STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Pride Care Center	901 South 4th Street Battle Creek, NE 68715

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42360 Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview the facility failed to complete a thorough investigation following a fall with injury for Resident 1. The sample size was 4 and the facility census was 44. Findings are: Review of the facility undated policy Accidents and Incidents -Investigating and Recording revealed the e Charge Nurse or Department Director would conduct an immediate investigation of accidents/incidents including the circumstances surrounding the accident/incident. Review of the facility undated policy and procedure Shower/Tub Bath revealed the staff were to stay with the resident throughout bathing and never to leave a resident unattended, however there was no indication the policy addressed making sure the safety belt was used to secure residents in the bathing chair. Review of Resident 1's Care Plan dated 1/23/24 revealed the resident was at risk for falling, needed assistance with activities of daily living and was dependent for bed mobility, grooming, dressing, bathing, toileting, and transferring. In addition, the resident had mental debility, abnormal brain function and was unable to make decisions. Further review revealed the Care Plan was revised on 3/20/24 indicating the resident had fallen while in the bathhouse and staff were to make sure the bathing straps were in place when in the bathing chair, and 2 staff members were to be in attendance for cares while in the bath house. Review of Resident 1's Progress note dated 3/19/24 at 11:52 AM revealed the resident was in a bathing chair outside of the tub and as the Bathing Aide reached to grab a towel the resident reached to the side and leaned out of the bathing chair and fell to the floor hitting (gender) head on the leg of a full body mechanical lift. The Bathing Aide immediately called for a nurse to assist. The nurse responded finding the Bathing Aide on the floor supporting the resident's head. The resident's forehead was lacerated. The resident's physician was contacted, and the resident was sent to the emergency room (ER) for evaluation. Further review revealed no evidence the resident had been secured in the bathing chair with a safety belt. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Reported Incident dated 3/19/24 revealed Resident 1 fell from a bathing chair at 11:17 AM and sustained a laceration to the forehead which required evaluation in the emergency room (ER). The diagnoses listed on the After Visit Summary included, fall, head injury, and laceration of forehead. The Physician Visit Record indicated the resident was to see the Primary Care Physician (PCP) in 5 days for suture (stitches) removal. The revisions dated 3/20/24 listed on the resident Care Plan indicated the facility would provide 2 person assists for transfers and cares while in the bath house and make sure the safety strap was in place. Further review revealed no indication the facility conducted an investigation to determine if the safety strap was in place during the resident's bath on 3/19/24 or following the bath when the resident fell . The report submitted to the State Agency did not include a determination that the safety strap on the bathing chair was not in use. During an interview on 4/1/24 at 8:50 AM with Nurse Aide (NA)-B revealed the NA had bathed residents in the past and was not aware of any requirement to use the safety belt for all residents while bathing. During an interview on 4/1/24 at 9:00 AM with Medication Aide (MA)-D revealed the MA infrequently gave residents baths. The MA reported being aware of an incident of Resident 1 falling from the bathing chair recently and reported being educated on the need to have 2 staff members present during bathing or sitting in the bath chair for this resident. Further interview revealed the MA was not aware of any previous requirement to secure all residents in the bathing chair with a safety belt. During an interview on 4/1/24 at 10:45 AM MA-H revealed having bathed many residents while working at the facility. MA-H was not aware of any requirement to secure all residents in a safety belt while bathing, however the MA did report securing some residents if they had difficulty sitting securely upright. During a phone interview on 4/1/24 with NA-K at 12:10 PM revealed the NA had bathed Resident 1 on 3/19/24 when the resident fell from the bathing chair. In addition, NA-K confirmed that Resident 1 was not secured in the bathing chair with a safety belt during or after bathing. During an interview on 4/1/24 at 12:15 PM with the Director of Nursing (DON) confirmed the facility did not have a policy for securing all residents in the bathing chairs during bathing and had no evaluation process in place to evaluate the safety of individual residents while bathing. Further interview confirmed the DON did not question the staff responsible for bathing Resident 1 regarding utilization of the safety belt in the bathing chair, when investigating following Resident 1's fall.

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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. 42360 Licensure Reference Number 175 NAC 12-006.09D7 Based on record review and interview the facility failed to ensure the safety of Resident 1 during bathing resulting in an injury. The sample size was 4 and the facility census was 44. Findings are: Review of the facility undated policy and procedure Shower/Tub Bath revealed the staff were to stay with the resident throughout bathing and never to leave a resident unattended, however there was no indication the policy addressed making sure the safety belt was used to secure residents in the bathing chair. Review of Resident 1's Progress note dated 3/19/24 at 11:52 AM revealed the resident was in a bathing chair outside of the tub and as the Bathing Aide reached to grab a towel the resident reached to the side and leaned out of the bathing chair and fell to the floor hitting (gender) head on the leg of a full body mechanical lift. The Bathing Aide immediately called for a nurse to assist. The nurse responded finding the Bathing Aide on the floor supporting the resident's head. The resident's forehead was lacerated. The resident's physician was contacted, and the resident was sent to the emergency room (ER) for evaluation. Further review revealed no evidence the resident had been secured in the bathing chair with a safety belt. Review of Resident 1's Care Plan dated 1/23/24 revealed the resident was at risk for falling, needed assistance with activities of daily living and was dependent for bed mobility, grooming, dressing, bathing, toileting, and transferring. In addition, the resident had mental debility, abnormal brain function and was unable to make decisions. Further review revealed the Care Plan was revised on 3/20/24 indicating the resident had fallen while in the bathhouse and staff were to make sure the bathing straps were in place when in the bathing chair, and 2 staff members were to be in attendance for cares while in the bath house. During an interview on 4/1/24 at 8:50 AM with Nurse Aide (NA)-B revealed the NA had bathed residents in the past and was not aware of any requirement to use the safety belt for all residents while bathing. During an interview on 4/1/24 at 9:00 AM with Medication Aide (MA)-D revealed the MA infrequently gave residents baths. The MA reported being aware of an incident of Resident 1 falling from the bathing chair recently and reported being educated on the need to have 2 staff members present during bathing or sitting in the bath chair for this resident. Further interview revealed the MA was not aware of any previous requirement to secure all residents in the bathing chair with a safety belt. During an interview on 4/1/24 at 10:45 AM MA-H revealed having bathed many residents while working at the facility. MA-H was not aware of any requirement to secure all residents in a safety belt while bathing, however the MA did report securing some residents if they had difficulty sitting securely upright. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/1/24 with NA-K at 12:10 PM revealed the NA had bathed Resident 1 on 3/19/24 when the resident fell from the bathing chair. In addition, NA-K confirmed that Resident 1 was not secured in the bathing chair with a safety belt during or after bathing. During an interview on 4/1/24 at 12:15 PM with the Director of Nursing (DON) confirmed the facility did not have a policy for securing all residents in the bathing chairs during bathing and had no evaluation process in place to evaluate the safety of individual residents while bathing. Further interview confirmed Resident 1 tended to lean forward at times when in a sitting position. The DON confirmed the facility staff did not secure Resident 1 in the bath chair during or after bathing on 3/19/24 resulting in a fall from the bath chair in which the resident sustained a laceration to the forehead requiring sutures (skin closure involving stitches) and evaluation for a head injury in the ER.