STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285150	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Care Center	420 Gordon Avenue Chadron, NE 69337

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 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 12-006.09(I) Based on record review and interview, the facility failed to determine root causes of falls and implement interventions of these identified risks to prevent fall from recurring for 1 (Resident 13) of 2 sample residents. The facility identified a census of 29.Findings are: A record review of the facility's policy, Fall Prevention and Response (dated April 2025) revealed it is the policy of the facility to identify residents who are at high risk for falls and develop individual precautions to prevent further falls. Additionally, the policy included steps to follow when a fall occurs as follows: 1) complete an incident report and a fall scene investigation after each fall; 2) falls will be logged through the completion of incident reports in PointClickCare (the medical record system); 3) initiate neuro checks if the resident hit their head or if the fall was unwitnessed and the resident cannot state if they hit their head or not; 4) notify the resident's physician; 5) notify the resident's family; 6) documentation of post-fall status in progress notes; and 7) update the care plan with any new or revised fall interventions. A record review of Resident 13's Medical Diagnoses revealed Resident 13 had been admitted to the facility on [DATE]. Resident 13 had a diagnosis of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior). A record review of Resident 13's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) (dated 5/14/2025) revealed Resident 13 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 3/15, which indicated the resident had severe cognitive impairment. Additionally, the MDS revealed the resident had sustained a fall prior to admission. A record review of Resident 13's quarterly MDS (dated 8/5/2025) revealed Resident 13 continued to have a BIMS of 3/15. Additionally, Resident 13 now required supervision with walking and had sustained two falls with injury since previous MDS. A record review of Resident 13's Care Plan revealed a focus care area identifying the resident was at a risk for fall due to confusion, gait/balance problems, and impaired awareness of safety needs had been initiated on 5/2/2025. Two interventions were also initiated on this date of: anticipate/meet the resident's needs and ensure the call light is within reach/encourage the resident to use it/answer promptly. A.A record review of Resident 13's Fall Scene Report from 6/16/2025 at 3:10 AM revealed the resident had been found on the floor next to their bed. The resident's head was found near the foot end of the bed. The resident was unable to communicate what they had been doing at the time of the fall, but the nurse had identified impaired memory, furniture, and lighting as factors observed at the time of the fall. It was also identified resident had one slipper and one gripper sock on. Root cause of the fall was determined as footwear, medical status/physical coordination/diagnosis, and impaired memory. Interventions to prevent future falls included bed in the lowest position, (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	both slippers on, and bathroom light left on with the door cracked open. A record review of Resident 13's Progress Notes from 6/16/2025 at 3:10 AM revealed the Resident was found by staff on the floor, beside their bed, with one foot resting on the side of the bed, with the overhead light on. Additional record review of Resident 13's Care Plan revealed no evidence an intervention had been placed, under the falls focus area. An interview on 12/8/2025 at 4:15 PM with the Administrator (ADM) and Corporate Nurse Consultant (CNC) confirmed no interventions following Resident 13's fall on 6/16/2025 had been placed. Additionally, it was revealed that the fall scene reports are preliminary interventions and not always do the interventions developed at the time of that form are used long-term, confirming no intervention was developed following this fall. B.A record review of Resident 13's Fall Scene Report from 7/17/2025 at 6:50 PM revealed the resident had been walking with staff back to their room, when their feet caught each other. Staff was too far way to catch the resident before they hit the wall and slid to the floor. Resident 13 sustained a skin tear to their elbow and a laceration above their eye. The root cause of the fall was determined as gait imbalance. Interventions for future falls included 15-minute checks and if staff were walking directly beside the resident, to use gait belt, if resident allows. Additional record review of Resident 13's Care Plan, under the fall focus area, revealed an intervention (initiated on 7/18/2025) had been added of the resident needs activities that minimize the potential for falls while providing diversion and distraction. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed this intervention was to occupy the resident's time and distraction, keeping the resident busy. However, additional record review of the resident's Care Plan, under the wandering/elopement section, revealed two intervention had already been placed, initially on 5/12/2025, of distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television book and provide structured activities: toileting, walking inside and outside, reorientation strategies including sign, pictures, and memory boxes. C.A record review of Resident 13's Fall Scene Report from 9/13/2025 at 8:25 PM revealed the resident had been found on the floor of the hallway. Root causes of the fall were determined as impaired memory and gait imbalance. Intervention to prevent future falls was listed as neuros performed so resident checked very frequently.A record review of Resident 13's Care Plan Report under the fall section, revealed Fall: 9/13/2025 had been added on 9/15/2025 to an already existing intervention of Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, which had been initiated on 5/2/2025. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed that the facility had been trying to get the resident to utilize the call light, however, the use of the resident's walker and call light are a [NAME] point because [gender] is never going to start using them. D.A record review of Resident 13's Fall Scene Report from 9/22/2025 at 4:20 AM revealed the resident had been found on the floor lying next to their bed and between the near by table. Resident's head was near the head of the bed. Resident 13 sustained two lacerations to the side of their face. Root cause of the fall was determined to be medical status/physical coordination/diagnosis, mood or mental status, and impaired memory. No interventions were placed in the boxed for interventions to prevent future falls.A record review of Resident 13's Progress Notes from 9/22/2025 revealed the following:- At 4:20 AM, Resident 13 was found on the floor beside their bed, with blood noted to be on the bedside table. Resident 13 had sustained two lacerations: one underneath their right eye and one on their right eyebrow. Resident 13 was sent to the hospital for sutures. A record review of Resident 13's Care Plan Report revealed an intervention had been initiated on 9/22/2025 following the resident's fall of Review information on past fall and attempt to determine cause of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the falls. Record possible root causes. Alter [or] remove any potential causes, if possible. Educate resident/family/caregivers/IDT [interdisciplinary team] as to causes. There was no evidence of an intervention to decrease the risk of additional fall in the same manner. Additionally, the Care Plan revealed, under the Activities of Daily Living (ADL) section, that it was identified and placed as an intervention for the resident's need for cueing and as needed repositioning in the bed. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed that the facility was unsure of the cause of the fall, stating the resident likes to be on the edge of the bed and needs cued to move back. Additionally, noting that the bed should be in low position to minimize the risk of the resident rolling out of bed, but confirming no intervention was placed following this fall. E.A record review of Resident 13's Fall Scene Report from 11/24/2025 at 4:01 AM revealed the resident had self-reported a fall. Previously, the resident had been in bed. Interventions to prevent future falls was to place bed in low position. Impaired memory and gait imbalance were determined as root causes of the fall. A record review of Resident 13's Progress Notes from 11/24/2025 revealed the following:- At 4:01 AM, it was noted Resident 13 had came out of their room at 3:50 AM with the top and side of their head covered in blood and continuing to bleed. It was also noted Resident 13 had a bump to the side of their head and believed the resident had sustained an unwitnessed fall. The nurse went to the resident's room and discovered blood close to the resident's headboard. The resident was sent to the hospital at 4:15 AM.- At 9:44 AM, it was noted the nurse had received report from the hospital at 6:28 AM, learning that Resident 13 had received 9 staples for their laceration. Additional record review of Resident 13's Care Plan Report under the fall section revealed an intervention entered on 12/2/2025 of Low bed to assist with decreasing risk. No mat use due to tripping hazard. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC revealed the intervention for the bed to be in the lowest position has only been in effect since 12/2/2025. The CNC was unable to speak as to why it had not been implemented on the care plan back in June. F.A record review of Resident 13's Fall Scene Report from 11/27/2025 at 6:10 AM revealed the resident was found on the floor, leaning partially up against their dresser. The resident stated they were attempting to use the restroom. Intervention to prevent future falls were to conduct frequent rounds to help anticipate resident's healthcare needs. No root cause of the fall had been determined. A record review of Resident 13's Care Plan Report revealed an intervention of Has had falls. Sleeps on edge of bed. Call lite within reach. Continue to check on rounds and passing by had been added on 12/2/2025. However, the intervention for the call light had already been in place since 5/2/2025, cueing for bed mobility had already been in place since 5/2/2025, and one-to-one care since 8/5/2025. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed the facility's expectation was for all staff from every department to keep eyes on the resident, not just the staff member conducting the one-to-one cares, but no other interventions were implemented. It was also revealed that the call light was not an effective or appropriate intervention as the resident does not use the call light.