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	12/08/2025

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

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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	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) 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.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 (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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, revealed two intervention had already been placed, initially on 5/12/2025, of distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television book and provide structured activities: toileting, walking inside and outside, reorientation strategies including sign, pictures, and memory boxes. C.A record review of Resident 13's Fall Scene Report from 9/13/2025 at 8:25 PM revealed the resident had been found on the floor of the hallway. Root causes of the fall were determined as impaired memory and gait imbalance. Intervention to prevent future falls was listed as neuros performed so resident checked very frequently.A record review of Resident 13's Care Plan Report under the fall section, revealed Fall: 9/13/2025 had been added on 9/15/2025 to an already existing intervention of Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, which had been initiated on 5/2/2025. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed that the facility had been trying to get the resident to utilize the call light, however, the use of the resident's walker and call light are a [NAME] point because [gender] is never going to start using them. D.A record review of Resident 13's Fall Scene Report from 9/22/2025 at 4:20 AM revealed the resident had been found on the floor lying next to their bed and between the near by table. Resident's head was near the head of the bed. Resident 13 sustained two lacerations to the side of their face. Root cause of the fall was determined to be medical status/physical coordination/diagnosis, mood or mental status, and impaired memory. No interventions were placed in the boxed for interventions to prevent future falls.A record review of Resident 13's Progress Notes from 9/22/2025 revealed the following:- At 4:20 AM, Resident 13 was found on the floor beside their bed, with blood noted to be on the bedside table. Resident 13 had sustained two lacerations: one underneath their right eye and one on their right eyebrow. Resident 13 was sent to the hospital for sutures. A record review of Resident 13's Care Plan Report revealed an intervention had been initiated on 9/22/2025 following the resident's fall of Review information on past fall and attempt to determine cause of the falls. Record possible root causes. Alter [or] remove any potential causes, if possible. Educate resident/family/caregivers/IDT [interdisciplinary team] as to causes. There was no evidence of an intervention to decrease the risk of additional fall in the same manner. Additionally, the Care Plan revealed, under the Activities of Daily Living (ADL) section, that it was identified and placed as an intervention for the resident's need for cueing and as needed repositioning in the bed. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed that the facility was unsure of the cause of the fall, stating the resident likes to be on the edge of the bed and needs cued to move back. Additionally, noting that the bed should be in low position to minimize the risk of the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident rolling out of bed, but confirming no intervention was placed following this fall. E.A record review of Resident 13's Fall Scene Report from 11/24/2025 at 4:01 AM revealed the resident had self-reported a fall. Previously, the resident had been in bed. Interventions to prevent future falls was to place bed in low position. Impaired memory and gait imbalance were determined as root causes of the fall. A record review of Resident 13's Progress Notes from 11/24/2025 revealed the following:- At 4:01 AM, it was noted Resident 13 had came out of their room at 3:50 AM with the top and side of their head covered in blood and continuing to bleed. It was also noted Resident 13 had a bump to the side of their head and believed the resident had sustained an unwitnessed fall. The nurse went to the resident's room and discovered blood close to the resident's headboard. The resident was sent to the hospital at 4:15 AM.- At 9:44 AM, it was noted the nurse had received report from the hospital at 6:28 AM, learning that Resident 13 had received 9 staples for their laceration. Additional record review of Resident 13's Care Plan Report under the fall section revealed an intervention entered on 12/2/2025 of Low bed to assist with decreasing risk. No mat use due to tripping hazard. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC revealed the intervention for the bed to be in the lowest position has only been in effect since 12/2/2025. The CNC was unable to speak as to why it had not been implemented on the care plan back in June. F.A record review of Resident 13's Fall Scene Report from 11/27/2025 at 6:10 AM revealed the resident was found on the floor, leaning partially up against their dresser. The resident stated they were attempting to use the restroom. Intervention to prevent future falls were to conduct frequent rounds to help anticipate resident's healthcare needs. No root cause of the fall had been determined. A record review of Resident 13's Care Plan Report revealed an intervention of Has had falls. Sleeps on edge of bed. Call lite within reach. Continue to check on rounds and passing by had been added on 12/2/2025. However, the intervention for the call light had already been in place since 5/2/2025, cueing for bed mobility had already been in place since 5/2/2025, and one-to-one care since 8/5/2025. During the interview on 12/8/2025 at 4:15 PM with the ADM and CNC, it was revealed the facility's expectation was for all staff from every department to keep eyes on the resident, not just the staff member conducting the one-to-one cares, but no other interventions were implemented. It was also revealed that the call light was not an effective or appropriate intervention as the resident does not use the call light.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E) Based on observations, interviews, and record reviews, the facility failed to dispose of expired foods, ensure hair was restrained in areas where food was prepared, and wash dishware at the required temperature to prevent the potential for foodborne illness for all residents in the facility. The facility census was 29. Findings Are: A.An observation on 12/01/2025 at 10:05 AM in the facility's dry storage room revealed the following items:-A jug of Sysco Classic Worcestershire Sauce which had an opened-on date of 7/22/2025 and was about 1/3 used. The jug had a Best By date of October 30, 2025. -Several cans of evaporated milk that had manufacture dates of 4/3/2024 and no expiration date. They were marked as being received on 10/1/2024. -13 cans of Casa Solana Sweetened Condensed Milk with expiration dates of 10/4/2025. An interview on 12/1/2025 at 10:20 AM with the Dietary Director (DD)-F confirmed the Worcestershire Sauce and Sweetened Condensed Milk were expired. DD-F also confirmed the evaporated milk cans expired 12-18 months from the manufacture date and that all items should have been disposed of. B.An observation on 12/2/2025 at 9:52 AM in the kitchen revealed Dietary Aide (DA)-D taking soiled dishes from the dining room into the kitchen and preparing these dishes to go through the dishwasher. DA-D loaded dishes onto a tray, pushed the tray into the dishwasher, and started the wash cycle. The wash cycle's maximum temperature was 91 degrees Fahrenheit (F), after the dishwasher completed the wash and rinse cycles, DA-D removed the tray of dishes from the machine and pushed a second tray in. The wash cycle for the second tray had a maximum temperature of 95 degrees F. After the dishwasher completed the wash and rinse cycles, DA-D removed the tray of dishes from the machine and pushed the third tray in. The wash cycle for the third tray had a maximum temperature of 111 degrees F. At this point, DA-D noticed that the temperature was too low, stopped the machine and opened it, then closed it and restarted it. The wash cycle temperature for this tray then reached 115 degrees F. When the wash and rinse cycle was complete, DA-D asked Cook-E for assistance, adjusted the dishwasher and then rewashed the tray of dishes, with the wash cycle temperature reaching 131 degrees F. DA-D then put away the dishes that had been washed so far, without re-washing the first two trays of dishes. An interview on 12/2/2025 at 12:15 PM with DD-F confirmed the facility's dishwasher was a low temp dishwasher. A record review of facility policy Dishwasher Temperature dated 2024 revealed it was the policy of the facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures. The policy also revealed guidelines stating for a low temp dishwasher, the wash temperature should be 120 degrees F. C.An observation on 12/01/2025 at 10:05 AM in the kitchen revealed DA-D was washing dishes in the dishwasher, which was in close proximity to the food preparation area, where food was being prepared. DA-D was wearing a hat and had their hair in a ponytail, which was hanging down their back unrestrained. An observation on 12/2/2025 at 9:52 AM in the kitchen revealed DA-D taking soiled dishes from the dining room into the kitchen. DA-D then prepped the dishes, ran them through the dishwasher and put them away. DA-D was wearing a hat and had their hair in a ponytail, which was hanging down their back unrestrained. Food was being prepared in the kitchen at this time. A record review of facility policy Dietary Employee Personal Hygiene dated 2024 revealed in section 4 that all dietary staff must wear hair restraints to prevent hair from contacting food. A record review of the Federal Drug Administration's 2022 Food Code revealed in section 2-402.11 that food employees shall wear restraints that cover body hair and that are designed and worn to effectively keep their hair from contacting exposed food. An interview on 12/2/25 at 12:10 PM with DD-F confirmed DA-D's hair was in a ponytail and not restrained under their hat.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Licensure Reference Number 175 NAC 12-006.18 Based on record review and interview, the facility failed to ensure they employed a qualified infection preventionist. This had the potential to affect all residents. The facility census was 29.Findings Are: A record review of a Professional Staff document provided by the facility on 12/1/2025 revealed the facility's infection preventionist was the administrator. An interview on 12/8/25 at 1:40 PM with the Administrator confirmed the administrator was the facility's infection preventionist despite not possessing the qualifications required by regulation to fill this role. The administrator also confirmed the facility's Corporate Nurse Consultant had been assisting with the facility's infection control program remotely from another state, which did not meet regulatory requirements.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1)Based on record review and interviews, the facility failed to ensure 1 of 5 sampled nurse aides completed 12 hours of annual ongoing training. This had the potential to affect all 29 residents who resided within the facility. Findings are: A record review of an untitled facility-provided document revealed a list of ongoing training hours for Nurse Aide-G (NA-G) between 10/11/24 and 9/26/25.A record review of the same document revealed 20 separate entries for coursework totaling 6.7 hours during that time period. An interview on 12/4/25 at 10:27 AM with the Administrator (ADM) confirmed the facility had not documented any other ongoing training hours for NA-G during that period except the 6.7 hours. The interview also confirmed NA-G did not have 12 hours as required and should have.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(D) Based on record reviews and interviews, the facility failed to protect the residents' right to be free from physical and verbal abuse by another resident for 4 (Residents 2, 24, 27 and 32) of 4 sampled residents. The facility identified a census of 29.Findings are: A record review of the facility's Abuse Prevention Policy and Procedure (dated December 2022) revealed the following:- It is the policy of the facility that all residents have the right to be free from abuse.- The Administrator was listed as the facility's Abuse Prevention Coordinator.- Abuse was defined as the willful inflection of injury, unreasonable confinement, intimidation, punishment, with resulting physical harm, pain, or mental anguish.- Willful was defined as an individual having acted deliberately, not that the individual intended to inflect injury or harm.- Physical abuse was defined as including, but not limited to, hitting, slapping, kicking, biting, scratching, pushing, and pinching.- Verbal abuse was defined as the use of oral, written or gestured language that willfully includes demeaning, disparaging, humiliating, harassing, threatening, or derogatory terms to residents or within their hearing distance.- Under the Prevention section, the policy revealed the assessment, care planning and monitoring of residents with needs or behaviors which might lead to conflict or neglect (such as verbal, physical or sexual aggression; wandering; communication disorders' self-injurious behaviors etc.) would be completed.- All incidents would have an intervention implemented at the time of the incident and be care planned to reduce the chance of recurrence.- Under the protection section, the facility would take appropriate corrective action resulting from investigation findings and ensure the action was effective. 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 with behavioral disturbances [common, distressing personality and behavior changes (like aggression, wandering, hallucinations, and apathy) that occur alongside cognitive decline, often signaling unmet needs (pain, hunger, boredom) or underlying issues (infection, medication side effects)]. 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 the following:- 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.- Resident 13 was usually able to express their ideas and wants and sometimes was able to understand others.- No physical or verbal behaviors had been identified. However, Resident 13 did wander one to three days during the 7-day look back period.- Resident 13 was able to walk at least 10 feet with supervision. A record review of Resident 13's hospital documentation prior to their admission (dated 4/29/2025) revealed Resident 13 had intermittent agitation and anxiety with their dementia. A record review of Resident 13's Progress Notes from 5/3/2025-5/8/2025 revealed the following:- On 5/3/2025, Resident 13 had attempted to take food from another resident's plate.- On 5/4/2025, Resident 13 had attempted to hit a Nurse Aide (NA) on two separate occasions.- On 5/8/2025 at 11:00 PM, Resident 13 had been wandering in and out of other resident's room, had been redirected easily for short periods of time. A record review of Resident 13's behavioral documentation for June 2025 revealed the following:- Resident 13 had wandered during six days of the month during day shift (6 AM - 6 PM). The resident also had one occasion of rejection of care.- Resident 13 had wandered during nine days of the month during night shift (6 PM - 6 AM). The resident also had 1 night on the19th of where yelling/screaming had been exhibited. A record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed Resident 13 had been identified as using an anti-psychotic medication for their anxiety and agitation. An intervention to monitor target behaviors, including violence/aggression towards staff/other and taking food from others plate had been initiated on 5/4/2025. However, there was no (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence of non-pharmacological interventions for anxiety or agitation prior to 7/4/2025 implemented. A.A record review of an admission Record revealed the facility admitted Resident 27 on 5/19/2025. A record review of Resident 27's admission MDS from 5/30/2025 revealed Resident 27 had a BIMS score of 10/15, which indicated the resident had moderate cognitive impairment. Additionally, it revealed Resident 27 had clear comprehension with understanding others and making self understood. A record review of an incident report from 7/3/2025 at 3:08 PM indicated that a Nursing Assistant (NA) notified the Registered Nurse (RN) that Resident 13 had been yelling at Resident 27. The report documented that Resident 27 stated they had been sitting in their recliner when Resident 13 began handling Resident 27's electric razor located on a table nearby. Resident 27 reported asking Resident 13 to put the razor down, but Resident 13 did not comply. When Resident 27 attempted to take the razor back, Resident 13 picked up a nearby mirror and struck Resident 27 several times. The incident report further noted that Resident 27 sustained a skin tear to the face and a skin tear to the right forearm. Resident 27 declined transfer to the Emergency Department for further medical treatment. Additional record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed a new focus area regarding Resident 13's potential to be physically aggressive by hitting others related to anger, history of harm to others, and poor impulse control had been initiated on 7/4/2025. The following interventions were also implemented on 7/4/2025:- Assess and anticipate Resident 13's needs: food, thirst, toileting, comfort level, body positioning, and pain etc.- Resident 13 tolerates people at a time. Resident 13 needs to have [gender] own room at all times.- When Resident 13 becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation; if response is aggressive, staff should walk away calmly and reapproach later. B.A record review of Resident 32's MDS from 4/28/2025 revealed Resident 32 had a BIMS score of 14/15, which indicated the resident was cognitively intact. Additionally, it revealed Resident 32 had clear comprehension with understanding others and making self understood. A record review of Resident 32's Progress Note from 7/16/2025 7:51 PM revealed that Resident 32 had been wheeling themself back to their room when Resident 13 stepped into their path. The note documented that Resident 32 yelled at Resident 13 to get out of their way. Resident 13 replied, well get up and fight me, while raising their arms and forming fists. The note further showed that three staff members attempted to intervene; however, the residents continued to argue. Resident 13 then yelled, you're not gonna be alive tomorrow. Staff were subsequently able to separate the residents. Additional record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed no evidence of additional interventions implemented following this incident. C.A record review of an admission Record revealed the facility admitted Resident 24 on 6/8/2023. A record review of Resident 24's MDS from 5/21/2025 revealed Resident 24 had a BIMS of 3/15, which indicated the resident had severe cognitive impairment. Additionally, it revealed Resident 24 usually understood others and is sometimes able to express their selves. A record review of an incident report from 8/5/2025 at 9:30 PM for Resident 24 revealed Resident 24's roommate had called staff to report that the resident was being hit. Resident 24 was found lying in the bed, curled up into a ball and yelling for help. Resident 24 had no immediate injuries observed. A record review of an incident report from 8/5/2023 at 9:30 PM for Resident 13 revealed that staff responded to Resident 24's room and found Resident 13 standing over Resident 24. Staff escorted Resident 13 out of the room; however, the report documented that Resident 13 continued to make threatening remarks about other residents. The incident report noted that Resident 13 had a diagnosis of end-stage dementia and a history of physical and verbal aggression toward residents and staff. A record review of Resident 13's Care Plan Report (with a print date of 12/3/2025) revealed an intervention for one-on-one care and to document observed behaviors, attempt interventions, and report to charge nurse had been initiated on 8/5/2025. D.A review of Resident 13's Progress Note, dated 9/19/2025, revealed that Resident 13 had an encounter with another resident at the dining room table to their right who was not polite. In response, Resident 13 stated that they should kick the other resident's ass. Resident 13 was able to be redirected. An (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 12/3/2025 at 11:15 AM with RN-B recalled the other resident involved in the incident on 10/6/2025 to be Resident 27. Additional record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed no evidence of additional interventions implemented following this incident. E.A record review of Resident 13's Progress Note from 10/6/2025 revealed that during supper the previous evening, Resident 13 became extremely agitated with another resident. RN-B documented hearing Resident 13 cuss and then threatened violence by stating that the resident had a gun or knife in their pocket. The note indicated that RN-B observed Resident 13 remove a belt buckle from their pants pocket. RN-B intervened and was able to redirect Resident 13 back to their room following the incident. An interview on 12/3/2025 at 11:15 AM with RN-B recalled the other resident involved in the incident on 10/6/2025 to be Resident 24. Additional record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed no evidence of additional interventions implemented following this incident. F. A record review of an admission Record revealed the facility admitted Resident 2 on 10/5/2021. Resident 2 had a diagnosis of dementia with behavioral disturbance. A record review of Resident 2's MDS from 10/15/2025 revealed Resident 2 had a BIMS score of 3/15, which indicated the resident had severe cognitive impairment. A record review of Resident 13's Progress Note from 10/16/2025 at 10:36 AM revealed Resident 13 had been at the breakfast table that morning and had gently poked Resident 2 with a butter knife. Staff intervened immediately and directed Resident 13 away. Resident 2 had no injuries. An interview on 12/3/2025 at 11:15 AM with RN-B revealed Resident 13 had been moved to a different table after this incident. An interview on 12/2/2025 at 3:30 PM with the Administrator and the Corporate Nurse Consultant revealed noise had been identified during Resident 13's first resident-to-resident altercation on 7/3/2025 and had moved Resident 13 to a different room. However, Resident 13 was bothered by Resident 24's hollering out at night, which attracted [gender] to wander into Resident 24's room, when one-to-one observation and cares were implemented. The facility confirmed these were the incidents that had interventions placed following and had attempted to find alternative placement for Resident 13 but had been denied by several other facilities, and will continue to redirect as needed.

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to attempt, implement, and document non-pharmacological interventions prior to administering an as needed (PRN) antipsychotic medication for Resident 13; failed to ensure PRN antipsychotics were not continued beyond 14 days for Residents 2 and 13; and failed to ensure as needed psychotropic medications were not continued past 14 days without a rationale for Resident 2 and 28. The sample size was 5 and the facility census was 29.Findings Are: A record review of the facility policy Antipsychotic Use Policy and Procedure dated November 2022 revealed a policy statement To ensure neuroleptics, hypnotic, sedative, antidepressant, anxiolytic, and antipsychotic medications will be used only when it is necessary to treat a specific condition. In the procedure section, it states residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. A. A record review of Resident 2's admission Record dated 12/4/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 2's order summary conducted on 12/4/2025 revealed the resident had the following as needed antipsychotic medication orders: -Haloperidol lactate (an antipsychotic medication) 2 milligrams (MG) per milliliter (ML) oral concentration, give 1 ML as needed (PRN) every 2 hours for anxiety, confusion or delirium. The order had a start date of 10/3/2025. This medication was not utilized between 11/1/2025 and 12/4/2025. -Haloperidol lactate 2 mg/mL oral concentration, give 1/2 ML PRN every 2 hours for anxiety, confusion or delirium. The order had a start date of 10/3/2025. This medication was not utilized between 11/1/2025 and 12/4/2025. -Seroquel (an antipsychotic medication) oral tablet 25 MG, give 1 tablet by mouth every 24 hours as needed for verbal outbursts related to unspecified dementia, moderate, with other behavioral disturbances. This order had a start date of 8/26/2025. This medication had been utilized 9 times between 11/1/2025 and 12/4/2025. A record review of Resident 2's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 9/29/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. -On 8/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. A record review of Resident 2's scanned documents in their electronic medical records revealed the resident was seen by their provider on the following dates: -On 7/16/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN antipsychotic medication orders. -On 9/24/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN antipsychotic medication orders. -On 11/17/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN antipsychotic medication orders. An interview on 12/8/25 at 2:20 PM with the [NAME] President of Operations (VPO) confirmed Resident 2's PRN antipsychotic medications had been in place for greater than 14 days and that there was no evidence of the provider re-evaluating the resident every 14 days for these medications to be continued. The VPO also confirmed that the pharmacist had made recommendations related to limiting the duration of PRN psychotropic medications and there was no evidence of the provider reviewing this information. B. A record review of the facility's policy, Behavioral Health Management, (dated March 2019), under the Treatment/Management section revealed medications will be used only after non-pharmacological interventions have been ineffective at the time. The staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's behavior. 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 with behavioral disturbances [common, distressing personality and behavior changes (like aggression, wandering, hallucinations, and apathy) that occur alongside cognitive decline, often signaling unmet needs (pain, hunger, boredom) or underlying issues (infection, medication side effects). A record review of Resident 13's hospital documentation prior to their admission (dated 4/29/2025) revealed Resident 13 had intermittent agitation and anxiety with their dementia. 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. No physical or verbal behaviors had been identified. However, Resident 13 did wander one to three days during the 7-day look back period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 13's Care Plan Report (with a print date of 12/4/2025) revealed the following: - Resident 13 had been identified as using an anti-psychotic medication for their anxiety and agitations. An intervention to monitor target behaviors, including violence/aggression towards staff/other and taking food from others plate had been initiated on 5/4/2025. - There was no evidence of non-pharmacological interventions for anxiety or agitation prior to 7/4/2025 implemented. - On 7/4/2025, a focus area for Resident 13's potential to be physically aggressive by hitting other related to anger, history of harm to others and poor impulse control was initiated. - Three interventions were initiated on 7/4/2025: Assess and anticipate Resident 13's needs: food, thirst, toileting, comfort level, body positioning, and pan etc; Resident 13 tolerates people at a time. Resident 13 needs to have [gender] own room at all times. ; and When Resident 13 becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation; if response is aggressive, staff should walk away calmly and reapproach later. - An intervention of Resident 13's trigger for noise and to remove the resident from any noisy areas was implemented on 12/3/2025. A record review of Resident 13's Order Summary Report (as of 12/4/2025) revealed an order for haloperidol (an antipsychotic) with instruction to give every twenty-four hours as needed intramuscularly for severe behavior and agitation. This medication had a start date of 8/11/2025 and no stop date. A record review of Resident 13's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate continued need. - On 10/30/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate continued need. -On 9/29/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days. A record review of Resident 13's medical record revealed no evidence the physician had evaluated the continued need for Resident 13's haloperidol. An interview on 12/8/25 at 2:20 PM with the VPO confirmed Resident 13's PRN antipsychotic medications had been in place for greater than 14 days and that there was no evidence of the provider re-evaluating the resident. C. A record review of an admission Record revealed the facility admitted Resident 28 on 3/17/2023. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 28 had a diagnosis of dementia with behavioral disturbance. A record review of Resident 28's Order Summary Report (as of 12/8/2025) revealed the following orders: - Lorazepam (an antianxiety/psychotropic medication) for 0.5 milligrams (mgs) with instruction to give 0.25 mg by mouth every 12 hours as needed for agitation. This medication had a start date of 9/2/2025. - Lorazepam 1 mg with instructions to give 1 mg every 12 hours as needed for agitation. This medication had a start date of 4/30/2024. A record review of Resident 28's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate. - On 10/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate. -On 9/30/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days. - On 7/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate. A record review of Resident 28's medical record revealed no evidence the physician had reviewed the pharmacy recommendations from 7/31/2025, 9/30/2025, 10/31/2025, or 11/30/2025. An interview on 12/8/25 at 2:20 PM with the VPO confirmed Resident 28's PRN psychotropic medications had been in place for greater than 14 days and that there was no evidence of the provider re-evaluating the resident every 14 days for these medications to be continued. D. A record review of Resident 2's admission Record dated 12/4/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 2's order summary conducted on 12/4/2025 revealed the resident had two PRN psychotropic medication order that was not an antipsychotic. The orders were for: -Ativan (an antianxiety medication) oral tablet 0.5 milligrams (MG), give 1 tablet by mouth every 30 minutes as needed for anxiety or shortness of breath. The order had a start date of 10/22/2025. This medication had been utilized 5 times between 10/22/2025 and 12/4/2025. - Ativan oral tablet 0.5 MG, give 2 tablets by mouth every 30 minutes as needed for anxiety. The order had a start date of 10/22/2025. This medication had been utilized 1 time between 10/22/2025 and 12/4/2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 2's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. -On 9/29/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. -On 8/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. A record review of Resident 2's scanned documents in their electronic medical records revealed the resident was seen by their provider on the following dates: -On 7/16/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN psychotropic medication orders. -On 9/24/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN psychotropic medication orders. -On 11/17/2025 the resident was seen for a 60-day visit. The provider did not address the resident's PRN psychotropic medication orders. An interview on 12/8/25 at 2:20 PM with the [NAME] President of Operations (VPO) confirmed Resident 2's PRN antipsychotic medications had been in place for greater than 14 days and that there was no evidence of the provider providing rationale for continuing the medications beyond 14 days. The VPO also confirmed that the pharmacist had made recommendations related to limiting the duration of PRN psychotropic medications and there was no evidence of the provider reviewing this information.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to initiate investigations of potential abuse, complete thorough investigations of alleged violations, and maintain documentation of the investigations, for 5 (Resident 2, 13, 24, 27, and 32) of 5 sample residents. The facility identified a census of 29.Findings are: A record review of the facility's Abuse Prevention Policy and Procedure (dated December 2022) revealed the following:- The Administrator was listed as the facility's Abuse Prevention Coordinator.- Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish.- Willful was defined as an individual acting deliberately, not necessarily intending to inflict injury or harm.- An alleged violation was defined as a situation that is observed or reported by staff, residents, or others but has not been investigated.- Physical abuse was defined as including, but not limited to, hitting, slapping, kicking, biting, scratching, pushing, and pinching.- Verbal abuse was defined as the use of oral, written, or gestured language that willfully includes demeaning, disparaging, humiliating, harassing, threatening, or derogatory terms to residents or within their hearing distance.- The facility would complete investigations. Designated personnel on duty would begin the investigation by conducting a physical assessment of the resident, speaking with all staff involved, documenting findings, and determining whether the resident(s) could explain the event or participate in the investigation.- Each incident would have an internal investigation to determine if it was reportable. The policy stated that all resident-to-resident altercations are reportable incidents. 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 with behavioral disturbances [common, distressing personality and behavior changes (like aggression, wandering, hallucinations, and apathy) that occur alongside cognitive decline, often signaling unmet needs (pain, hunger, boredom) or underlying issues (infection, medication side effects)]. 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 the following:- 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.- Resident 13 was usually able to express their ideas and wants and sometimes was able to understand others.- No physical or verbal behaviors had been identified. However, Resident 13 did wander one to three days during the 7-day look back period.- Resident 13 was able to walk at least 10 feet with supervision. A record review of Resident 13's hospital documentation prior to their admission (dated 4/29/2025) revealed Resident 13 had intermittent agitation and anxiety with their dementia. A record review of Resident 13's Progress Notes from 5/3/2025-5/8/2025 revealed the following:- On 5/3/2025, Resident 13 had attempted to take food from another resident's plate.- On 5/4/2025, Resident 13 had attempted to hit a Nurse Aide (NA) on two separate occasions.- On 5/8/2025 at 11:00 PM, Resident 13 had been wandering in and out of other resident's room, had been redirected easily for short periods of time. A record review of Resident 13's behavioral documentation for June 2025 revealed the following:- Resident 13 had wandered during six days of the month during day shift (6 AM - 6 PM). The resident also had one occasion of rejection of care.- Resident 13 had wandered during nine days of the month during night shift (6 PM - 6 AM). The resident also had 1 night on the19th of where yelling/screaming had been exhibited. A.A record review of an admission Record revealed the facility admitted Resident 27 on 5/19/2025. A record review of Resident 27's admission MDS from 5/30/2025 revealed Resident 27 had a BIMS score of 10/15, which indicated the resident had moderate cognitive impairment. Additionally, it revealed Resident 27 had clear comprehension with understanding others and making self understood. A record review of an incident report from 7/3/2025 at 3:08 PM indicated that a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Assistant (NA) notified the Registered Nurse (RN) that Resident 13 had been yelling at Resident 27. The report documented that Resident 27 stated they had been sitting in their recliner when Resident 13 began handling Resident 27's electric razor located on a table nearby. Resident 27 reported asking Resident 13 to put the razor down, but Resident 13 did not comply. When Resident 27 attempted to take the razor back, Resident 13 picked up a nearby mirror and struck Resident 27 several times. The incident report further noted that Resident 27 sustained a skin tear to the face and a skin tear to the right forearm. Resident 27 declined transfer to the Emergency Department for further medical treatment. A record review of the facility's internal investigation of the incident from 7/3/2025 revealed a statement had been obtained from the nurse on duty, however, no other staff had been interviewed. Additionally, there was no documentation Resident 13 had been attempted to interviewed, or the reason they were unable to be interviewed, or evidence a record review had been completed as part of a thorough investigation. B.A record review of Resident 32's MDS from 4/28/2025 revealed Resident 32 had a BIMS score of 14/15, which indicated the resident was cognitively intact. Additionally, it revealed Resident 32 had clear comprehension with understanding others and making self understood. A record review of Resident 32's Progress Note from 7/16/2025 7:51 PM revealed that Resident 32 had been wheeling themself back to their room when Resident 13 stepped into their path. The note documented that Resident 32 yelled at Resident 13 to get out of their way. Resident 13 replied, well get up and fight me, while raising their arms and forming fists. The note further showed that three staff members attempted to intervene; however, the residents continued to argue. Resident 13 then yelled, you're not gonna be alive tomorrow. Staff were subsequently able to separate the residents. A record review of the facility's internal investigation records revealed no evidence that staff assessed the resident's statement for potential abusive or aggressive intent nor had initiated a timely investigation following this incident. C.A record review of Resident 13's Progress Note from 7/26/2025 at 3:39 AM revealed Resident 13 had displayed aggression towards another resident, telling the other resident to shut up and had made a threat. The residents were separated before physical altercation occurred. A record review of the facility's internal investigation records revealed no evidence that staff assessed the resident's statement for potential abusive or aggressive intent nor had initiated a timely investigation following this incident. D.A record review of an admission Record revealed the facility admitted Resident 24 on 6/8/2023. A record review of Resident 24's MDS from 5/21/2025 revealed Resident 24 had a BIMS of 3/15, which indicated the resident had severe cognitive impairment. Additionally, it revealed Resident 24 usually understood others and is sometimes able to express their selves. A record review of an incident report from 8/5/2025 at 9:30 PM for Resident 24 revealed Resident 24's roommate had called staff to report that the resident was being hit. Resident 24 was found lying in the bed, curled up into a ball and yelling for help. Resident 24 had no immediate injuries observed. A record review of an incident report from 8/5/2023 at 9:30 for Resident 13 revealed that staff responded to Resident 24's room and found Resident 13 standing over Resident 24. Staff escorted Resident 13 out of the room; however, the report documented that Resident 13 continued to make threatening remarks about other residents. The incident report noted that Resident 13 had a diagnosis of end-stage dementia and a history of physical and verbal aggression toward residents and staff. A record review of Resident 13's Care Plan Report (with a print date of 12/3/2025) revealed an intervention for one-on-one care and to document observed behaviors, attempt interventions, and report to charge nurse had been initiated on 8/5/2025. A record review of the facility's internal investigation from 8/5/2025 revealed no evidence the on-duty nurse or other staff had been interviewed, the residents involved had been interviewed or why they were incapable of being interviewed, or record review had been completed. E.A review of Resident 13's Progress Note, dated 9/19/2025, revealed that Resident 13 had an encounter with another resident at the dining room table to their right who was not polite. In response, Resident 13 stated that they should kick the other resident's ass. Resident 13 was able to be redirected. An interview on 12/3/2025 at 11:15 AM with RN-B recalled the other resident involved in the incident on (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/6/2025 to be Resident 27. A record review of the facility's internal investigation records revealed no evidence that staff assessed the resident's statement for potential abusive or aggressive intent nor had initiated a timely investigation following this incident. F.A record review of Resident 13's Progress Note from 10/6/2025 revealed that during supper the previous evening, Resident 13 became extremely agitated with another resident. RN-B documented hearing Resident 13 cuss and then threatened violence by stating that the resident had a gun or knife in their pocket. The note indicated that RN-B observed Resident 13 remove a belt buckle from their pants pocket. RN-B intervened and was able to redirect Resident 13 back to their room following the incident. An interview on 12/3/2025 at 11:15 AM with RN-B recalled the other resident involved in the incident on 10/6/2025 to be Resident 24. A record review of the facility's internal investigation records revealed no evidence that staff assessed the resident's statement for potential abusive or aggressive intent nor had initiated a timely investigation following this incident. G. A record review of an admission Record revealed the facility admitted Resident 2 on 10/5/2021. Resident 2 had a diagnosis of dementia with behavioral disturbance.A record review of Resident 2's MDS from 10/15/2025 revealed Resident 2 had a BIMS score of 3/15, which indicated the resident had severe cognitive impairment. A record review of Resident 13's Progress Note from 10/16/2025 at 10:36 AM revealed Resident 13 had been at the breakfast table that morning and had gently poked Resident 2 with a butter knife. Staff intervened immediately and directed Resident 13 away. Resident 2 had no injuries. A record review of the facility's internal investigation records revealed no evidence that staff assessed the resident's statement for potential abusive or aggressive intent nor had initiated a timely investigation following this incident. An interview on 12/2/2025 at 3:30 PM with the Administrator (ADM) and the Corporate Nurse Consultant (CNC) confirmed the only investigation the facility had completed were from the incidents on 7/3/2025 and 8/5/2025, additionally investigations were only completed if physical harm occurs. Additionally, they confirmed they had not maintained documentation of additional staff interview, had attempted to interview Resident 13 regarding the incident nor documented why the resident was not capable of being interviewed, nor maintained documentation of Resident 13's completed record review.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure the attending physician reviewed the monthly pharmacist recommendations and documented in 3 (Residents 2, 13, and 28) of 5 sampled residents' medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. The facility census was 29. Findings Are: A. A record review of Resident 2's admission Record dated 12/4/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 2's order summary revealed the resident had the following psychotropic medication orders: -Ativan (an antianxiety medication) oral tablet 0.5 milligrams (MG), give 1 tablet by mouth every 30 minutes as needed for anxiety or shortness of breath. The order had a start date of 10/22/2025. -Haloperidol lactate (an antipsychotic medication) 2 MG per milliliter (ML) oral concentration, give 1 ML PRN every 2 hours for anxiety, confusion or delirium. The order had a start date of 10/3/2025. -Haloperidol lactate 2 mg/mL oral concentration, give 1/2 ML PRN every 2 hours for anxiety, confusion or delirium. The order had a start date of 10/3/2025. -Seroquel (an antipsychotic medication) oral tablet 25 MG, give 1 tablet by mouth every 24 hours as needed for verbal outbursts related to unspecified dementia, moderate, with other behavioral disturbances. This order had a start date of 8/26/2025. -Seroquel oral tablet 25 MG, give 1 tablet by mouth at bedtime related to unspecified dementia, moderate, with other behavioral disturbances. This order had a start date of 8/26/2025. -Dulcolax (a laxative medication) soft chews, give 1 tablet by mouth every 72 hours as needed for constipation. This order had a start date of 10/27/2022. -Tylenol with Codeine #3 (a pain medication) tablet 300-30 MG, give 1 tablet by mouth every 4 hours as needed for pain. This order had a start date of 5/18/2022. A record review of Resident 2's October 2025 Medication Administration Record revealed an order for Coumadin (warfarin) 2.5 MG daily for Health Maintenance. This order had a start date of 8/27/2025 and a discontinue date of 10/22/2025. A record review of Resident 2's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote to consider discontinuing the resident's PRN Tylenol #3 as it had not been used in the past 2 months. The pharmacist also wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate further (continued on next page)

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	285150	A. Building B. Wing	12/08/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	need. -On 9/29/2025 the pharmacist wrote that the warfarin diagnosis needed to be updated from health maintenance to an appropriate diagnosis. The pharmacist also wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. -On 8/31/2025 the pharmacist wrote that the warfarin diagnosis needed to be updated from health maintenance to an appropriate diagnosis. The pharmacist also wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate further need. -On 5/31/2025 the pharmacist made a recommendation to discontinue the resident's Dulcolax soft chews as it had not been used in the prior 3 months, and the resident had multiple PRN medications for constipation. A record review of Resident 2's scanned documents in their electronic medical records revealed the resident was seen by their provider on the following dates: -On 7/16/2025 the resident was seen for a 60-day visit. There was a note that stated stable and no changes to their orders. -On 9/24/2025 the resident was seen for a 60-day visit and had a suspected diagnosis of pneumonia. The documentation does not address the pharmacy recommendations from May or August 2025. -On 11/17/2025 the resident was seen for a 60-day visit. There was a note that stated stable and no changes to their orders. An interview on 12/8/25 at 2:20 PM with the [NAME] President of Operations (VPO) confirmed there was no evidence Resident 2's provider had reviewed the pharmacy recommendations from 5/31/2025, 8/31/2025, 9/29/2025 or 11/30/2025 and that changes had not been made to the orders referenced in the pharmacists recommendations. B. 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 with behavioral disturbances [common, distressing personality and behavior changes (like aggression, wandering, hallucinations, and apathy) that occur alongside cognitive decline, often signaling unmet needs (pain, hunger, boredom) or underlying issues (infection, medication side effects)]. 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. No physical or verbal behaviors had been identified. However, Resident 13 did wander one to three days during the 7-day look back period. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 13's Order Summary Report (as of 12/4/2025) revealed an order for haloperidol (an antipsychotic) with instruction to give every twenty-four hours as needed intramuscularly for severe behavior and agitation. This medication had a start date of 8/11/2025 and no stop date. A record review of Resident 13's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate continued need. - On 10/30/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate continued need. -On 9/29/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days. A record review of Resident 13's medical record revealed no evidence the physician had reviewed the pharmacy recommendations from 9/29/2025, 10/30/2025, or 11/30/2025. An interview on 12/8/25 at 2:20 PM with the [NAME] President of Operations (VPO) confirmed there was no evidence Resident 13's provider had reviewed the pharmacy recommendations from 9/29/2025, 10/30/2025, or 11/30/2025. C. A record review of an admission Record revealed the facility admitted Resident 28 on 3/17/2023. Resident 28 had a diagnosis of dementia with behavioral disturbance. A record review of Resident 28's Order Summary Report (as of 12/8/2025) revealed the following orders: - Lorazepam (an antianxiety/psychotropic medication) for 0.5 milligrams (mgs) with instruction to give 0.25 mg by mouth every 12 hours as needed for agitation. This medication had a start date of 9/2/2025. - Lorazepam 1 mg with instructions to give 1 mg every 12 hours as needed for agitation. This medication had a start date of 4/30/2024. A record review of Resident 28's Progress Notes revealed the following pharmacy medication reviews with recommendations: -On 11/30/2025 the pharmacist wrote that per Centers for Medicare and Medicaid (CMS) guidance, PRN psychotropics should be limited to 14 days and to evaluate. -On 10/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate. -On 9/30/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14 days. -On 7/31/2025 the pharmacist wrote that per CMS guidance, PRN psychotropics should be limited to 14 days and to evaluate. A record review of Resident 13's medical record revealed no evidence the physician had reviewed the pharmacy recommendations from 7/31/2025, 9/30/2025, 10/31/2025, or 11/30/2025. An interview on 12/8/25 at 2:20 PM with the [NAME] President of Operations (VPO) confirmed there was no evidence Resident 28's provider had reviewed the pharmacy recommendations from 7/31/2025, 9/30/2025, 10/31/2025 or 11/30/2025.

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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** Based on record review and interview, the facility failed to notify the ombudsman of a discharge for 1 (Resident 37) of 1 sampled resident. The facility census was 29.Findings Are: A record review of Resident 37's admission Record dated 12/3/2025 revealed the resident was admitted to the facility on [DATE] and was discharged from the facility on 9/26/2025. A record review of Resident 37's Progress Note dated 9/26/2025 revealed the resident was discharged from the facility and left with their child and personal belongings. An interview on 12/2/25 at 2:05 PM with Social Services (SS) revealed SS did not send notifications to the ombudsman for any resident who had a planned discharge and as such, had not notified the ombudsman of Resident 37's discharge.

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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. Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview, the facility failed to develop a comprehensive care plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) regarding Activities of Daily Living (ADLs, tasks related to personal care, such as dressing, eating, and mobility) for 1 (Resident 1) of 13 sampled residents. The facility identified a census of 29. Findings are: A record review of the facility's policy, Comprehensive Care Plans (dated 4/23/2019) revealed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the resident's comprehensive assessment. Additionally, the policy revealed that at minimum all services that are to be furnished to attain or maintain that resident's high practical well-being would be included. A record review of an admission Record revealed the facility admitted Resident 1 on 6/2/2025. Resident 1 had diagnoses of absence of the right leg above the knee, absence of left toe, and hemiplegia/hemiparesis (one-sided weakness) following a stroke. A record review of Resident 1's Significant Change 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 11/5/2025) revealed Resident 1 utilized a wheelchair for locomotion and required supervision for eating, upper body dressing personal hygiene and bed mobility; partial assistance with bathing and putting on/taking off footwear; and substantial assistance with toileting, lower body dressing, and transfers. A record review of Resident 1's Care Plan Report revealed a focus area for ADL self care performance deficit related to their amputation of their left lower extremity, that had been initiated on 8/12/2025. An intervention for bed mobility, stating the resident can independently maneuver themselves with the assistance of the grab bar had been added on 8/12/2025. There was no evidence of Resident 1's needs related to toileting, dressing, personal hygiene, bathing, or transfers. An interview on 12/8/2025 at 2:08 PM with the Corporate Nurse Consultant (CNC) confirmed Resident 1's care plan did not include information on Resident 1's needs related to toileting, dressing, personal hygiene, bathing, or transfers and confirmed it should contain that information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(vi) Based on observation, record review, and interview; the facility failed to ensure a medication cassette reflected the correct administration time for 1 (Resident 27) of 6 sampled residents. The facility census was 29.Findings Are: A record review of the facility policy Labeling of Medications and Biologicals dated 2025 revealed all medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. A record review of the facility policy Medication Reconciliation Policy dated December 2022 revealed the facility would verify medication labels match physician orders and consider rights of medication administration each time a medication is given. A record review of Resident 27's December 2025 Medication Administration Record (MAR) revealed the resident was admitted to the facility on [DATE] and had an order for atorvastatin calcium 80 milligram (MG) tablet to be given once daily at 8:00 AM. The order had a start date of 8/6/2025. An observation on 12/2/2025 at 8:00 AM revealed Medication Aide (MA)-H preparing Resident 27's medications. MA-H dispensed one tablet from the medication cassette labeled atorvastatin into a cup, along with Resident 27's other medications. MA-H then administered the medications to Resident 27 and documented this as completed in the MAR. A record review of Resident 27's atorvastatin medication cassette revealed instructions Take one tablet by mouth once daily at bedtime. Further observation on 12/2/2025 at 8:05 AM of Resident 27's atorvastatin cassette revealed there were 12 doses that had been administered from the cassette with 2 doses remaining. An interview on 12/2/2025 at 8:05 AM with MA-H confirmed Resident 27's atorvastatin order stated to administer the medication once daily at 8:00 AM and that facility staff had been administering this medication from the cassette that was labeled to be administered at bedtime. MA-H confirmed that the label did not match the resident's order.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.11(D) Based on observation, record review, and interview; the facility failed to ensure nutritive value was maintained for 2 (Residents 24 and 28) of 2 sampled residents who received pureed meals. The facility census was 29.Findings Are: A record review of a facility provided document Dining Manager- Pureed Beef & Broccoli Stir Fry dated 2025 revealed serving size options for 5, 10, and 20 servings. The ingredients for preparing 5 servings of the dish were:-1 quart and 1 cup of Beef & Broccoli Stir Fry,-1 teaspoon of beef base, and-3/4 cup of water. A record review of a facility provided bag revealed the bag contained Trio Low Sodium [NAME] Gravy Mix. The back of the bag contained preparation instructions which stated to make 2 cups of gravy, 1/2 cup of gravy mix should be prepared with 2 cups of water. A record review of a facility provided bag revealed the bag contained Excel Gold Mashed Potatoes. The back of the bag contained preparation instructions which stated to use 2 cups of hot water for every 1 cup of dry potatoes. An observation on 12/2/25 beginning at 11:17 AM in the kitchen revealed Cook-E pouring prepared Beef & Broccoli Stir Fry from a pot on the stove into a container on the steam table. Cook-E took a pot to the sink, filled it partially with water and placed it on the stove, which was turned on. The cook then obtained a bag of instant potatoes and a partially used bag of brown gravy mix and placed them on the prep counter. Cook-E poured all of the brown gravy mix from the bag into a large measuring cup without leveling the mix in the cup and then poured an unmeasured amount of hot water from a pitcher into the cup. Cook-E then whisked the gravy, added more water, whisked it again and then poured it into a pan on the steam table. Cook-E continued to whisk the gravy and added more water 5 times, whisking in between each time water was added. Cook-E then scooped several spoonsful of the Beef & Broccoli Stir Fry into a bowl, then transferred it to the food processor and pureed it. After using a spoon to check the consistency, Cook-E poured an unmeasured amount of water into the food processor and turned it back on. Cook-E then poured the food onto three plates on the counter and covered each plate with a dome. Cook-E returned to the prep counter, picked up the bag of instant potatoes, and poured part of the bag into the pot of boiling water on the stove. After whisking this together, Cook-E spooned the potatoes into a pan on the steam table. An interview on 12/2/25 at 12:10 PM with the Dietary Director (DD)-F confirmed recipes should be followed, including the pureed Beef & Broccoli Stir Fry recipe, to ensure they retain nutritive value. An observation on 12/2/2025 at 12:20 PM revealed the dietary staff were beginning to serve plates to the residents. B.A record review of Resident 24's undated care plan revealed the resident was admitted on [DATE], had difficulty chewing, and required a pureed diet. C.A record review conducted on 8/2/2025 of Resident 28's physician's orders revealed an order for pureed texture foods. This order had a start date of 11/20/2025. A record review of Resident 28's Progress Note dated 11/5/2025 revealed a note stating the resident had lost an additional 6 pounds and was triggering for a 30-day and a 6-month weight loss. The resident's intake at meals remained at 25% or below. A record review of Resident 28's Progress Note dated 12/1/2025 revealed the resident continued to trigger for a 6-month weight loss and their food intake remained poor. A continuous observation on 12/2/2025 from 9:00 AM until 9:29 AM revealed Resident 28 sitting at the dining room table. The resident had consumed a small amount of food from each section of their plate. At 9:29 AM Resident 28 was assisted out of the dining room and had not consumed any additional food. An observation on 12/2/25 at 1:33 PM revealed Resident 28 had finished eating their lunch. Their plate contained mashed potatoes and gravy as well as pureed Beef and Broccoli Stir Fry. Resident 28 had consumed less than 50% of the meal.