

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Crest View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(l) Based on record review and interview, the facility failed to determine root causes of falls and implement interventions of these identified risks to prevent fall from recurring for 1 (Resident 13) of 2 sample residents. The facility identified a census of 29. Findings are: A record review of the facility's policy, Fall Prevention and Response (dated April 2025) revealed it is the policy of the facility to identify residents who are at high risk for falls and develop individual precautions to prevent further falls. Additionally, the policy included steps to follow when a fall occurs as follows: 1) complete an incident report and a fall scene investigation after each fall; 2) falls will be logged through the completion of incident reports in PointClickCare (the medical record system); 3) initiate neuro checks if the resident hit their head or if the fall was unwitnessed and the resident cannot state if they hit their head or not; 4) notify the resident's physician; 5) notify the resident's family; 6) documentation of post-fall status in progress notes; and 7) update the care plan with any new or revised fall interventions. A record review of Resident 13's Medical Diagnoses revealed Resident 13 had been admitted to the facility on [DATE]. Resident 13 had a diagnosis of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior). A record review of Resident 13's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) (dated 5/14/2025) revealed Resident 13 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 3/15, which indicated the resident had severe cognitive impairment. Additionally, the MDS revealed the resident had sustained a fall prior to admission. A record review of Resident 13's quarterly MDS (dated 8/5/2025) revealed Resident 13 continued to have a BIMS of 3/15. Additionally, Resident 13 now required supervision with walking and had sustained two falls with injury since previous MDS. A record review of Resident 13's Care Plan revealed a focus care area identifying the resident was at a risk for fall due to confusion, gait/balance problems, and impaired awareness of safety needs had been initiated on 5/2/2025. Two interventions were also initiated on this date of: anticipate/meet the resident's needs and ensure the call light is within reach/encourage the resident to use it/answer promptly. A record review of Resident 13's Fall Scene Report from 6/16/2025 at 3:10 AM revealed the resident had been found on the floor next to their bed. The resident's head was found near the foot end of the bed. The resident was unable to communicate what they had been doing at the time of the fall, but the nurse had identified impaired memory, furniture, and lighting as factors observed at the time of the fall. It was also identified resident had one slipper and one gripper sock on. Root cause of the fall was determined as footwear, medical status/physical coordination/diagnosis, and impaired memory. Interventions to prevent future falls included bed in the lowest position, both slippers on, and bathroom light left on with the door cracked open. A record review of Resident 13's Progress Notes from 6/16/2025 at 3:10 AM revealed the Resident was found by staff on the floor, beside their bed, with one foot resting on the side of the bed, with the overhead light on. Additional record review of Resident 13's Care Plan revealed no evidence an intervention had been placed, under the falls focus area. An interview on 12/8/2025 at 4:15 PM with the Administrator (ADM) and Corporate Nurse Consultant (CNC) confirmed no interventions following Resident 13's fall on 6/16/2025 had been placed. Additionally, it was revealed that the fall scene reports are preliminary interventions and not always do the interventions developed at the time of that form are used long-term, confirming no intervention was developed following this fall. B.A record review of Resident 13's Fall Scene Report from 7/17/2025 at 6:50 PM revealed the resident had been walking with staff back to their room, when their feet caught each other. Staff was too far way to catch the resident before they hit the wall and slid to the floor. Resident 13 sustained a skin tear to their elbow and a laceration above their eye. The root cause of the fall was determined as gait imbalance. Interventions for future falls included 15-minute checks and if staff were walking directly beside the resident, to use gait belt, if resident allows. Additional record review of Resident 13's Care Plan, under the fall focus area, revealed an intervention (initiated on 7/18/2025) had been added of the resident needs activities that minimize the potential for falls while providing diversion and distraction. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed this intervention was to occupy the resident's time and distraction, keeping the resident busy. However, additional record review of the resident's Care Plan, under the wandering/elopement section</p>		