed Resident 11's practitioner ordered medication that included Diltiazem (medication used to treat high blood pressure) 180 mg capsule to be given at bed time. Observation on 10-28-2024 at 8:00 PM revealed Registered Nurse (RN) B prepared Resident 11's medication to be administered. During the observation the Diltiazem was not available to be given to Resident 11. On 10-28-2024 at 8:10 PM an interview was conducted with RN B. During the interview RN B confirmed the Diltiazem was not available to be given to Resident 11 and was an error. C. Record review of Resident 13's MAR for October 2024 revealed Resident 13's practitioner order medications that included Calcium Carbonate 600 mg tablets , twice a day. Further review of Resident 13's MAR for October 2024 revealed the Calcium Carbonate was scheduled for 10 am and 3 PM. Observation on 10-29-2024 at 7:23 AM revealed RN D prepared Resident 13's medications for administration including the Calcium Carbonate and administered them to Resident 13. On 10-29-2024 at 7:35 AM an interview was conducted with RN D. During the interview RN D confirmed the Calcium Carbonate was given early and was an error.