

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42679</p> <p>Licensure Reference Number 175 NAC 12-006.02(8)</p> <p>Based on record review and interview, the facility failed to provide a written investigation to the State Agency within the required five working days for 1 (Resident 1) of 4 sampled residents. The facility census was 56.</p> <p>Findings are:</p> <p>A. Review of the facility policy Abuse, Neglect, and Exploitation dated 5/8/23 revealed the following:</p> <ul style="list-style-type: none"> -It is the policy of Continental Springs LLC to protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. -The facility will have written procedures that include reporting of all alleged violations to the Administrator/Director of Nurses (DON), a state agency, Adult Protective Services (APS), and all other required agencies within specified time frames; immediately, but no later than 2 hours if the events involve abuse and no later than 24 hours if the events do not involve abuse and/or serious bodily injury. -The Administrator/DON will provide a summary of the investigation to the state agency within 5 business days. <p>B. Review of a facility investigation dated 3/6/24 related to a fall with significant injury for Resident 1 revealed the following: On 2/28/24 the resident was found at the bedside with bleeding on the left side of the face. The resident complained of pain was sent to the hospital for evaluation. The facility staff were notified the resident had a brain bleed and a facial fracture and remained at the hospital. Further review revealed the facility had not submitted the written investigation to the State Agency within the required 5 business days. The facility submitted the written investigation to the State Agency on 3/6/24.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the DON on 3/19/24 at 12:40 PM confirmed Resident 1 had a fall with significant injury that occurred on 2/28/24 and the written investigation was not submitted to the State Agency within the required 5 business days.</p>