STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falls City Care Center	2800 Towle Street Falls City, NE 68355

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H)Based on record reviews and interviews, the facility failed to report an allegation of abuse to the State Agency within the required timeframe for Resident 2. This affected 1 of 3 residents reviewed for abuse. The facility census was 56.Findings are:A record review of the facility's Abuse Prevention Plan last revised February 2023 revealed that the Administrator (ADM), Director of Nursing (DON), or Nursing Supervisor would make sure that a report was filed and an initial investigation begun immediately. The policy also stated that any allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property should be reported to the State Agency immediately, within two hours if the event that caused the allegation included abuse or there was serious bodily harm, and within 24 hours if abuse was not involved and there was no serious bodily harm.A record review of Resident 2's Order Summary dated 06/25/2026 revealed the facility admitted the resident on 12/01/2025, and the resident did not have a diagnoses of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities).A record review of Resident 2's Quarterly Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 06/03/2026 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function. The test is scored from 0-15, and the higher the score, the higher the cognitive function) of 13, indicating the resident was cognitively intact.A review of a Grievance/Concern Report Form dated 05/27/2026 revealed that Resident 2 had filed the grievance to report that the nurse stole medications from Resident 2.An interview on 06/25/2026 at 1:22 PM with Resident 2 confirmed that when they came back from the appointment with their provider, they had a new medication order for Metamucil (a fiber supplement used to promote bowel regularity). Resident 2 stated they stopped at the nurse's desk to give them the paperwork from the appointment and told Licensed Practical Nurse (LPN) A they had a bottle of Metamucil in the basket of the walker and would take care of it. The resident stated LPN A started to open the basket to take the Metamucil and the resident said no, but the LPN kept opening the basket and hitting the resident's hands. Resident 2 reported that their left hand was bruised and the right middle finger would not bend all the way, and that their hands hurt terribly at first, but they were almost healed now. Resident 2 denied having seen a provider for their hands.An interview on 06/25/2026 at 2:17 PM with LPN A confirmed that on 05/27/2026 the LPN had removed Resident 2's medications from the basket of the resident's walker.An interview on 06/25/2026 at 4:11 PM with the Director Of Nursing (DON) confirmed that the incident involving Resident 2 occurred on 05/27/2026. The DON further confirmed that the Resident 2 had stated that LPN A stole (gender's) medications.An interview on 06/25/2026 at 4:30 PM with the Administrator confirmed that the facility should have reported the allegation to the State Agency and did not.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falls City Care Center	2800 Towle Street Falls City, NE 68355

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interviews, the facility failed to investigate an allegation of abuse for Resident 2. This affected 1 of 3 residents reviewed for abuse. The facility census was 56.Findings are:A record review of the facility's Abuse Prevention Plan last revised February 2023 revealed that the facility would investigate all incidences such as falls, bruises, medication errors, and resident complaints.A record review of the facility's Skin Program Policy last revised March 2019 revealed that when a bruise or a skin tear was noted, a thorough assessment or comprehensive wound assessment sheet should be completed and documented.A record review of Resident 2's Order Summary dated 06/25/2026 revealed the facility admitted the resident on 12/01/2025, and the resident did not have a diagnoses of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities).A record review of Resident 2's Quarterly Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 06/03/2026 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function. The test is scored from 0-15, and the higher the score, the higher the cognitive function) of 13, indicating the resident was cognitively intact.A record review of Resident 2's Progress Notes from 05/01/2026 to 06/25/2026 revealed the only documentation on 05/27/2026 was of the resident's return from an appointment and new orders. There was no mention of the resident's mention of hand pain, or assessment of the hands for injuries. Further review revealed a Skin Issues Progress Note dated 05/31/2026 at 3:54 PM that documented purple bruising to left hand base of middle finger extending to palm of hand. There was no documentation of investigation done regarding how the bruising occurred.An interview on 06/25/2026 at 1:22 PM with Resident 2 confirmed that when they came back from the appointment with their provider, they had a new medication order for Metamucil (a fiber supplement used to promote bowel regularity). Resident 2 stated they stopped at the nurse's desk to give them the paperwork from the appointment and told Licensed Practical Nurse (LPN) A they had a bottle of Metamucil in the basket of the walker and would take care of it. The resident stated LPN A started to open the basket to take the Metamucil and the resident said no, but the LPN kept opening the basket and hitting the resident's hands. Resident 2 reported that their left hand was bruised and the right middle finger would not bend all the way, and that their hands hurt terribly at first, but they were almost healed now. Resident 2 denied having seen a provider for their hands.An interview on 06/25/2026 at 4:11 PM with the Director of Nursing (DON) confirmed that on 05/27/2026 the DON had worked the evening shift and overheard another staff member who stated Resident 2 said that Licensed Practical Nurse (LPN) A had hurt Resident 2. The DON confirmed they had not gone to assess Resident 2 for injury at that time. The DON further confirmed there was no documentation that an investigation was done for the bruising documented on 05/31/2026.