STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285093	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Cozad	318 West 18th Street Cozad, NE 69130

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 - 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. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)(i)Based on record review and interview the facility failed to ensure that post fall procedures were followed for 1 of 4 sampled residents (Resident 1). The facility census was 36. Findings are:Record review of the facility policy titled Falls Management dated 1/2024 revealed that in the event of a fall a complete head to toe assessment must be performed. Obtain vital signs. The nurse will complete documentation to include vital signs. Contact the physician and family and document in the medical record, including time and person spoken with. The resident fall will be documented for 24 hours for post fall monitoring. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 1 dated 11/4/25 revealed that Resident 1 admitted into the facility on [DATE]. The MDS revealed that Resident 1 had two falls with no injury, and one fall with injury since the previous MDS assessment (dated 9/19/25). Record review of the facility Incidents by Incident Type (a listing of resident falls, skin injuries, and other injuries) dated 11/13/25 revealed that Resident 1 had falls on:9/28/25 at 1:55 PM- witnessed fall.10/12/25 at 1:50 PM- unwitnessed fall.10/23/25 at 1:31 PM- unwitnessed fall. 10/30/25 at 11:10 AM- witnessed fall.Record review of the current Care Plan (an individualized written comprehensive plan detailing interventions to provide quality care for a resident) dated 11/13/25 for Resident 1 revealed that Resident 1 was at risk for falls. New interventions to prevent falls were added to the care plan for the resident falls on 9/28/25, 10/12/25, 10/23/25, and 10/30/25. The intervention for the 10/30/25 fall was initiated on 11/4/25 directing staff to ensure that the resident was properly hooked up to the stand up lift if it needed to be used. (A stand up lift is a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position. A fabric sling device with straps that are secured to the hooks on the stand lift is placed around the back of a resident when a sit to stand lift is used to transfer a resident and must be hooked up properly to prevent accidents or injury.)Record review of the progress note for Resident 1 dated 10/29/25 at 10:00 PM revealed that Resident 1 remained extremely confused. Vital signs stable.Record review of the next progress note for Resident 1 was dated 10/30/25 at 4:26 PM. The progress note revealed that the physician was in the facility and ordered labs to be done for the resident. The physician revealed that if there were any lab concerns the physician would see Resident 1 on 10/31/25. (The progress note contained no information about Resident 1's fall on 10/30/25 at 11:10 AM.)Record review of the next progress note for Resident 1 dated 10/30/25 at 4:29 PM revealed that the Power of Attorney (POA) of resident 1 was notified of the same (that the physician ordered labs for the resident). Record review of the next progress note for Resident 1 dated 10/31/25 at 11:37 PM revealed that Resident 1 continued on an antibiotic for cellulitis of the left arm. (The note contained no information about Resident 1's fall or fall follow-up.)Record review of the medical record for Resident 1 revealed that it did not contain any post fall head to toe assessment, vital signs, physician notification, or family notification of the fall documented in the medical record for Resident 1's fall on 10/30/25 at 11:10 AM.Interview on 11/13/25 at 11:17 AM with Nurse Aide-A (NA-A) revealed that Resident 1 had developed more confusion and weakness so the staff used the sit to stand lift to transfer the resident. NA-A confirmed that Resident 1 fell out of the lift on 10/30/25. Interview on 11/13/25 at 1:03 PM with the facility Director of Nursing (DON) confirmed that the facility staff are expected to follow the facility Falls Management policy. The DON confirmed that after a resident fall (post fall) the nurse is to notify the resident's physician and the resident's family and document the notification in the resident's medical record. The DON confirmed that Resident 1 fell on [DATE]. The DON confirmed that there was no documentation of Resident 1's fall on 10/30/25 in the progress notes as required. The DON confirmed that there was no documentation of a head to toe assessment as required. The DON confirmed that there was no documentation in the facility risk management that the resident family was notified of the fall as required. Interview on 11/13/25 at 1:41 PM with the Facility Administrator (FA) confirmed that the facility did not have the required documentation for Resident 1's fall on 10/30/25. The FA confirmed that the facility had no documentation that the POA notification was provided as required. The FA confirmed that the facility Falls Management policy interventions were not followed by staff as required.