STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285116	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkson Community Care Center Inc	212 Sunrise Drive Clarkson, NE 68629

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(8)Based on record review and interview; the facility failed to investigate and submit a completed investigation report related to abuse and neglect to the State Agency within the required time frame for Residents 1 and 2. The sample size was 3 and the facility census was 29.Findings are: A. Review of the facility policy Abuse, Neglect and Exploitation with an implementation date of 9/2017 revealed each resident had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. In response to allegations of abuse, neglect exploitation or mistreatment, the facility was to: -ensure all alleged allegations were reported immediately, but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury. But not later than 24 hours if the advents that caused the allegation did not involve abuse and did not result in serious bodily injury. To be reported to the Administrator of the facility and to other officials (including the State Survey Agency and Adult Protective Services (APS) where state law provides for jurisdiction in long-term care facilities) in accordance with State law. -have evidence all alleged violations were thoroughly investigated. -prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in process. -report the results of all investigations to the Administrator or their designee and to the other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified the appropriate corrective action taken. B. Review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) revealed the resident was admitted on [DATE]; had severe cognitive impairment; required staff assistance with toileting, dressing, transfers, mobility and hygiene; had diagnoses of Alzheimer's Disease, Dementia, Anxiety and Pain; had a fall in the month prior to admission, and one fall with no injury since admission to the facility; and was admitted to the facility on Hospice Services. Review of Resident 1's Care Plan last revised 5/7/26 revealed the resident had impaired cognitive (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function related to Dementia; required staff assistance with bed mobility, dressing, eating, hygiene, and toileting; and the resident was at risk for falls related to their confusion, balance problems and unaware of safety needs. Review of Resident 1's Progress Notes from 5/22/26 through 5/26/26 revealed the following entries: -On 5/22/26 at 4:17 AM the resident was standing in front of a recliner. The writer and a Certified Nursing Assistant (NA) witnessed the resident fall and land on their right hip. -On 5/23/26 at 7:49 AM during a bath a large purple bruise was observed to the right hip. The resident did not cry out when the area was assessed and palpated but would not able to follow commands to perform range of motion exercises. The resident had been ambulating on the leg since the fall on 5/22/26. -On 5/23/26 at 11:59 AM the resident was observed to be favoring their left leg leading to an unsteady gait. The resident seems to be experiencing discomfort related to the fall on 5/22/26. -On 5/23/26 at 3:08 PM the resident was making comments like Oh this leg hurts and nursing staff attempted to give pain medication but the resident refused and would spit out initially but did finally accept the medication. The resident continued to favor the left extremity. -On 5/24/26 at 4:29 PM the resident was observed walking in the hallway, stopped to pull their pants and brief down and started to squat to relieve themselves. The NA observed the resident fall forward, hit their head on the medication cart and fall onto their right hip. The resident refused vital signs and a neurological assessment. The resident was noted to hobble and favor their left side while ambulating. The resident continued to self-ambulate although the resident was unsteady. -On 5/24/26 at 4:58 PM an attempt to notify the resident's responsible party was unsuccessful and unable to leave them a message. -On 5/24/26 at 6:01 PM the Hospice nurse was in the facility and assessed the resident. The Hospice nurse notified the family of the fall and assessment and planned to keep the resident comfortable. -On 5/25/26 at 12:56 PM the Hospice nurse spoke with the residents responsible party and stated the family would like to focus on pain management and comfort medications for the resident. -On 5/26/26 at 2:45 PM The Director of Nursing (DON) was reviewing documentation that resident had been experiencing discomfort with ambulation after a fall. The DON confirmed the family was aware and were choosing no follow up. A report was made to APS. Review of the investigation report dated 5/26/26 revealed the facility investigated the fall on 5/22/26 and 5/24/26. An attached facsimile (fax) dated 5/29/26 revealed the facility attempted to fax the report, but the fax contained a printout that had no response and The following data could not be sent report attached. Interview with the DON on 6/15/26 at 1:30 PM revealed the DON was not aware that the report did not go through. Further interview confirmed the investigation report was not submitted to the State Agency within 5 working days. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Review of Resident 2's MDS dated [DATE] revealed diagnoses of fractures and other multiple traumas, atrial fibrillation, high blood pressure, deep vein thrombosis, urinary tract infection in the last 30 days, arthritis, and Alzheimer's disease. The following was assessed regarding the resident: -moderate cognitive impairment. -required staff assistance with toileting, transfers, dressing and personal hygiene. -bowel and bladder incontinence. -one fall with a major injury since the previous assessment. Review of the resident's current Care Plan with a revision dated of 3/17/26 revealed the resident was at risk for falls due to diagnosis of high blood pressure and osteoarthritis. Fall prevention interventions included: anticipating and meeting the resident's needs; ensuring the call light was in reach, with prompt assistance for all requests; and ensuring the resident was wearing appropriate footwear when ambulating. Review of an Incident Audit Report dated 4/18/26 at 2:15 AM revealed the resident was found seated on the floor of the bathroom of the resident's room. The resident's head was bleeding and the resident voiced complaints of a headache and of neck pain. The on-call physician was notified and an order was received to transfer the resident to the hospital for evaluation. Review of a Progress Note dated 4/18/26 at 4:00 AM revealed the facility was notified by the hospital the resident had a spinal neck fracture. Review of a Progress Note dated 4/18/26 at 6:18 AM revealed APS was notified of the resident's fall with injury. Review of the facility investigations of potential abuse/neglect from 9/3/25 to 4/20/26 revealed no investigation was completed regarding Resident 2's fall with a significant injury. During an interview on 6/15/26 at 11:00 AM, the DON the resident had a fall on 4/18/26 at 2:15 AM and sustained a significant injury. APS was notified but the facility failed to submit an investigation related to the resident fall to the State Agency within the required time frame.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l)(i) Based on record review and interview; the facility failed to identify causal factors of falls and to revise and/or develop interventions based on those factors to prevent ongoing falls for Residents 1 and 3. The sample size was 3 and the facility census was 29. Findings are:A. Review of the facility policy Fall Risk Assessment with an implementation date of 10/21/25 revealed it was the policy for the facility to provide an environment that was free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. An explanation and compliance guidelines included the following: -a risk assessment was to be completed upon admission, quarterly or when a significant change was identified. -the risk assessment was to identify environmental hazards and individual risks, including the need for supervision and to evaluate and analyze hazards and risks. -an at risk care plan was to be completed for each resident to address items identified on the risk assessment and was to be updated accordingly. -the at risk care plan was to include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice, to reduce the risk of an accident. -monitor the effectiveness of interventions and modify the interventions, as necessary. B. Review of Resident 3's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/14/26 revealed diagnoses of anemia, heart failure, coronary artery disease, high blood pressure, aphasia (communication disorder affecting speech, understanding, reading, and writing due to brain injury), Non-Alzheimer's dementia, hemiplegia (loss of movement or control to one side of the body), anxiety, and depression. The following was assessed for the resident: -cognition was moderately impairment. -behaviors which included wandering and verbal/physical behaviors directed toward others. -required substantial to maximal assistance with toileting, dressing and bathing/showering. -bowel and bladder incontinence. -history of falls with 2 falls since the previous assessment. Review of a Fall Risk Assessment completed 12/11/25 revealed a score of 15 which indicated the resident was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Fall Data Collection form revealed the resident had a fall on 3/6/26 at 6:12 AM. The resident was found seated on the floor next to the bed with the resident's back to a dresser. The resident reported trying to turn on a light and lost balance. The fall alarm sounded and alerted the staff. The resident was alert but confused. An intervention was identified for 15 minute checks. Further review revealed no documentation regarding the 15 minute checks to identify how long they were completed and what staff was responsible for completing. Review of a Fall Data Collection form revealed the resident had a fall on 4/20/26 at 2:20 AM. The fall occurred in the bathroom of the resident's room. The resident indicated loss of balance when self-transferring to the toilet. The resident was identified as confused with increased weakness. The reason for the fall was identified as an unwillingness to accept staff assistance. A new intervention was listed for the resident to make sure the resident felt the back of legs touch the bed. Review of a Fall Data Collection Form dated 6/10/26 revealed the resident was found on the floor in front of the resident's wheelchair at 6:45 PM. The resident was confused and had been self-propelling in the corridor. No causal factors were identified. An intervention to remind the resident not to get up alone was listed. During an interview on 6/15/26 at 1:20 PM, Nurse Aide (NA)-D reported the resident was always confused with short and long term memory loss and the resident would not remember to use the call light or to wait for staff assistance before self-transferring. Interview with the Director of Nursing (DON) on 6/15/26 at 1:45 PM confirmed the following: -the resident was at high risk for falls. -on 3/6/26 at 6:12 AM, the resident had a fall when trying to turn on a light at bedside. An intervention was indicated for 15 minute checks. There was no evidence that the 15 minute checks were completed, how long they were done and who was responsible for completion. The DON verified the intervention did not address the resident's inability to safely turn on a light at bedside which was the casual factor of the fall. -on 4/20/26 the resident had a fall in the bathroom of the resident's room at 2:20 AM. The resident reported a loss of balance when self-transferring to the toilet. An intervention was listed to make sure the resident felt the back of the resident's legs touch the bed before sitting down to prevent further falls. A causal factor on the form indicated the resident was unwilling to accept staff help. The DON verified the intervention for the resident to make sure the back of the resident's leg touched the bed did not address the resident's failure to wait for staff assistance with transfers. -on 6/10/26 at 6:45 PM, the resident was found on the floor in front of the resident's wheelchair in the corridor. The assessment indicated the resident was confused and had been self-propelling in the corridor. Further review revealed no casual factors were identified. An intervention was listed to remind the resident not to get up alone. The DON acknowledged no causal factors were identified. In addition, the resident had ongoing confusion and an intervention to remind the resident not to self-transfer was not a measurable or an effective intervention. C. (continued on next page)

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(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	Review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) revealed the resident was admitted on [DATE]; had severe cognitive impairment; required staff assistance with toileting, dressing, transfers, mobility and hygiene; had diagnoses of Alzheimer's Disease, Dementia, Anxiety and Pain; had a fall in the month prior to admission, and one fall with no injury since admission to the facility; and was admitted to the facility on Hospice Services. Review of Resident 1's Care Plan last revised 5/7/26 revealed the resident had impaired cognitive function related to Dementia; required staff assistance with bed mobility, dressing, eating, hygiene, and toileting; the resident was at risk for falls related to their confusion, balance problems and unaware of safety needs; and the resident had falls on 5/22/26 and 5/24/26 with interventions of a bed alarm applied to alert the staff to self-transferring out of bed per hospice nurse, anticipate the residents needs, educate the resident/family/caregivers about safety and what to do if a fall occurred, and to follow the facility fall protocol. Review of the Fall Risk Assessment completed 4/29/26 revealed a score of 12 which indicated the Resident 1 was at high risk for falls. Review of the Fall Data Collection Form dated 4/21/26 at 4:00 AM revealed the resident was observed lying on the floor in the resident room on their left side. The resident had been trying to get out of bed. The incident was unwitnessed. The root cause of the fall was identified as confusion and the intervention implemented was 1:1 supervision. Review of the Fall Data Collection Form dated 5/24/26 at 4:00 PM revealed Resident 1 was witnessed to fall at the nurses station. The resident was attempting to toilet themself next to the medication cart and fell, hitting their head on the medication cart and falling onto their right side. The resident was unable to state what happened. The root cause of the fall was identified as weakness, confusion, pain, toileting needs, and wandering. The intervention implemented was close observation. Interview with Medication Aide (MA)-B revealed the resident had a decline, was now using a full body lift for transfers and the fall intervention was a bed alarm when the resident was in bed. Interview with the DON on 6/15/26 at 1:30 PM confirmed the resident was identified to be high risk for falls, the intervention implemented for the fall on 4/21/26 was 1:1 supervision, and the intervention implemented for the fall on 5/24/26 was close observation. The DON confirmed the interventions implemented for the falls on 4/21/26 and 5/24/26 were not measurable and were not based on the identified causal factors of the falls.