STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285210	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowell Memorial Home	245 South 22nd Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview, the facility failed to report a significant injury to the state agency in appropriate time frames for 1(Resident 2) of 4 residents sampled. The facility census was 77. The findings are:Record review of the facility's policy dated 09-23-2022 titled Abuse, Neglect and Exploitation revealed it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under section Identification of Abuse, Neglect and Exploitation:-the facility will have procedures to assist staff in identifying the different types of abuse.-possible indicators of abuse include but are not limited to: --Resident, staff or family report abuse,--Physical marks such as bruises --Physical injury of a resident of unknown source--Resident reports theft of property--Verbal abuse of a resident is observed--Physical abuse of a resident is observed--Psychological abuse of a resident is observed--Failure to provide care such as comfort, safety, feeding, bathing, dressing, turning and positioning. --Evidence of photographs or videos of a resident that are demeaning or humiliating in nature. --Sudden or unexplained changes in behaviors and or activities such as fear of a person or place or feelings of guilt or shame.Under section Reporting/Response of the policy revealed the facility will have procedures for reporting of all alleged violations to the Administrator (ADM), state agency, adult protective services and to all other required agencies within specified time frames: immediately, but no later than 2 hours after the allegation is made, if the events caused the allegation involve abuse or result in serious bodily injury and no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 12-29-2025 revealed the facility staff assessed the following about the resident:-was rarely able to make self-understood.-was always incontinent of bowel and bladder.-required extensive assistance with toilet transfers-required total assistance with lower body dressing, personal hygiene, bed mobility and transfers from bed to chair.-had a fall with major injury-had a closed fracture of the pelvis. Record review of Resident 2's Progress Notes (PN) dated 12-19-2025 at 9:47 PM revealed Resident 2 had fallen while being transferred from the toilet to the wheelchair, had complained of left knee pain and had been transferred to the emergency room.Record review of Resident 2's PN dated 12-20-2025 revealed Resident 2's had complained of left hip pain and the facility staff noted the left leg was rotated inward and was shorter than the right leg. Resident 2 had been transferred to the hospital and had been admitted for a possible pelvic fracture. Record review of Resident 2's Emergency Department Course dated 12-20-2025 revealed Resident 2 had a second visit to the emergency room in 24 hours for a fall sustained on 12-19-25 while being assisted to the bathroom by the nursing home staff. The final impression was closed fracture of the left inferior pubic ramus (left side of the pelvis).Record review of Resident 2's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After Visit Summary (AVS) dated 12-23-2025 revealed the primary diagnosis was a closed fracture of the pelvis.An interview conducted with the Director of Nursing (DON) on 02-18-2026 confirmed Resident 2's fall with pelvic fracture had not been reported to the State Agency (SA).An interview with the Administrator on 02-18-2026 at 2:50 PM confirmed the diagnosis on Resident 2's After Visit Summary (AVS) dated 12-23-25 was a closed fracture of the left inferior pubic ramus (pelvic bone fracture). An interview conducted with the DON and the ADM on 02-18-2026 at 3:15 PM revealed Resident 2's pelvic fracture was not reported to the state agency because the facility felt it was not a new injury.

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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 observation, interview and record review the facility failed to implement interventions identified on the care plan to prevent falls for 3 (Resident 1, 2 and 4) of 4 residents sampled. The facility census was 77. Findings are:Record review of the facility's undated policy titled Fall Prevention Program revealed the following:-each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -the facility uses a standardized risk assessment for determining a resident's fall risk.-the risk assessment categorizes residents according to low, moderate or high risk.-for program purposes the facility utilizes High Risk protocols and Low/Moderate risk protocols. -upon admission the nurse will complete a fall risk assessment to determine the resident's level of risk.-the nurse will indicate the resident's fall risk and initiate interventions on the resident's care plan, in accordance with the resident level of risk. -the nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. -Low/Moderate Risk Protocols: implement universal environmental interventions that decrease the risk of the resident falling, implement routine rounding schedule, monitor for changes in the resident's cognition, gait or balance, encourage resident's to use non slip footwear when ambulating, ensure eye glasses are in use if applicable, monitor vital signs in accordance with facility policy and complete a fall risk assessment every 90 days and as needed when the resident's condition changes. -High Risk Protocols: implement interventions from the Low/Moderate Risk Protocols, provide interventions that address unique risk factors measured by the risk assessment tool such as medications, cognitive status, psychological or functional status.-each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.-interventions will be monitored for effectiveness and the care plan will be revised as needed. A.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 12-29-2025 revealed the facility staff assessed the following about the resident:-was rarely able to make self-understood.-was always incontinent of bowel and bladder.-required extensive assistance with toilet transfers-required total assistance with lower body dressing, personal hygiene, bed mobility and transfers from bed to chair.-had a fall with major injury-had a closed fracture of the pelvis. Record review of Resident 2's Comprehensive Care Plan (CCP) under the Category Activities of Daily Living (ADL) dated 09-15-2022 revealed Resident 2 required limited to extensive assistance with ADLs and required a Hoyer (a mechanical lift that utilizes a sling to the lift a person) for transfers at all times. Record review of Resident 2's Progress Notes (PN) dated 12-19-2025 at 9:47 PM revealed Resident 2 had fallen while being transferred from the toilet to the wheelchair, had complained of left knee pain and had been transferred to the emergency room. Record review of Resident 2's Incident and Investigation Form dated 12-19-2025 revealed the root cause of the fall was the Nursing Assistant (NA) transferred Resident 2 without a gait belt. Record review of Resident 2's CCP revealed the only method of transfer for Resident 2 was a Hoyer lift. Record review of Resident 2's PN dated 12-19-2025 revealed Resident 2 had returned to the facility at 10:45 PM and had a new order to change the band-aid to the left shin daily. Record review of Resident 2's PN dated 12-20-2025 revealed Resident 2 had complained of left hip pain and the facility staff noted the left leg was rotated inward and was shorter than the right leg. Resident 2 had been transferred to the hospital and was being admitted for a possible pelvic fracture. Record review of Resident 2's Emergency Department Course dated 12-20-2025 revealed Resident 2 had a second visit to the emergency room in 24 hours for a fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sustained on 12-19-25 while being assisted to the bathroom by the nursing home staff. The final impression was closed fracture of the left inferior pubic ramus (left side of the pelvis). Record review of Resident 2's After Visit Summary (AVS) dated 12-23-2025 revealed the primary diagnosis was a closed fracture of the pelvis. Record review of Resident 2's PN dated 12-23-2025 revealed Resident 2 had returned to the facility. An interview conducted with the Director of Nursing on 02-18-2026 at 1:30 PM confirmed Resident 2 had not been transferred properly and Resident 2 sustained a pelvic fracture. B. Record review of Resident 1's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-was rarely able to make self-understood-required extensive assistance with eating-required total assistance with transfers, toileting, hygiene, dressing, bed mobility and bathing-was always incontinent of bowel and bladder Record review of Resident 1's CCP printed on 02-11-2026 revealed Resident 1 was at risk for falls related to medications increasing the risk for falls, ADL and mobility deficits, weakness, incontinence, decreased safety awareness and/or cognitive deficits. Resident 1's Fall Risk Score was 15. The goal identified Resident 1 would not sustain a serious injury should a fall occur through the review date of 03-06-2026. Approaches identified for the staff to utilize were:-place Resident 1 in bed for a nap after lunch dated 12-16-2025,-place Resident 1 in bed for a nap dated 12-17-2025,-Fall assessment upon admission, quarterly, annually and PRN (as needed) dated 12-05-2025,-Pharmacy to monitor medications increasing the risk for falls monthly and as needed dated 12-05-2025,-While Resident 1 is in [gender] w/c tilt the w/c back so she isn't sitting upright dated 12-05-2025,-Place in lounge for observation as Resident 1 desires dated 12-05-2025,-Resident 1 to be taken out of the dining area after eating dated 12-05-2025,-Assist with toileting prior to bedtime dated 12-05-2025,-Bolster mattress placed dated 12-05-2025,-Fall mat next to bed dated 12-05-2025,-Place body pillow next to Resident 1 on right side dated 12-05-2025,-Keep call light and frequently used items (i.e. Kleenex, water pitcher) within reach. dated 12-05-2025,-Assist with toileting and transfers as needed dated 12-05-2025. An observation conducted on 02-18-2026 at 1:00 PM revealed Resident 1 was lying in bed and the fall mat was leaning against the wall at the foot of the bed and the absence of a fall alarm. An interview conducted with Nursing Assistant (NA) C on 02-18-2026 at 1:05 PM confirmed that the fall mat was not next to the bed and the fall alarm had not been moved from the wheelchair to the bed and both should have been in place. C. Record review of Resident 4's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required limited assistance with toileting, transfers, bathing and dressing.-required extensive assistance when going from sitting to standing.-required total assistance with shower transfers. -was occasionally incontinent of bladder.-required oxygen. Record review of Resident 4's CCP printed on 02-11-2026 revealed Resident 4 was at risk for falls related to: medications increasing the risk for falls, ADL and mobility deficits, weakness, and occasional incontinence of bowel or bladder. Resident 4's fall risk score was 13. On 02-09-2026 Resident 4's legs gave out and was lowered to the floor while ambulating to the bathroom with walker. The goal was Resident 4 would not sustain a serious injury if a fall occurs through the review date. The approaches listed were:- Approach start date: 02/09/2026 Transfer with gait belt to wheelchair, propel resident to bathroom, assist on toilet.-Approach start date 06-20-2025 -Fall assessment upon admission, quarterly, annually and PRN.-Pharmacy to monitor medications increasing the risk for falls monthly and PRN -(Resident name) will participate in restorative program when offered.-Assist with toileting and transfers as needed.-Keep call light and frequently used items (i.e. Kleenex, water pitcher, phone, etc.) within reach.-Larger recliner placed -Keep blue Dycem (a non-slip material used (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to provide grip and stability) between seat of wheelchair and gel cushion to prevent gel cushion from slipping off of w/c seat. An observation on 02-18-2026 at 6:45 AM revealed Resident 4's the absence of blue Dycem between the seat of the wheelchair and the gel cushion. An observation on 02-18-2026 at 8:50 AM of NA- A assisting Resident 4 to the bathroom which revealed Resident 4 was ambulated to the bathroom with a walker and a gait belt. An observation on 02-18-2026 at 8:55 AM with NA- A revealed the absence of blue Dycem in between the wheelchair seat and the gel cushion. An interview conducted with NA-A at 8:55 AM confirmed the absence of the blue Dycem in the wheelchair and revealed NA -A was not aware Resident 4 was to be taken to the bathroom by wheelchair. An interview conducted with the Director of Nursing on 02-18-2026 at 3:00 PM confirmed Resident 4 should not have been ambulated to the bathroom.