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	09/03/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Licensure Reference Number: 175 NAC 12-006.04D(i) Based on record reviews and interviews; the facility failed to provide full time hours for the designated Director of Nursing (DON) who was working as a Charge Nurse. This failure had the potential for affecting nursing care to all the residents. The total sample size was 15 and the facility census was 30.Findings are: Review of an undated Job Description for the Director of Nursing (DON) revealed the DON was responsible for effective overall management of the Nursing Department and coordination with other disciplines to provide quality care to all residents. The following duties and responsibilities were identified:-ensure nursing interventions meet the physical, personal, and cognitive needs of each resident as well as maximize their self-care capacities, identify, independence, choice, and opportunity for social interaction. -monitors the outcomes of nursing service activity by evaluating the performance of nursing staff, ensuring compliance with all facility and regulatory agencies standards, coordinating the facility committees, and monitoring the effective use of resources.-assumes full responsibilities for the operation and management of the facility in the temporary absence of the Administrator as directed by the Administrator.-develops short and long range plans for the nursing department that are compatible with those of the facility.-assists in recruiting and selects nursing service employees appropriate to facility need and guidelines of the budget.-works in establishing and facilitating effective employee relations. -maintains adequate staffing ratios and levels of preparation to meet the needs of residents. -participates in the selection of residents admitted by evaluating the level and amount of care required by prospective residents in relation to existing nursing capabilities.-coordinates requirements and cooperates with all other departments in providing favorable physical, social, and emotional environment for residents.-shall work during the day, 4-5 days a week, totaling 40 hours per week, except when it was necessary to vary working hours to provide supervision. Review of the Facility Assessment Resource Tool for staffing revealed the following recommendations regarding Nursing Services. Full time DON, 3 Registered Nurses (RN), 2 Licensed Practical Nurses (LPN), 7 Medication Aides (MA), and 24 Certified Nursing Assistants (CNA). Review of Nursing Schedules for August 2025 revealed from 8/1/25 to 8/29/25 the DON worked as the Charge Nurse on 8/1/25 from 6PM to 9PM, 8/2/24 from 6AM to 10PM, 8/4/25 from 6AM to 6PM and from 6PM to10PM, 8/5/25 from 6AM to 6PM, 8/6/25 from 6AM to 2:30PM, 8/7/25 from 6AM to 6PM, 8/8/25 from 6AM to 6PM, 8/9/25 from 4PM to 10PM, 8/10/25 from 2PM to 10PM, 8/11/25 from 6AM to 6PM, 8/12/25 from 6AM to 6PM, 8/13/25 from 2PM to 6PM, 8/14/25 from 6AM to 6PM, 8/15/25 from 6AM to 1PM, 8/16/25 from 12PM to 6PM, 8/17/25 from 6AM to 6PM, 8/18/25 from 1PM to 6PM, 8/19/25 from 6AM to 6PM, 8/20/25 from 2PM to 6PM, 8/21/25 from 6AM to 10AM, 8/22/25 from 1PM to 6PM, 8/23/25 from 6AM to 6PM and from 6PM to 10PM, 8/24/25 from 6AM to 6PM and from 6PM to 10PM, 8/25/25 from 6AM to 6PM, 8/26/25 from 6AM to 8AM, 8/27/24 from 6AM to 6PM, 8/28/25 from 6AM to 6PM, and on 8/29/25 from 6AM to 9PM. During an interview on 9/2/25 at 3:11 PM, the DON verified working as the only full time RN in the building. The DON worked several hours each week in the Charge Nurse position and was only designating approximately 4 hours a week for the DON role. In addition, the DON reported due to the current schedule the DON had failed to report a fall with injury for Resident 24 on 8/1/25 and an injury (continued on next page)

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of unknown origin on 8/8/25 for Resident 7 as potential abuse allegations and had failed to complete a Discharge Summary for Resident 35 after the resident was discharged home.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E)Based on record review and interview; the facility fails to obtain informed consent for the use of psychotropic (medications that effect the brain and alter mental processes, emotions, and behavior) medications for Residents 12,16, 17, and 29. The sample size was 5 and the facility census was 30. Findings are: A. Review of the facility undated policy Use of Psychotropic Medication revealed the following;-Residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). -The indications for use of psychotropic drugs were documented in the medical record. -Targeted symptoms for monitoring were documented in the resident record.-Residents and/or their representative/s were educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. B. Review of Resident 12's MDS (Minimum Data Set-federally mandated comprehensive assessment used to develop resident care plans) dated 7/8/25 revealed the resident cognitive impairment and a TBI (traumatic brain injury). The resident received assistance with bed mobility, transfers, toileting, bathing, and dressing. In addition, the resident had received antipsychotic, antidepressant, and hypnotic medication. Review of Resident 12's Care Plan with a revision date of 7/8/25 revealed the resident took psychotropic medication for behavior management and the facility was to educate the resident/family/caregivers about the risks and benefits, side effects and/or toxic symptoms of the medication/s given. Review of Resident 12's Order Summary dated 9/3/25 revealed the following psychotropic medications:-Ativan (Lorazepam)-an antianxiety medication-1milligram/s (mg) daily -Buspirone HCL an antianxiety medication 5mg two times daily-Lorazepam Oral Concentrate an antianxiety medication 20mg per milliliter (ml), give 1/2 ml by mouth every 2 hours as needed-Seroquel (Quetiapine) an antipsychotic medication 50mg 1 tablet daily-Sertraline HCL an antidepressant medication 50mg 1 tablet daily-Trazadone HCL an antidepressant medication 50mg 1 tablet daily Review of the Psychotropic Informed Consent dated 2/2/25 revealed the facility listed the medication Seroquel (Quetiapine) 25mg 1/2 tab daily on the form. There was no evidence the facility obtained informed consent for the resident's current dose of 50mg of Quetiapine, or any consent for the use of Ativan (Lorazepam), Buspirone, Sertraline, or Trazadone. During an interview on 9/2/25 at 11:44 AM the Director of Nursing (DON) confirmed the facility had no evidence they obtained informed consent for the current dose of Seroquel/Quetiapine or any evidence of consent for the psychotropic medications Sertraline, Trazadone, Buspirone, and Ativan/Lorazepam for Resident 12. C. Review of Resident 16's MDS dated [DATE] revealed Resident 16 had cognitive impairment, used a walker and a wheelchair, received assistance with transfers, toileting, bathing, and dressing, and was occasionally incontinent of urine. The resident had a diagnosis of dementia. Additional information on Resident 16's MDS revealed Resident 16 used a Bed, chair and wander alarms used. Further review revealed the resident had taken antipsychotic and antianxiety medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 16's Care Plan with a revision date of 6/16/25 revealed the use of a antipsychotic and antianxiety medications for behavior management and the facility was to educate the resident/family/caretaker/s about the risks, benefits, and the side effects of and/or toxic symptoms of psychoactive medications being given. Review of Resident 16's Order Summary revealed the following psychotropic medications:-Lorazepam 0.5 mg daily-Quetiapine 50mg two times daily During an interview on 9/3/25 at 11:19 AM the DON confirmed the facility had no evidence the facility obtained informed consent for Resident 16's psychotropic medications Lorazepam and/or Quetiapine. D. Review of Resident 29's MDS dated [DATE] revealed the resident received assistance with bathing, dressing, hygiene, toileting, bed mobility, and transfers. The resident had Dementia, Anxiety, and Depression. Further review revealed the resident had taken antipsychotic and antidepressant medications. Review of Resident 29's Psychotropic Informed Consent dated 1/27/25 revealed signed consent for Seroquel/Quetipine 25mg daily. There was no further consent for Duloxetine (antidepressant) or for the current dose of Seroquel/Quetiapine 50mg daily. Review of Resident 29's Care Plan with a revision date of 6/12/25 revealed the resident had mood and behavior concern as well as hallucination. The resident had Parkinson's disease and took psychotropic medications. Staff were to educate the resident/family/caregiver about the benefits, risks, and side effects of his psychotropic medication. Review of Resident 29's Order Summary dated 9/3/25 revealed the resident took the following psychotropic medication:-Duloxetine (antidepressant) 60mg daily-Quetiapine 50mg daily During an interview on 9/3/25 at 11:19 AM the DON confirmed the facility had no evidence the facility obtained informed consent for Resident 29's current dose of the antipsychotic medication Seroquel/Quetiapine and no consent for the antidepressant medication Duloxetine. E. Review of Resident 17's MDS dated [DATE] revealed the resident had severe cognitive impairment; required assistance with toileting, dressing, and hygiene; had diagnoses of Alzheimer's Dementia, Anxiety, and Depression; and received antianxiety and antidepressant medications. Review of Resident 17's Care Plan last revised 8/21/25 revealed the resident had cognitive impairment related to Dementia and received antianxiety and antidepressant medications. Review of the facility form Psychotropic Informed Consent for Resident 17 revealed consent for Sertraline 25mg was obtained on 2/14/25. Review of Resident 17's Order Summary Report with active medication orders as of 9/3/25 revealed the resident had an order for Sertraline 50 mg daily with a start date of 3/11/25. Interview on 9/2/25 at 2:00 PM with the DON confirmed Resident 17 had an increase of the Sertraline on 3/11/25 and there was no evidence the facility obtained signed informed consent.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on observation, record review, and interview; the facility failed to review and revise Care Plans to accurately reflect Residents 5 and 6's Enhanced Barrier Precautions (EBP-an infection control strategy that involves the use of gown and gloves during high contact resident care activities to reduce the spread of drug resistant organisms in settings such as nursing homes) and Residents 7, 12, 16, and 24's fall interventions. The sample size was 12 and the facility census was 30. Findings are: A. Review of the facility policy Baseline Care Plan undated revealed the following:-The facility developed and implemented a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the residents that met professional standards of quality. Review of the undated facility policy Comprehensive Care Plans revealed the following;-The facility developed and implemented a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental health and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.-Resident specific interventions that reflected the resident's needs and preferences and aligned with the resident's cultural identity, as indicated. Review of the facility undated Care Plan Revision Upon Status Change policy revealed the following;-the purpose was to review and revise the care plan as needed to provide a consistent process including updated or modified interventions and to ensure the care plan reflected the resident's current status. B. Review of Resident 12's Minimum Data Set (MDS-federally mandated assessment used to develop resident care plans) dated 7/8/28 revealed the resident was cognitively impaired, used both a w/c and walker, and received assistance with transfers, toileting hygiene, dressing and bathing. The resident had 2 or more falls with minor injuries and used bed, chair, and wander alarms daily. The resident was diagnosed with dementia. Review of Resident 12's Fall Events revealed the following:-On 5/25/25 at 10:10 AM the resident was found in lobby on hands and knees. The fall was alarm ringing. There was no evidence the facility identified a cause for the fall or updated the care plan.-On 6/8/25 at 2:50 PM the resident was found sitting on the floor in another resident's room. There was no evidence the facility identified a cause for the fall or updated the care plan. -On 6/8/25 at 1:30 PM the resident was seen kneeling out of the wheelchair to pick up food off the floor in the dining room. The facility had no evidence they updated the care plan. -On 6/22/25 at 4:40 PM the resident was seen falling near the nurses' station after standing up from a wheelchair, attempted to walk and then fell. The resident obtained a small abrasion on the left side of back. There was no evidence the facility identified a cause for the fall or updated the care plan. Review of Resident 12's Care Plan with a revision date of 7/8/25 revealed the resident was at risk for falling and had falls on 5/1/25, 5/13/25, 5/25/25, 6/8/25 x 2, and 6/22/25. Interventions included encouraging activity such as folding laundry, prompt response to assistance requests, educating the resident/family/caregivers about safety, ensuring the functioning of bed and chair alarms, anticipating the resident's needs, ensuring a safe environment, and re-evaluation to ensure continued (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriateness of interventions. On 5/1/25 the care plan was updated, indicating staff were to ensure anti-rollbacks on the wheelchair were functioning properly, and to ensure the bed and chair alarms were functioning properly. On 5/13/25 the staff were to check the residents' blood pressure for 3 days and notify the doctor with the results. There was no evidence the facility implemented any new interventions after 5/13/25. During an interview on 9/3/25 at 8:41 AM the Director of Nursing (DON) confirmed that Charge Nurses were to review falls and implement new measures to prevent ongoing falls for Resident 12. Further review revealed the facility had no evidence the facility was identifying causal factors and implementing new measures to prevent falls for Resident 12 and revising the care plan of new interventions. C. Review of Resident 16's MDS dated [DATE] had cognitive impairment, used a walker and a wheelchair, received assistance with transfers, toileting, bathing, and dressing, and was occasionally incontinent of urine. The resident had a diagnosis of dementia. Bed, chair and wander alarms were in use. Further review revealed the resident had fallen and sustained minor injury. Review of Resident 16's Fall Events revealed the following;-On 5/21/25 at 7:15 AM the resident was sitting on the floor beside the bed and reported sliding off the bed while try to put on shoes. The pressure pad alarm (fall alarm) was not working. There was no indication what the facility did to correct or ensure a function pressure pad alarm or updated the care plan. -On 5/25/25 at 3:10 AM the resident was lying on the floor with forehead against the nightstand. There was no evidence the facility identified a cause for the fall or updated the care plan.-On 5/30/25 at 6:00 AM the resident was found sitting on the floor in front of the bed. There was no evidence the facility identified a cause for the fall or updated the care plan.-On 6/15/25 at 4:00 PM the resident was on a floor mat next to the bed with head next to the night stand. A bruised and area was noted on right side of the head with some bleeding from the bruised area. There was no evidence the facility identified a cause for the fall or updated the care plan. -On 6/22/25 at 12:15 AM The resident was lying on the floor beside the bed with forehead touching the nightstand. There was no evidence the facility identified a cause for the fall or updated the care plan. Review of Resident 16's Care Plan with a revision date of 6/13/25 revealed the resident was determined to be at high risk for falling due to confusion, gait/balance problems, poor communication/comprehension, psychoactive (mind altering) drug use, and a lack of safety awareness. The facility staff were to keep the residents' call-light in reach and encourage it's use. The resident required prompt responses to all requests for assistance. The resident was to be encouraged to participate in physical activity to promote strength and improved mobility. In addition, staff were to review past falls to determine possible causes, and alter causes if possible. There was no evidence the care plan approaches were updated following the residents falls on 5/21/25, 5/25/25, 5/30/25, 6/15/25, and 6/22/25. During an interview on 9/3/25 at 8:41 AM the DON confirmed that Charge Nurses were to review falls and implement new measures to prevent ongoing falls for Resident 16. In addition, the facility failed to update Resident 16's Care Plan with new fall prevention interventions following falls. D. Review of Resident 5's MDS dated [DATE] revealed the resident was cognitively intact; required assistance with dressing, hygiene, and mobility; had heart disease; and had a Stage 2 (a partial thickness skin loss that presents as an abrasion, blister or a shallow crater) pressure ulcer with application of a dressing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's Care Plan last revised 7/29/25 revealed the resident required extensive assist with mobility, transfers, dressing, toileting, and hygiene; was at risk for skin breakdown, and there was no documentation that the resident had EBP in place. Interview with Resident 5 on 8/27/25 at 1:21 PM revealed the resident had an open wound with a dressing to their buttocks and staff had to wear Personal Protective Equipment (PPE-gowns and gloves) while providing cares. The following observations were made for Resident 5: -on 8/27/25 at 10:00 AM there was a sign on the residents door indicating the resident had EBP in place with PPE noted behind the resident door, and -on 8/28/25 at 12:50 PM the resident had refused an observation of cares, but the EBP sign was located on the resident's door and NA-C was observed performing hand hygiene and putting on a gown and gloves upon entering the resident room. Review of Resident 5's Order Summary Report with active orders as of 9/3/25 revealed they had an order for a duoderm (a type of wound dressing with a water proof backing used to protect wounds to buttocks wound every 7 days and as needed with an order date of 6/27/25. Interview on 8/28/25 at 12:50 PM with the DON confirmed the resident was on EBP. Further interview on 9/3/25 at 9:30 AM confirmed EBP was not implemented onto Resident 5's care plan. E. Review of Resident 6's MDS dated [DATE] revealed the resident was cognitively intact; dependent with toileting and dressing and was independent with hygiene; had diagnoses of Diabetes, Anxiety, and Schizophrenia (a mental health condition that affects the way a person thinks, feels, and behaves); and was frequently incontinent of bladder. Review of Resident 6's Care Plan last revised 8/21/25 revealed the resident required assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. There was no documentation that the resident had EBP in place. The following observations were made for Resident 6: -on 8/27/25 at 1:30 PM, there was a sign on the resident's door indicating the resident had EBP in place with PPE noted behind the resident door, and -on 9/2/25 at 12:10 PM, the resident was in the resident room working with NA-C and NA-H. Both NA's had on PPE. The resident refused to allow observation of cares and there was a sign on the resident's door indicating EBP was in place. Interview on 9/3/25 at 9:30 AM with the DON revealed Resident 6 had EBP in place due to the resident having a urinary tract infection. Further interview confirmed that EBP was not implemented onto the resident's care plan. F. Review of Resident 7's MDS dated [DATE] revealed the resident was cognitively intact; was independent with toileting, dressing, and hygiene; had diagnoses of Stroke, Heart Disease, Arthritis, and Fractures; and had 2 or more falls with no injury, 1 fall with a minor injury, and 1 fall with a major (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	injury. Review of Resident 7's Care Plan last revised 8/21/25 revealed the resident required assistance with mobility, was at a high risk for falls, and there was 1 documented fall intervention implemented in 2025. Review of the facility incident forms for falls regarding Resident 7 revealed the following: -a fall on 3/27/25 at 9:45 PM the resident was found on the floor on their hands and knees with no immediate intervention, -a fall on 6/16/25 at 9:45 PM the resident was found on the floor by the bed laying on their left side with no immediate intervention, -a fall on 6/26/25 at 7:05 AM the resident was found sitting on the floor on their buttocks with no immediate intervention. Interview with the DON on 9/3/25 at 11:45 AM confirmed interventions were not changed/revised for Resident 7's falls on 3/27/25, 6/16/25, and 6/26/25. G. Review of Resident 24's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of anemia, heart failure, stroke, and depression. The following was assessed for the resident: -cognition was moderately impairment. -incontinent of bowel and bladder. -required moderate staff assistance with personal hygiene, dressing, transfers, toileting hygiene and bed mobility. -two or more falls without injury since the previous assessment. Review of an Incident Report dated 4/25/25 at 6:10 PM revealed the resident was found on the floor of the resident's room next to the bed. Resident 24 indicated attempting to get into bed and then sliding onto the floor. Review of an Incident Report dated 5/3/25 at 10:11 PM revealed the staff found the resident on the floor outside of the resident's bathroom. The resident's walker was lying sideways on the floor next to the resident. Review of an Incident Report dated 6/25/25 at 1:00 PM revealed the resident was found seated on the floor and reported trying to transfer out of bed without locking wheelchair brakes and then falling to the floor. Review of an Incident Report dated 7/1/25 at 2:30 AM revealed the resident was found on the floor of the resident's room. The resident identified attempting to get out of the bed to use the bathroom and then falling. A new intervention was identified to ensure the resident wore gripper socks at night. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current Care Plan for Resident 24 with a revision date of 7/1/25 revealed the resident was at risk for falls due to deconditioning, problems with gait and balance and history of falls. The residents' falls on 6/25/25 and on 7/1/25 were identified on the assessment. The following interventions were identified with the dates of their implementation: -12/10/24 hourly rounds for safety. -12/10/24 encourage the resident to use the call light and wait for assistance with walking/toileting. -12/10/24 signs placed in the resident's room and bathroom to remind the resident to use the call light and wait for assistance. -12/10/24 chair/bed electronic fall alarm. -12/10/24 video monitor placed to allow staff to see when the resident was attempting to get out of bed without assistance. -7/1/25 gripper socks on at night. Review of a Nursing Progress Note dated 8/21/25 revealed at 2:15 AM, the staff heard a loud noise and found the resident on the floor of the resident's room. A laceration was observed to the back of the resident's head and the resident complained of pain to the right elbow. The resident was transferred to the emergency room for evaluation. Observations of Resident 24 on 9/2/25 revealed the following: -8:30 AM the resident was seated in the wheelchair in the facility dining room at the breakfast meal. No fall alarm was observed to the resident's chair. -9:45 AM the resident was lying in bed in the resident's room. No fall alarm was in place to the resident's bed. -10:03 AM and 12:57 PM the resident was in the wheelchair and no fall alarm was in place. During an observation on 9/3/24 at 7:15 AM revealed Resident 24 was seated in a wheelchair in the commons area next to the Nurses Station. No fall alarm was observed on the resident's wheelchair. During an interview on 9/2/25 at 11:13 AM, the DON confirmed the residents' falls on 4/25/25 at 6:10 PM, 5/3/25 at 10:11 PM and on 8/21/25 at 2:15 AM were not identified on the resident's care plan. In addition, the fall alarm to the resident's bed and wheelchair were no longer in use as the resident was noncompliant. This intervention should have been removed from the residents' care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)(i)Based on interview and record review; the facility failed to review for causal factors and implement measures to prevent ongoing falls for Resident's 12, 16, 7, and 24. The sample size was 4 and the facility census was 30. Findings are: A. Review of the undated facility policy Accidents and Supervision revealed the following;-The resident environment remained as free from accident hazards as possible.-Each resident received adequate supervision and assistive devices to prevent accidents. -The facility established and utilized a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents through Identification, Evaluation and Analysis, Implementation of Interventions, and Monitoring and Modification. Review of the undated facility Fall Checklist revealed the following;-The fall and an intervention were to be added to the resident care plan.-The investigation included a root cause analysis of the fall and an intervention to prevent future falls. B. Review of Resident 12's Minimum Data Set (MDS-federally mandated assessment used to develop resident care plans) dated 7/8/28 revealed the resident was cognitively impaired, used both a w/c and walker, and received assistance with transfers, toileting hygiene, dressing and bathing. The resident had 2 or more falls with minor injuries and used bed, chair, and wander alarms daily. The resident was diagnosed with dementia. Review of Resident 12's Fall Events revealed the following:-On 5/1/25 at 5:30 PM the resident was found sitting on the floor in the hallway, holding onto the handrail. The resident reported getting something out of a pocket and sliding to knees. It was noted the antiroll backs on the w/c were loose and the residents' alarm was turned off. Further note indicated the resident had turned the alarm off 2 previous times during the shift. The resident's plan of care was ongoing. There was no evidence the facility identified a cause for the fall. -On 5/1/25 at 8:50 PM the resident was found lying on the floor in the facility lobby. The wheelchair brakes were not locked. There was no evidence the facility identified a cause for the fall. -On 5/13/25 at 9:20 PM the resident was found kneeling on the floor in front of the wheelchair in a linen closet. The resident got back into the wheelchair unassisted after the fall and reported slipping out of the wheelchair while try to get a nightgown. -On 5/25/25 at 10:10 AM the resident was found in lobby on hands and knees. The fall was alarm ringing. There was no evidence the facility identified a cause for the fall.-On 6/8/25 at 2:50 PM the resident was found sitting on the floor in another resident's room. There was no evidence the facility identified a cause for the fall.-On 6/8/25 at 1:30 PM the resident was seen kneeling out of the wheelchair to pick up food off the floor in the dining room. The facility had no evidence they were reviewing each fall for causal factors and/or implementing new measures to prevent on-going falls. -On 6/22/25 at 4:40 PM the resident was seen falling near the nurses' station after standing up from a wheelchair, attempted to walk and then fell. The resident obtained a small abrasion on the left side of back. There was no evidence the facility identified a cause for the fall. Review of Resident 12's Care Plan with a revision date of 7/8/25 revealed the resident was at risk for falling and had falls on 5/1/25, 5/13/25, 5/25/25, 6/8/25 x 2, and 6/22/25. Interventions included encouraging activity such as folding laundry, prompt response to assistance requests, educating the resident/family/caregivers about safety, ensuring the functioning of bed and chair alarms, anticipating the resident's needs, ensuring a safe environment, and re-evaluation to ensure continued appropriateness of interventions. On 5/1/25 the care plan was updated, indicating staff were to (continued on next page)

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	285116	A. Building B. Wing	09/03/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure anti-rollbacks on the wheelchair were functioning properly, and to ensure the bed and chair alarms were functioning properly. On 5/13/25 the staff were to check the residents' blood pressure for 3 days and notify the doctor with the results. There was no evidence the facility implemented any new interventions after 5/13/25. During an interview on 9/3/25 at 8:41 AM the Director of Nursing (DON) confirmed that Charge Nurses were to review falls and implement new measures to prevent ongoing falls for Resident 12. Further review revealed the facility had no evidence the facility was identifying causal factors and implementing new measures to prevent falls for Resident 12. C. Review of Resident 16's MDS dated [DATE] had cognitive impairment, used a walker and a wheelchair, received assistance with transfers, toileting, bathing, and dressing, and was occasionally incontinent of urine. The resident had a diagnosis of dementia. Bed, chair and wander alarms were in use. Further review revealed the resident had fallen and sustained minor injury. Review of Resident 16's Fall Events revealed the following;-On 5/21/25 at 7:15 AM the resident was sitting on the floor beside the bed and reported sliding off the bed while try to put on shoes. The pressure pad alarm (fall alarm) was not working. There was no indication what the facility did to correct or ensure a function pressure pad alarm. -On 5/25/25 at 3:10 AM the resident was lying on the floor with forehead against the nightstand. There was no evidence the facility identified a cause for the fall.-On 5/30/25 at 6:00 AM the resident was found sitting on the floor in front of the bed. There was no evidence the facility identified a cause for the fall.-On 6/15/25 at 4:00 PM the resident was on a floor mat next to the bed with head next to the night stand. A bruised and area was noted on right side of the head with some bleeding from the bruised area. There was no evidence the facility identified a cause for the fall. The bed was replaced with a low bed. -On 6/22/25 at 12:15 AM The resident was lying on the floor beside the bed with forehead touching the nightstand. There was no evidence the facility identified a cause for the fall. Review of Resident 16's Care Plan with a revision date of 6/13/25 revealed the resident was determined to be at high risk for falling due to confusion, gait/balance problems, poor communication/comprehension, psychoactive (mind altering) drug use, and a lack of safety awareness. The facility staff were to keep the residents' call-light in reach and encourage it's use. The resident required prompt responses to all requests for assistance. The resident was to be encouraged to participate in physical activity to promote strength and improved mobility. In addition, staff were to review past falls to determine possible causes, and alter causes if possible. There was no evidence the care plan approaches were updated following the residents falls on 5/21/25, 5/25/25, 5/30/25, 6/15/25, and 6/22/25. During an interview on 9/3/25 8:41 AM the DON confirmed that Charge Nurses were to review falls and implement new measures to prevent ongoing falls for Resident 16. In addition, the facility failed to update Resident 16's Care Plan with new fall prevention interventions following falls. D. Review of Resident 7's MDS dated [DATE] revealed the resident was cognitively intact; was independent with toileting, dressing, and hygiene; had diagnoses of Stroke, Heart Disease, Arthritis, and Fractures; and had 2 or more falls with no injury, 1 fall with a minor injury, and 1 fall with a major injury. Review of Resident 7's Care Plan last revised 8/21/25 revealed the resident required assistance with mobility, was at a high risk for falls, and there was 1 documented fall intervention implemented in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025. Review of the facility incident forms for falls regarding Resident 7 revealed the following: -a fall on 3/27/25 at 9:45 PM the resident was found on the floor on their hands and knees with no immediate intervention, -a fall on 6/16/25 at 9:45 PM the resident was found on the floor by the bed laying on their left side with no immediate intervention, -a fall on 6/26/25 at 7:05 AM the resident was found sitting on the floor on their buttocks with no immediate intervention. Interview with the DON on 9/3/25 at 11:45 AM confirmed there were no interventions for the falls on 3/27/25, 6/16/25, and 6/26/25 documented. E. Review of Resident 24's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of anemia, heart failure, stroke, and depression. The following was assessed for the resident: -cognition was moderately impairment. -incontinent of bowel and bladder. -required moderate staff assistance with personal hygiene, dressing, transfers, toileting hygiene and bed mobility. -two or more falls without injury since the previous assessment. Review of an Incident Report dated 4/25/25 at 6:10 PM revealed the resident was heard calling for assistance. The staff found the resident on the floor of the resident's room next to the bed. Resident 24 indicated attempting to get into bed and then slid onto the floor. Further review of the report revealed no causal factors were identified regarding the fall. Review of the resident's electronic medical record revealed no evidence a new intervention was developed or that current interventions were reviewed and/or revised. Review of an Incident Report dated 5/3/25 at 10:11 PM revealed the staff found the resident on the floor outside of the resident's bathroom. The resident's walker was lying sideways on the floor next to the resident. Review of the resident's electronic medical record revealed no documentation to indicate causal factors were assessed, a new fall intervention was developed/implemented or that current interventions were reviewed and/or revised. Review of an Incident Report dated 6/25/25 at 1:00 PM revealed the resident was heard calling for help. The resident was found seated on the floor and reported to staff attempting to transfer out of bed, not locking wheelchair brakes, and then falling to the floor. The resident had been sleeping on top of the comforter and was incontinent of urine. Further review of the report revealed no evidence (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	current fall interventions were assessed for revision or that a new intervention was developed to prevent further falls. Review of an Incident Report dated 7/1/25 at 2:30 AM revealed the resident was found on the floor of the resident's room. The resident identified attempting to get out of the bed to use the bathroom and then falling. A new intervention was identified to ensure the resident wore gripper socks at night. Review of a current Care Plan with a revision date of 7/1/25 revealed the resident was at risk for falls due to deconditioning, problems with gait and balance and history of falls. The following interventions were identified with the dates of their implementation: -12/10/24 hourly rounds for safety. -12/10/24 encourage the resident to use the call light and wait for assistance with walking/toileting. -12/10/24 signs placed in the resident's room and bathroom to remind the resident to use the call light and wait for assistance. -12/10/24 chair/bed electronic fall alarm. -12/10/24 video monitor placed to allow staff to see when the resident was attempting to get out of bed without assistance. -7/1/25 gripper socks on at night. Review of a Nursing Progress Note dated 8/21/25 revealed at 2:15 AM, the staff heard a loud noise and found the resident on the floor of the resident's room. A laceration was observed to the back of the resident's head and the resident complained of pain to the right elbow. The resident was transferred to the emergency room for evaluation. Review of the resident's electronic medical record revealed no evidence an Incident Report had been completed to determine causal factors and no new fall interventions were identified or current interventions revised to prevent further falls. During an interview on 9/2/25 at 11:13 AM, the DON confirmed the staff were to assess each fall to determine causal factors and then to develop new interventions or revise current interventions to prevent further falls. The DON verified with Resident 24's falls on 4/25/25 at 6:10 PM, 5/3/25 at 10:11 PM, and on 8/21/25 at 0215 the facility staff failed to identify causal factors and to revise and/or develop new interventions to prevent ongoing falls. Regarding the resident's fall on 6/25/25 at 1:00 PM, causal factors were identified however, no new interventions were developed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to report a fall with injury for Resident 24 and an injury of unknown origin for Resident 7 as potential allegations of abuse and/or neglect. The sample size was 2 and the facility census was 30. Findings are: A. Review of the undated facility policy Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revealed it was the policy of the facility to report all allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of resident property. Allegations were to be reported immediately to the Administrator and to other appropriate agencies in accordance with current state and federal regulations within the prescribed timeframes. The Administrator or designee was to notify the appropriate agencies immediately; as soon as possible, but no later than 24 hours after the discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming suspicion. B. Review of Resident 24's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 8/6/25 revealed the resident was admitted [DATE] with diagnoses of anemia, heart failure, stroke, and depression. The following was assessed for the resident: -cognition was moderately impairment. -incontinent of bowel and bladder. -required moderate staff assistance with personal hygiene, dressing, transfers, toileting hygiene and bed mobility. -two or more falls without injury since the previous assessment. Review of a Nursing Progress Note dated 8/21/25 revealed at 2:15 AM, the staff heard a loud noise and found the resident on the floor of the resident's room. A laceration was observed to the back of the resident's head and the resident complained of right elbow pain. The resident was transferred to the emergency room for evaluation. Review of Discharge Instructions dated 8/21/25 at 6:10 AM revealed the resident was to wear a sling for 1-2 days to the right arm and to use ice and Tylenol to address the resident's pain. In addition, an order was received to have the 9 staples to the back of the resident's head removed in 10 days. Review of the facility's reports of alleged and/or suspected abuse from 8/22/24 through 8/21/25 revealed no documentation a report had been filed for the allegation of potential abuse/neglect related to Resident 24's fall with injury. During an interview on 9/2/25 at 11:13 AM, the Director of Nursing (DON) confirmed the following regarding Resident 24: -the resident had an unwitnessed fall on 8/21/25 at 2:15 AM in the resident's room and sustained a laceration to the back of the head which required sutures. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the facility did not report the resident's fall with injury to the State Agency as a potential abuse/neglect allegation. C. Review of Resident 7's MDS dated [DATE] revealed the resident was cognitively intact; was independent with toileting, dressing, and hygiene; had diagnoses of Stroke, Heart Disease, Arthritis, and Fractures; and had 2 or more falls with no injury, 1 fall with a minor injury, and 1 fall with a major injury. Review of Resident 7's Care Plan last revised 8/21/25 revealed the resident required assistance with mobility, was at a high risk for falls, and on 7/29/25 the resident had a fall. The resident and family declined for the resident to be sent to the emergency room. On 8/12/25 the resident complained of arm/chest pain when lifting their arm. The resident was sent to their Primary Care Practitioner (PCP) and had an Xray done which showed a new 8th rib fracture, although they were unable to determine the age of the fracture. Review of the facility form Consultation Visit Report dated 8/8/25 for Resident 7 revealed the resident was complaining of sharp pain to the left upper chest which increased with pressure, deep breathing, cough and movement. The resident rated pain 10 out of 10. The resident first alerted staff of the pain on 8/7/25 in the afternoon during therapy. The PCP documented the resident was sent for a chest Xray and rib Xray and the PCP would inform the facility of results once they had them. Review of the facility form Imaging Information dated 8/12/25 with Xray results revealed Resident 7 had an old left 10th rib fracture and the age was not able to be determined of a rib fracture to the left 8th rib that was not identified on a prior scan which suggested the fracture to the 8th rib was acute (sudden onset, opposite of chronic). The PCP documented that the resident had a fracture of the 8th rib, unable to tell how old it is but it could possibly be new and the fracture to the 10th rib was old. Review of Resident 7's Progress Notes revealed the following entries: -an entry on 8/9/25 at 2:00 AM The resident was seen in clinic on 8/8/25. The resident taken for X-rays of the chest and left ribs and the PCP will report results next week., -an entry on 8/12/25 at 4:52 PM A fax was received with results of X-rays. It states: Chest X-ray is clear; X-ray of left ribs shows a fracture of the 8th rib. They can't tell how old it is. It possibly could be new. Resident 7 has a fracture of the 10th rib, this is an old fracture, but it did not heal correctly., and -an entry on 8/12/25 at 9:04 PM Fax returned stating the resident has a fracture of 8th posterior left rib. The residents Power of Attorney was notified. Interview on 9/2/25 at 11:45 with the DON confirmed the rib fracture was not reported to the State Agency within the required time frame.

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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(H)Based on interview and record review; the facility failed to investigate and to submit the results of the investigation to the State Agency within the required time frame a fall with significant injury for Resident 24 and an injury of unknown origin for Resident 7. The sample size was 2 and the facility census was 30. Findings are: A. Review of the undated facility policy Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revealed it was the policy of the facility to report all allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of resident property. Allegations were to be reported immediately to the Administrator. The Administrator or designee were to ensure all alleged or suspected violations were thoroughly investigated and were to prevent further potential abuse while the investigation was in progress. The results of all investigations were to be reported to other officials in accordance with state law, including the State Survey and Certification Agency within 5 working days of the event. If the alleged or suspected violation was verified, appropriate corrective action was to be taken. B. Review of Resident 24's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 8/6/25 revealed the resident was admitted [DATE] with diagnoses of anemia, heart failure, stroke, and depression. The following was assessed for the resident: -cognition was moderately impairment. -incontinent of bowel and bladder. -required moderate staff assistance with personal hygiene, dressing, transfers, toileting hygiene and bed mobility. -two or more falls without injury since the previous assessment. Review of a Nursing Progress Note dated 8/21/25 revealed at 2:15 AM, the staff heard a loud noise and found the resident on the floor of the resident's room. A laceration was observed to the back of the resident's head and the resident complained of pain to the right elbow. The resident was transferred to the emergency room for evaluation. Review of Discharge Instructions dated 8/21/25 at 6:10 AM revealed the resident was to wear a sling for 1-2 days to the right arm and to use ice and Tylenol to address the resident's pain. In addition, an order was received to have the 9 staples to the back of the resident's head removed in 10 days. Review of the facility's reports of alleged and/or suspected abuse from 8/22/24 through 8/21/25 revealed no documentation an investigation was completed regarding Resident 24's fall with significant injury. During an interview on 9/2/25 at 11:13 AM, the Director of Nursing (DON) confirmed the following regarding Resident 24: -the resident had an unwitnessed fall on 8/21/25 at 2:15 AM in the resident's room and sustained a laceration to the back of the head which required sutures. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the facility failed to complete an investigation of potential abuse/neglect for the resident's fall and to submit the results of the investigation to the State Agency. C. Review of Resident 7's MDS dated [DATE] revealed the resident was cognitively intact; was independent with toileting, dressing, and hygiene; had diagnoses of Stroke, Heart Disease, Arthritis, and Fractures; and had 2 or more falls with no injury, 1 fall with a minor injury, and 1 fall with a major injury. Review of Resident 7's Care Plan last revised 8/21/25 revealed the resident required assistance with mobility, was at a high risk for falls, and on 7/29/25 the resident had a fall. The resident and family declined for the resident to be sent to the emergency room. On 8/12/25 the resident complained of arm/chest pain when lifting their arm. The resident was sent to their Primary Care Practitioner (PCP) and had an Xray done which showed a new 8th rib fracture, although they were unable to determine the age of the fracture. Review of the facility form Consultation Visit Report dated 8/8/25 for Resident 7 revealed the resident was complaining of sharp pain to the left upper chest which increased with pressure, deep breathing, cough and movement. The resident rated pain 10 out of 10. The resident first alerted staff of the pain on 8/7/25 in the afternoon during therapy. The PCP documented the resident was sent for a chest Xray and rib Xray and the PCP would inform the facility of results once they had them. Review of the facility form Imaging Information dated 8/12/25 with Xray results revealed Resident 7 had an old left 10th rib fracture and the age was not able to be determined of a rib fracture to the left 8th rib that was not identified on a prior scan which suggested the fracture to the 8th rib was acute (sudden onset, opposite of chronic). The PCP documented that the resident had a fracture of the 8th rib, unable to tell how old it is but it could possibly be new and the fracture to the 10th rib was old. Review of Resident 7's Progress Notes revealed the following entries: -an entry on 8/9/25 at 2:00 AM The resident was seen in clinic on 8/8/25. The resident taken for X-rays of the chest and left ribs and the PCP will report results next week., -an entry on 8/12/25 at 4:52 PM A fax was received with results of X-rays. It states: Chest X-ray is clear; X-ray of left ribs shows a fracture of the 8th rib. They can't tell how old it is. It possibly could be new. Resident 7 has a fracture of the 10th rib, this is an old fracture, but it did not heal correctly., and -an entry on 8/12/25 at 9:04 PM Fax returned stating the resident has a fracture of 8th posterior left rib. The residents Power of Attorney was notified. Interview on 9/2/25 at 11:45 with the DON confirmed the rib fracture was not investigated and a report was not submitted to the State Agency within the required time frame.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 1Number of residents cited: 1Based on record review and interview; the facility failed to ensure a comprehensive discharge summary for completed for Resident 35. Licensure Reference Number NAC 175-12 006.09(G)(i)7Based on record review and interview; the facility failed to document a recapitulation (a complete summary of the residents stay in nursing facility from admittance to discharge) for a resident-initiated discharge for 1 (Resident 35) of 1 sampled resident. The facility identified a census of 30. Findings are: A. Review of the facility Discharge Summary and Plan with a revision date of 12/2016 revealed when a resident's discharge was anticipated, a discharge summary and post-discharge plan were to be developed to assist the resident to adjust to their new living environment. The discharge summary was to include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge. The summary was to include the following:-current diagnoses.-medical history.-course of illness, treatment, and/or therapy since entering the building.-current laboratory, radiology, consultation, and diagnostic tests results. -physical and mental functioning.-ability to perform activities of daily living.-sensory and physical impairments.-nutritional status.-special treatments and procedures.-mental and psychosocial status.-discharge potential.-dental condition.-activities potential.-rehabilitation potential. -cognitive status.-medication therapy. B. Review of Resident 35's undated Care Plan revealed the resident was admitted [DATE]. The resident had been living independently at home, fell and dislocated the resident's right shoulder. The resident had a goal to return to home when safe and when care and rehabilitation goals were met. Review of a Nursing Progress Note dated 6/13/25 at 11:55 AM revealed the resident was discharged home with all belongings and own medications. Review of a Discharge Summary-Interdisciplinary form dated 6/13/25 at 1:04 PM for Resident 35 revealed no documentation of a recapitulation summary of the residents stay at the facility. During an interview with the Director of Nursing (DON) on 9/3/25 at 9:52 AM the DON confirmed a discharge summary with a recapitulation of the resident's stay at the facility had not been completed when the resident was discharged on 6/13/25.

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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 review and interview; the facility failed to ensure a Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) was completed for Resident 12 for a hospice admission. The sample size was 12 and the facility census was 30.Findings are: Review of the undated facility policy MDS 3.0 Completion revealed the following;-The residents were assessed, using a comprehensive assessment which used core elements for use in assessing nursing home residents.-According to Federal regulation, the facility conducted initial and periodic comprehensive, accurate and standardized assessment of each resident's functional capacity, using the resident assessment instrument specified by the State. -Assessments completed included initial/admission assessment, annual assessment, and significant change assessment.-All disciplines followed the guidelines used in the current Resident Assessment Instrument (RAI-a standardized, comprehensive process used in nursing facilities to evaluate resident's needs, strengths, and preferences to create individualized care plans and ensure high quality care and life) manual for coding each assessment.Review of the undated facility policy Hospice Services Facility Agreement revealed the following;-The facility policy was to provide and/or arrange for hospice services to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. -If hospice is furnished in the facility through an agreement, the facility ensured the hospice services met professional standards.-The facility had a designee responsible for working with hospice representatives for coordination of care planning, communication with hospice representatives, and coordination of care provision. Review of Resident 12's Physician Orders revealed the resident was admitted to hospice on 4/28/25. Review of Resident 12's MDS quarterly assessment dated [DATE] revealed the resident had cognitive impairment, received assistance with bed mobility, transfers, toileting, bathing, and dressing. The resident had neurological conditions including a traumatic brain injury and was also receiving hospice services. Further review of Resident 12's MDS assessments revealed no assessments were completed following Resident 12's admission to hospice until 7/8/25 (more than 2 months later) and revealed no significant change assessment was completed as required when a resident is admitted to hospice care. During an interview on 9/3/25 at 11:00 AM the Director of Nursing confirmed the facility had not completed a significant change MDS as required when the Resident 12 was admitted to hospice.

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	285116	A. Building B. Wing	09/03/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(B)(iv)Based on record review and interview; the facility failed to ensure Resident 2's MDS (Minimum Data Set-federally mandated comprehensive assessment used to develop resident care plans) was coded accurately to reflect which type of medications were being administered. The sample size was 12 and the facility census was 30.Findings are: Review of the undated facility policy MDS 3.0 Completion revealed the following;-The residents were assessed, using a comprehensive assessment which used core elements for use in assessing nursing home residents.-According to Federal regulation, the facility conducted initial and periodic comprehensive, accurate and standardized assessment of each resident's functional capacity, using the resident assessment instrument specified by the State. -Assessments completed included initial/admission assessment, annual assessment, and significant change assessment.-All disciplines followed the guidelines used in the current Resident Assessment Instrument (RAI-a standardized, comprehensive process used in nursing facilities to evaluate resident's needs, strengths, and preferences to create individualized care plans and ensure high quality care and life) manual for coding each assessment.Review of Resident 2's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] and had diagnoses of heart disease, hypertension, and fractures and had received antidepressant, hypnotic, anticoagulant, antibiotic, opioid, and anticonvulsant medication. Review of Resident 2's Medication Administration record dated August 2025 revealed no evidence the resident had taken hypnotic medication. Review of Resident 2's Care Plan dated 8/6/25 revealed the resident was admitted to the facility following a hospitalization following a fall for a rehabilitative stay with a plan to return home. There was no evidence the resident had insomnia and no evidence the resident was taking hypnotic medication. During an interview on 9/3/25 at 11:25 AM the Director of Nursing (DON) confirmed Resident 2 was not taking a hypnotic medication and the MDS with a reference date of 8/8/25 Section N (Medications) was not accurately coded.During an interview on 9/3/25 at 1:00 PM Licensed Practical Nurse (LPN)-G confirmed having coded Resident 2's MDS as having taken a hypnotic medication not knowing the medication was actually an antidepressant and not a hypnotic.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09ABased on record review and interview: the facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) screen was completed accurately for 1 (Resident 6) of 1 sampled residents. Findings are: Review of the facility policy Resident Assessment Coordination with PASARR Program, undated revealed the following:-the facility would coordinate assessments with the preadmission screening and resident review to ensure that individuals with a mental disorder, intellectual disability, or a related condition received care and services in the most integrated setting appropriate for their needs,-all applicants would be screened for serious mental disorders, intellectual disabilities and related conditions,-a negative Level I screen permitted admission and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later,-a positive Level I screen necessitated a PASARR Level II evaluation prior to admission,-PASARR Level II was a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that would determine whether the individual had a mental disorder, intellectual disability or a related condition, determined the appropriate setting for the individual, and recommended any specialized services and/or rehabilitative services the individual needed,-the Social Services Director would be responsible for keeping track of each resident's PASARR screening status and would refer to the appropriate authority, and-any resident who exhibited a newly evident or possible serious mental disorder, intellectual disability, or a related condition would be referred promptly to the state mental health or intellectual disability authority for Level II review. Review of Resident 6's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning, dated 8/13/25 revealed the resident was admitted on [DATE], received antipsychotic and antianxiety medications, and diagnoses included Anxiety and Schizophrenia (a mental health condition that affects the way a person thinks, feels, and behaves). Review of Resident 6's Care Plan last revised 8/21/25 revealed the resident was taking antidepressant and antipsychotic medications. Review of Resident 6's Order Summary Report with active medications as of 9/3/25 revealed an order for Latuda (an antipsychotic medication) with a start date of 8/1/25 with a diagnosis of Schizoaffective Disorder (a mental health condition including Schizophrenia and a mood disorder), Bipolar (a mental health disorder that causes changes in a person's mood, energy, and ability to function). Review of Resident 6's PASARR dated 8/1/25 revealed no documentation that the resident was taking an antipsychotic with a mental health diagnosis. An interview on 9/2/25 at 2:00 PM with the Director of Nursing confirmed Resident 6 was taking an antipsychotic, had a diagnosis of Schizoaffective disorder with Bipolar that was not indicated on the PASARR and it should have been included.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E)Based on record review and interview; the facility failed to ensure Resident 2's Care Plan was comprehensive and accurately reflected the residents diagnoses and high-risk medication use. The sample size was 12 and the facility census was 30. Findings are: Review of the facility policy Baseline Care Plan undated revealed the following:-The facility developed and implemented a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality. Review of the undated facility policy Comprehensive Care Plans revealed the following;-The facility developed and implemented a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental health and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.-Resident specific interventions that reflected the resident's needs and preferences and align with the resident's cultural identity, as indicated. Review of Resident 2's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop care plans) dated 8/8/25 revealed the resident was admitted to the facility on [DATE] with diagnoses including heart disease and fractures. In addition, the resident was taking medications including antidepressant, hypnotic, anticoagulant, diuretic, opioid, and anticonvulsant medication. Review of Resident 2's Care Plan with a revision date of 8/26/24 revealed the resident was admitted following a fall and plan to return home following rehabilitation. The care plan revealed no evidence the resident was taking antidepressant, anticoagulant, diuretic, or anticonvulsant medication or the need to monitor for potential adverse effects or risks of those medications. Further review revealed no evidence the resident had multiple heart-related diagnosis or the required monitoring of those conditions. During an interview on 9/3/25 at 11:25 AM Interview with the Director of Nursing confirmed all residents were to have a comprehensive care plan completed following the initial MDS completion and confirmed Resident 2's Care plan was not comprehensive and did not include black box medication warnings for use of high-risk medications such as antidepressant, anticoagulants, diuretic, and anticonvulsant medications. In addition, the care plan did not address the resident's heart disease related diagnoses.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility staff failed to complete an assessment for Resident 6 for potential adverse effects from antipsychotic (a type of medication that alters the chemicals in the brain to effect change in behavior, mood and emotion). The sample size was 5 and the facility census was 30. Findings are: Review of the facility undated policy Use of Psychotropic Medication revealed the following;-Residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s),-the indications for use of psychotropic drugs were documented in the medical record,-targeted symptoms for monitoring were documented in the resident record,-Residents and/or their representative/s were educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions, and -Residents who used psychotropic drugs would have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, as needed or as per facility policy. Review of Resident 6's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 8/13/25 revealed the resident was admitted on [DATE], received antipsychotic and antianxiety medications, and diagnoses included Anxiety and Schizophrenia (a mental health condition that affects the way a person thinks, feels, and behaves). Review of Resident 6's Care Plan last revised 8/21/25 revealed the resident was taking antidepressant and antipsychotic medications. Review of Resident 6's Order Summary Report of active medication orders as of 9/3/25 revealed an order for Latuda (an antipsychotic medication) with a start date of 8/1/25 with a diagnosis of Schizoaffective Disorder (a mental health condition including Schizophrenia and a mood disorder), Bipolar (a mental health disorder that causes changes in a person's mood, energy, and ability to function). Review of the facility form AIMS- Abnormal Involuntary Movement Scale for Resident 6 dated 8/19/25 revealed the assessment was open and there was no documentation that the assessment had been completed. An interview on 9/2/25 at 2:00 PM with the Director of Nursing confirmed Resident 6 was receiving an antipsychotic medication. Further interview confirmed that an AIMS assessment had not been completed and should have been completed upon admission to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18(B)Based on observation, record review, and interview; the facility failed to ensure hand hygiene was completed at appropriate intervals during wound care for Resident 16 to prevent potential cross-contamination. The sample size was 12 and the facility census was 30. Findings are: Review of the facility policy Hand Hygiene with a revision date of 7/1/25 revealed the following: -All staff to perform hand hygiene procedures to prevent the spread of infection to other personnel and residents. -Staff were to perform hand hygiene as indicated using proper technique consistent with accepted standards of practice. -The use of gloves did not replace hand hygiene. If the task required gloves, staff were to perform hand hygiene prior to putting on gloves and immediately after removing gloves. -Hand Hygiene is to be performed using soap and water when hands were visibly soiled, and/or soiled with blood or other body fluids, and following exposure to curtain pathogens/bacteria,after caring for a resident with known or suspected diarrhea, and /or after handling items potentially contaminated with blood, body fluids, secretions or excretions -Hand Hygiene should also be performed during resident care when moving from a contaminated body site to a clean body site.During an observation of wound care on for Resident 16 on 9/2/25 at 10:26 AM the Licensed Practical Nurse (LPN-G) Infection Preventionist (IP) for the facility entered the resident's room, put on disposable gloves, set up treatment supplies, and then removed a foam dressing from the residents right knee and left great toe (medial aspect) without changing gloves between the wounds. LPN-G then disposed of the dressings, changed gloves and without hand sanitizing put on clean gloves, cleaned the left great toe wound with wound cleaner/normal saline applied to gauze, and then while wearing the same gloves cleaned the right knee wound with normal saline using a clean gauze. LPN-G then removed the gloves and put on clean gloves without sanitizing and proceeded to place clean dressing on both the left great toe and right knee while again using the same gloves. LPN-G then removed the gloves and performed hand hygiene. Review of Resident 12's Care Plan with a revision date of 7/30/25 revealed the resident had pressure injuries (skin breakdown secondary to lack of circulation from prolonged pressure to an area of skin, to the right knee and the left great toe. Staff were to treat the areas as ordered and monitor for effectiveness as well as documenting the status of wound healing. Review of Resident 12's Order Summary Report dated 9/3/25 revealed the current orders: -Cleanse area to the right knee with normal saline and pat dry, apply petroleum gauze and then a foam dressing every other day. -Cleanse area to the left great toe with normal saline and pat dry, apply petroleum gauze and then a foam dressing every other day. During an interview on 9/3/25 at 9:40 AM the Director of Nursing confirmed that hand hygiene should be performed after removing gloves and care provided for wounds requires separate treatment for each wound to prevent potential cross-contamination between the wounds and LPN-G should not have cares for both wounds on Resident 16 wearing the same gloves. During an interview on 9/3/25 at 1:45 PM LPN-G confirmed using the same gloves while caring for Resident 16's left great toes and right knee and confirmed not performing hand hygiene between glove changes.