

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Kimball County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 810 East 7th Street Kimball, NE 69145	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(G) Licensure Reference Number 175 NAC 12-006.09(I) Based on record reviews and interviews, the facility failed to determine the root cause of every fall incident, implement interventions that prevented recurrence of falls related to the identified causes, and develop and implement new interventions after subsequent falls occurred for 3 (Residents 1, 2, and 3) of 3 sampled residents. The facility identified a census of 38. Findings are: An interview on 8/27/2025 at 10:25 AM with the Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed that the facility's process following a resident fall includes the nurse completing an incident report, noting what was happening before the fall. The facility holds a Utilization Review (UR) meeting daily (except Thursdays and weekends) to discuss falls and assign interventions. The interdisciplinary team (IDT) determines if interventions are appropriate based on the cause of the fall. The DON gave an example that if a resident falls while reaching for a remote on a dresser, an appropriate intervention would be to move the remote closer, not lower the bed, to prevent the fall from recurring. The DON revealed the facility utilizes the following policies for falls: Fall Prevention Program (Angel Watch), Incident Report, Protocol for Neurological Assessment, and Possible Injury After a Fall. A record review of the facility's Fall Prevention Program (Angel Watch) policy dated 1/2013, revealed the policy states residents with two falls in one week or three in a month should be placed on the Angel Watch program, identified by an angel marker on their assistive devices and door. The policy did not include conducting root cause analysis or specifying development of fall-prevention interventions. A record review of the facility's Possible Injury After a Fall policy dated 4/2024, revealed that falls with injury must be reported to Adult Protective Services (APS) within two hours, and a five-day investigation submitted to the state. The policy did not include requirements for conducting a root cause analysis or implementing fall-prevention interventions. A. A record review of Resident 3's Face Sheet revealed the facility admitted the resident on 2/3/2022. Resident 3 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 3's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 7/3/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 6/15, which indicated Resident 3 had severe cognitive impairment. Additionally, it revealed the resident had one-sided lower extremity impairment and utilized a walker for mobility. The resident required partial assistance with toileting and dressing, and was independent with bed mobility, ambulation, and transfers. A record review of Resident 3's Event Reports dated 5/31/2025 revealed the resident was found naked on the floor beside their spouse's bed. The resident stated they had been engaging in sexual activity with their spouse when they fell. There was no documented evidence that a root cause analysis had been conducted following this fall, nor were interventions identified to reduce the risk of recurrence. A record review of Resident 3's Event Reports dated 6/23/2025 revealed the resident was found on the floor beside their spouse's bed. On 6/24/2025, a UR meeting was held and an intervention of no sense of safety due to resident failing to ask for assistance for intimacy had been implemented. There was no evidence that the root cause had been identified and no specific intervention to prevent recurring falls during intimacy was developed. A record review of Resident 3's Event Reports dated 7/3/2025 revealed the resident was found sitting on the floor in their room with back against the bed. Resident 3 was sitting with their pants and brief around their ankles with regular socks on. The resident reported they were attempting to get in their spouse's bed to engage in sexual activity. The resident's fall root-cause was identified as slipping from regular socks. An intervention for physical therapy (PT) and occupational therapy (OT) evaluation for balance was placed, however, no intervention was put in place to mitigate the specific slipping hazard. An interview on 8/27/2025 at 10:50 AM with the NHA and DON revealed the following:- Confirmed there was no documented evidence a root cause had been identified in the resident's medical record for the 5/31/2025 fall. However, it was determined the root cause to be from losing balance. An intervention for gripper socks had been added. The DON confirmed the gripper socks was not related to the cause or prevention of that fall.- Confirmed no root cause or intervention for prevention had been placed for the 6/23/2025 fall.- The DON confirmed the cause of the 7/3/2025 fall was slipping on the floor in regular socks, and acknowledged that a PT/OT evaluation would not mitigate slipping in inappropriate		