| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285256 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/27/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kimball County Manor | 810 East 7th Street<br>Kimball, NE 69145 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(G) Licensure Reference Number 175 NAC 12-006.09(I) Based on record reviews and interviews, the facility failed to determine the root cause of every fall incident, implement interventions that prevented recurrence of falls related to the identified causes, and develop and implement new interventions after subsequent falls occurred for 3 (Residents 1, 2, and 3) of 3 sampled residents. The facility identified a census of 38. Findings are: An interview on 8/27/2025 at 10:25 AM with the Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed that the facility's process following a resident fall includes the nurse completing an incident report, noting what was happening before the fall. The facility holds a Utilization Review (UR) meeting daily (except Thursdays and weekends) to discuss falls and assign interventions. The interdisciplinary team (IDT) determines if interventions are appropriate based on the cause of the fall. The DON gave an example that if a resident falls while reaching for a remote on a dresser, an appropriate intervention would be to move the remote closer, not lower the bed, to prevent the fall from recurring. The DON revealed the facility utilizes the following polices for falls: Fall Prevention Program (Angel Watch), Incident Report, Protocol for Neurological Assessment, and Possible Injury After a Fall. A record review of the facility's Fall Prevention Program (Angel Watch) policy dated 1/2013, revealed the policy states residents with two falls in one week or three in a month should be placed on the Angel Watch program, identified by an angel marker on their assistive devices and door. The policy did not include conducting root cause analysis or specifying development of fall-prevention interventions. A record review of the facility's Possible Injury After a Fall policy dated 4/2024, revealed that falls with injury must be reported to Adult Protective Services (APS) within two hours, and a five-day investigation submitted to the state. The policy did not include requirements for conducting a root cause analysis or implementing fall-prevention interventions. A. A record review of Resident 3's Face Sheet revealed the facility admitted the resident on 2/3/2022. Resident 3 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 3's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 7/3/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 6/15, which indicated Resident 3 had severe cognitive impairment. Additionally, it revealed the resident had one-sided lower extremity impairment and utilized a walker for mobility. The resident required partial assistance with toileting and dressing, and was independent with bed mobility, ambulation, and transfers. A record review of Resident 3's Event Reports dated 5/31/2025 revealed the resident was found naked on the floor beside their spouse's bed. The resident stated they had been engaging in sexual activity<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with their spouse when they fell. There was no documented evidence that a root cause analysis had been conducted following this fall, nor were interventions identified to reduce the risk of recurrence. A record review of Resident 3's Event Reports dated 6/23/2025 revealed the resident was found on the floor beside their spouse's bed. On 6/24/2025, a UR meeting was held and an intervention of no sense of safety due to resident failing to ask for assistance for intimacy had been implemented. There was no evidence that the root cause had been identified and no specific intervention to prevent recurring falls during intimacy was developed. A record review of Resident 3's Event Reports dated 7/3/2025 revealed the resident was found sitting on the floor in their room with back against the bed. Resident 3 was sitting with their pants and brief around their ankles with regular socks on. The resident reported they were attempting to get in their spouse's bed to engage in sexual activity. The resident's fall root-cause was identified as slipping from regular socks. An intervention for physical therapy (PT) and occupational therapy (OT) evaluation for balance was placed, however, no intervention was put in place to mitigate the specific slipping hazard. An interview on 8/27/2025 at 10:50 AM with the NHA and DON revealed the following:- Confirmed there was no documented evidence a root cause had been identified in the resident's medical record for the 5/31/2025 fall. However, it was determined the root cause to be from losing balance. An intervention for gripper socks had been added. The DON confirmed the gripper socks was not related to the cause or prevention of that fall.- Confirmed no root cause or intervention for prevention had been placed for the 6/23/2025 fall.- The DON confirmed the cause of the 7/3/2025 fall was slipping on the floor in regular socks, and acknowledged that a PT/OT evaluation would not mitigate slipping in inappropriate footwear. B.A record review of Resident 1's Face Sheet revealed the facility admitted the resident on 8/26/2024. Resident 1 had a diagnosis of Lewy Body Dementia (LBD, a progressive disease caused by abnormal protein clumps, Lewy bodies, in the brain cells that leads to decline in thinking, movement, sleep, and behavior. Key symptoms include fluctuating alertness, visual hallucinations, and acting out dreams during sleep). Additionally, Resident 1 had a diagnosis of repeated falls. A record review of Resident 1's MDS dated [DATE] revealed the resident had a BIMS score of 11/15, which indicated the resident had moderate cognitive impairment. Additionally, the MDS revealed Resident 1 was independent with bed mobility, transfers, and ambulation of 10 feet. A record review of an Event Report for Resident 1 with a date of 6/7/2025 revealed the resident was found on the floor in a pool of blood, having hit their head on a nightstand after reportedly rolling out of bed during a bad dream. The resident required six staples at the Emergency Room. An intervention was added on 6/9/2025 to lower the bed and place a fall mat. There was no evidence of a root cause analysis or additional interventions to prevent the recurrence of the fall. A record review of an Event Report for Resident 1 with a date of 8/16/2025 revealed the resident reported falling out of bed during the night, sustaining a bruise to the right wrist. The resident could not give an exact time but stated they had been roaming early in the morning. The intervention section had none of the above marked. There was no evidence an intervention was developed or root cause identified. A record review of Resident 1's Fall Care Plan, with a last reviewed/revised date of 8/18/2025, listed the interventions of lowering the bed and moving nightstand away from the head of the bed for the 6/7/2025 but did not include any additional interventions for that fall nor any interventions for the 8/16/2025 fall. An interview on 8/27/2025 at 10:30 AM with the NHA and DON revealed the facility had identified Resident 1 had rolled out of bed due to having bad dreams on 6/7/2025. They confirmed no further root cause analysis of the dream-related behavior had been completed and no additional intervention had been developed to prevent the fall from recurring. Regarding the fall on 8/16/2025, the NHA and DON confirmed no root cause or intervention had been<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | identified or implemented, stating they did not believe the fall occurred because the resident would not have been able to get off the floor without assistance. C. A record review of Resident 2's Face Sheet revealed the resident was admitted to the facility on [DATE]. Resident 2 had diagnoses of dementia, hemiplegia (one-side paralysis), and weakness. A record review of Resident 2's MDS, dated [DATE], revealed the resident had a BIMS score of 5/15, which indicated sever cognitive impairment. Resident 2 required full assistance with toileting and dressing. Resident 2 also required moderate assistance with bed mobility and transfers. A record review of an Event Report for Resident 2 with a date of 7/8/2025 revealed the resident was self-ambulating to the bathroom when they bent down to retrieve a tissue from the floor and lost their balance, resulting in a fall. The intervention implemented was the application of gripper socks while ambulating. There was no evidence of a root cause analysis beyond balance was conducted or additional fall prevention interventions were developed to address the mobility deficit. An interview on 8/27/2025 at 10:45 AM with the NHA and DON revealed that the root cause of Resident 2's fall on 7/8/2025 was identified as a loss of balance and underlying weakness. The NHA and DON confirmed the fall was unwitnessed, and since it was unclear whether the loss of balance was related to the resident's foot slipping, no additional interventions beyond gripper socks were developed or implemented. |