

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Falls City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.04(F)(i) Based on record review, and interview, the facility failed to notify the resident's physician of a change in condition, and failed to notify family representative for 1 resident (Resident 2) of 5 sampled residents a change in condition. The facility census was 56. Findings are: A record review of the admission Record revealed Resident 2 was admitted to the facility on [DATE] with the diagnosis of Age-related osteoporosis without current pathological fractures (occurs when bones naturally lose density and mass as you age, becoming weak), Dementia, psychotic disturbance, mood disturbance and anxiety (describes a cognitive decline (such as memory loss and impaired problem-solving) occurring without psychiatric or physical symptoms like aggression, wandering, or anxiety) , Depression (persistent sadness, loss of interest, and a lack of energy), Atrial Fibrillation (rapid quivering in the heart's upper chambers (atria), causing an irregular and often fast heartbeat), Hypertension (high blood pressure), Dizziness and Giddiness (feelings of lightheadedness, faintness, or unsteadiness). A record review of the facility policy Incidents and Accidents with a date (reviewed/revised) of 7/2026 revealed: 9) The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). 11) The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital 12) The nurse will enter the incident/accident information into the appropriate form/system within 1 hours of occurrence and will document all pertinent information A record review of Resident 2 progress notes revealed that an late entry dated 6.27.26 at 1:24 PM noting that Resident was being pushed down the hallway in a wheelchair where Resident 2 dropped (gender) right foot off the foot pedal and Resident 2 right leg bend backwards under the wheelchair. A record review of Resident 2 progress notes revealed that on 6/27/26 at 8:30 PM Resident 2 complained of pain to Resident 2's right foot/ankle when touched. A record review of Resident 2 progress notes revealed that there was no progress notes on 6/28/26 for day shift, evening shift or night shift. A record review of Resident 2 progress notes revealed that on 6/29/26 at 1:04 PM that if there is touch to the right ankle Resident 2 will yell out in pain. An appointment was made to see primary physician for the right ankle/foot pain. A record review of Resident 2 progress notes revealed that on 6/29/26 at 2:15 PM Resident 2 yells out in pain with just touching the right ankle. At 4:20 PM a PRN (when needed) Tylenol was given and charted effective. A record review of Resident 2 progress notes revealed that on 6/30/26 at 3:00 PM Resident 2 returned to facility and seeing medical provider and was diagnosed with a right fibular fracture (a break in the smaller, outer bone of the lower leg). The Director of Nursing (DON) was unable to produce documentation that the physician or family representatives had been notified of the (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 0580 Level of Harm - Actual harm Residents Affected - Few	incident with the right foot/ankle when a change of condition occurred. An interview on On 7/20/26 at 11:00 AM the DON confirmed that the physician was not notified of the incident of the right ankle/foot being bent-over for Resident 2 until Tuesday (6/30/26), the day of Resident 2's appointment. The DON stated the facility did not do a change of condition to the physician nor did the facility notify family representatives due to nothing was out of the ordinary with Resident 2 . DON confirmed that Resident 2 did complaint of pain with touching of the right ankle but when asked why Resident 2 was screaming Resident 2 stated (gender) didn't know. The DON confirmed that this incident happened on 6/27/26 and Resident 2 was seen by the physician on 6/30/26 where x-rays were done and Resident 2 found to have a right fibular fracture. The DON confirmed that a change of condition should of been done and the physician and family representative should of been updated when the incident had happened and the physician and the family representatives had not been notified.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 (C)(ii) Based on record reviews and interviews, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities within 14 days of a significant change for 2 (Resident 2 and 3) of 5 residents sampled. The facility census was 56. Findings are: A.A record review of the admission Record revealed Resident 2 was admitted to the facility on [DATE] with the diagnosis of Age-related osteoporosis without current pathological fractures (occurs when bones naturally lose density and mass as you age, becoming weak), Dementia, psychotic disturbance, mood disturbance and anxiety (describes a cognitive decline (such as memory loss and impaired problem-solving) occurring without psychiatric or physical symptoms like aggression, wandering, or anxiety), Depression (persistent sadness, loss of interest, and a lack of energy), Atrial Fibrillation (rapid quivering in the heart's upper chambers (atria), causing an irregular and often fast heartbeat), Hypertension (high blood pressure), Dizziness and Giddiness (feelings of lightheadedness, faintness, or unsteadiness). A record review of progress notes 6/30/26 for Resident 2 revealed that Resident 2 had an injury to Resident 2's right foot/ankle and an x-ray revealed a right fibular fracture (a break in the smaller, outer bone of the lower leg). A record review of the MDS revealed that there was no SCSA done for Resident 2's fracture within the 14 day of the change in condition. The Director of Nursing (DON) was unable to provide a policy or documentation on when and how a significant change is to be done on a MDS. An interview at 2:47 PM 7/20/26 with the DON and Licensed Practical Nurse (LPN)-A confirmed that a SCSA MDS was not completed after Resident 2 fracture and it should have been done. LPN-A confirmed that (gender) thought it had been done. The LPN-A confirmed that (gender) is the one who does the MDS for the facility. B.A record review for Resident 3 admission Record revealed that Resident 3 was admitted to the facility on [DATE] with the diagnosis of Mental Disorders due to known Physiological conditions (a psychiatric syndrome directly caused by an underlying medical or neurological disease), Transient Ischemic Attack (little strokes), Cerebral Infarction (stroke) without residual deficits, Hypothyroidism, Absence of right and left legs above the knee, Dementia, A record review of progress notes dated 12/1/25 revealed Resident 3 had an x-ray revealing a fracture to the left elbow. A record review of the Clinical documentation for the MDS revealed that there was no significant change done for Resident 3 within the 14 day of the change in condition. The DON was unable to provide a policy or documentation on when and how a significant change is to be done on a MDS. An interview at 2:47 PM on 7/20/26 with the DON and Licensed Practical Nurse (LPN)-A confirmed that a SCSA MDS was not completed after Resident 3's fracture and it should have been done.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(i)(1) Based on record review and interview the facility failed to identify causative factors for one (Resident 1) of 5 sampled residents and the facility failed to put in new interventions to prevent falls for one (Resident 1) of 5 sampled residents. The facility census was 56 Finding are: A record review of admission Record revealed Resident 1 was admitted to the facility on [DATE] with the diagnosis of Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Injuries of left hip, Hypertension (high blood pressure), Dementia, and Fracture of Superior Rim of left Pubis (pelvic fracture). A record review of Resident 1's progress notes dated 7/14/26 revealed Resident 1 had a fall. Upon assessment resident is lying on left side next to (gender) bed in fetal position. Floor is clean and clutter free, walker is within reach, call light within reach but not in use at time of fall and resident has bare feet. Resident 1 was sent to ER where the x-rays revealed Resident 1 had a nondisplaced left superior pubis ramus fracture. A record review of Resident 1's Care plan (a written instruction needed to provide effective and person centered care of the resident that meet professional standards of quality care) with last completed dated 3/18/2026 revealed that Resident 1 had actual fall with interventions with dates of 3/05/2025, 3/7/2026, 3/16/2026, 3/17/26. There was no new interventions in place for fall on 7/14/26. A record review of the risk management forms revealed that predisposing section was marked as other with no explanation, and the predisposing situation factors marked other with no explanation to determine the causative factor of the fall for Resident 1. A record review of the facility's Fall prevention and Response Policy dated April 2025 revealed:7) The care plan will be updated with any new or updated fall interventions A record review of the facility's policy Care Planning dated March 2019 revealed:5) Interventions act as the means to meet the individual's needs (not to continue outmoded institutional practices). The recipe for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when and how the individual residents goals are being addressed and met. An interview on 7/20/26 at 2:30 PM with the Director of Nursing (DON) confirmed that interventions had been put in place and had thought that revising old interventions was enough. The DON confirmed that the fall and fracture had not been added to the care plan and it should of been.		