STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285150	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest View Care Center	420 Gordon Avenue Chadron, NE 69337

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49263 Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview, the facility failed to submit their investigation of a fall with major injury to the state agency within five working days for 3 (Residents 1, 2, and 3) of 4 sampled residents. The facility census was 34. The Findings Are: A record review of the facility policy, Abuse Prevention Policy and Procedure dated December 2022, revealed in the investigation section that the facility will investigate all incidences such as falls, bruises, medication errors, resident complaints, etc. The Reporting and Response section revealed that the Administrator, DNS, or Nursing Supervisor will make sure that a report is filed, that the internal investigation begins immediately, and the appropriate reporting takes place. A record review of a document provided by the facility Administrator revealed the facility attempted to fax a 5-page Investigation Report to (402) [PHONE NUMBER] on 3/6/24 at 5:47 PM. The document stated pages not sent due to No Answer. The 5-page document included details regarding Resident 1's fall on 3/2/24, that the resident's arm had been broken, follow up care provided, and an intervention of assess resident's clothing for ease of toileting. The section regarding when the next re-evaluation would take place states, When resident can have his cast off, we can assess more thoroughly. There was no evidence that the facility had re-attempted to send the document to the state agency. A record review of a document provided by the facility administrator revealed Resident 2 had a fall on 12/19/23, the facility had called APS on 12/20/23, and that the facility had filled out the document on 12/23/23. The document included details regarding the resident's fall, that the resident's hip had been broken, follow up care provided, and an intervention of Increase rounds and encourage resident to come out to the living room where (gender) can interact with more people. The section regarding when the next re-evaluation would take place states, We will be monitoring (gender) when (gender) returns from Scottsbluff. There was no evidence that the facility had attempted to send this report to the state agency. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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Crest View Care Center	420 Gordon Avenue Chadron, NE 69337

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a document provided by the facility Administrator revealed Resident 3 had a fall on 12/21/23 and the Investigative Report was filled out on 12/22/23. The document included details regarding the resident's fall, that the Resident 3's arm had been broken, follow up care provided, and an intervention of increase rounding and encourage resident to come out to the dining room. The section regarding when the next re-evaluation would take place states We are monitoring (gender) to see if this is something that will work. (Gender) is a very interdependent (gender). There was no evidence that the facility had attempted to send this report to the state agency. An interview on 4/2/24 at 10:48 AM with the Administrator confirmed that the (gender) was the person who was responsible for sending investigations to the state agency. The administrator also confirmed that the fax sheet for Resident 1 was sent to the fax number listed, that Resident 1, Resident 2, and Resident 3's investigations were submitted on an outdated version of the investigation template that contained an incorrect fax number for the state agency, and that the (gender) had been sending investigations to that fax number.

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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. 49766 Licensure Reference 175 NAC 12-006.09D7(3) Based on interviews and record reviews, the facility failed to implement interventions to reduce falls for 1 (Resident 1) of 3 sampled residents. The facility identified a census of 34. The findings are: A record review of the facilities' policy Fall Prevention and Response Policy with a last revised date of October 2022 revealed post-fall documentation includes root-cause analysis, interventions, response to interventions, and effectiveness of interventions. It also revealed the Interdisciplinary Team Fall Committee will meet and complete a fall review on each resident the following week where the care plan will be updated with a new or decided interventions. A record review of an Admission Record indicated the facility admitted Resident 1 on 8/19/2021 with diagnoses of: epilepsy, vascular dementia, depression, anxiety, and osteoarthritis. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 1/23/2024 revealed Resident 1 was severely impaired with daily decision-making skills. Resident 1 required moderate assistance with all Activities of Daily Living. Resident 1 also had a history of more than two minor injury falls and more than two non-injury falls since admission. A record review of the facility provided incident reports revealed Resident 1 had fallen on 1/11/2024. Resident 1 was found on the floor of the resident's room in front of the television. A record review of Resident 1's undated Care Plan revealed no new intervention was placed after the fall on 1/11/2024. An interview on 4/2/2024 at 9:56 AM with Registered Nurse (RN)-A confirmed the facility does not utilize paper Care Plans and all interventions are updated right away after a fall occurs on the electronic Care Plan. An interview on 4/2/2024 at 10:49 AM with RN-A confirmed no new interventions were placed after Resident 1's fall on 1/11/2024. RN-A had shaken head in a no gesture and had stated What else are you going to do? We just continue to use the same interventions. An interview on 4/2/2024 at 10:55 AM with the Social Services Director (SSD) confirmed no new intervention was put in place after Resident 1's fall on 1/11/2024, and had stated I'm not finding it, it should have been put on the Care Plan.