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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285210 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>09/25/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Crowell Memorial Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>245 South 22nd Street<br>Blair, NE 68008 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)Based on record review and interview; the facility staff failed to implement assessed interventions to prevent falls for 1 (Resident 4) of 3 sampled residents. The facility staff identified a census of 66. Findings are:Record review of Resident 4's Face Sheet dated 9/15/2025 revealed Resident 4 had the diagnoses of Parkinson's disease, Spinal stenosis (narrowing of the spaces between spinal bones) of the Lumbar area, Radiculopathy ( a pinched or pressed nerve) in the spine of the lumbar area, hypertension, muscle weakness and Depression.Record review of Resident 4's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 7/24/2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS, method to evaluate cognitive status) was a 10. According to the MDS Manual, a score of 8 to 12 indicates moderately impaired cognition.-Required partial to moderate assistance with eating, oral hygiene, upper body dressing, personal hygiene, sitting to standing position, and toilet transfers. -Used chair and bed alarms daily.Record review of Resident 4's Comprehensive Care Plan (CCP) dated 7/10-2024 revealed Resident 4 was at risk for falls. The goal identified on Resident 4's CCP was Resident 4 would be free of falls through the next review date. Interventions listed were to assess for pain, encourage Resident 4 to reside in the lounge area, attend activities and encourage socialization, Keep snacks at bed time and to use a pd (movement of pressure detection) alarm in Resident 4's wheelchair or bed due to Resident 4's non-compliance with calling for assistance.Record review of a Incident &amp; Investigation sheet dated 9/10-2025 revealed Resident 4 was found on the floor. Further review of the Incident &amp; Investigation sheet dated 9/10-2025 revealed the call light within reach was identified as the intervention in place at the time of Resident 4 being found on the floor. The wheelchair, bed/chair alarm was not identified as being in use at the time of Resident 4 being found on the floor. According to the Incident &amp; investigation sheet dated 9-10-2025 the post fall follow up intervention was the use of the sit stand alarm to the bed would be implemented. On 9-25-2025 at 12:34 PM an interview was conducted with Registered Nurse (RN) A. During the interview RN A reported Resident 4 did have falls and that a alarm pad was in use for the resident. RN A reported when Resident 4 was found on the floor on 9-10-2025 an alarm should have been in place. On 9-25-2025 at 2:45 PM an interview was conducted with the Director of Nursing. During the interview the DON reported Resident 4 did have falls and the pd alarm should have been in place according to resident 4's care plan.</p> |

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.

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