STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285260	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chimney Rock Villa	106 East 13th Street Bayard, NE 69334

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. 49766 Licensure Reference Number 175 NAC 12-006.02(H) Based on record reviews and interview, the facility failed to report to the State Agency a fall with major injury as a potential allegation of abuse/neglect within 2 hours and submit a complete investigation within five working days of the incident as required for 1 (Resident 7) of 2 sampled residents. The facility identified a census of 24. Findings are: A record review of an undated facility policy, Abuse and Neglect Reporting defined neglect as a failure to provide care, treatment, goods or services necessary to avoid physical harm or mental anguish of a resident. The policy revealed an alleged case of neglect should be reported to the state agency within 24 hours and a completed internal investigation of the facility's conclusion and follow-through within five days to the state agency. There was no evidence of the requirement to report serious bodily injury to the State Agency within two hours as required. A record review of an Admission Record revealed the facility admitted Resident 7 on 9/27/2024 with diagnoses 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)], repeated falls, and a broken ankle. A record review of Resident 7's discharge 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) with an Assessment Reference Date of 11/12/2024 revealed Resident 7 had impaired short-term memory and some difficulty in new situations with cognitive skills for daily decision making. Resident 7 also required supervision with toileting and set-up assistance with ambulation. A record review of an Un-witnessed Fall report with a date of 11/10/2024 revealed Resident 7 was found on the floor in front of their bed with their walker nearby. Resident 7 stated they were trying to get to their bed and lost control of their walker and fell . (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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(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	A record review of an Un-witnessed Fall report with a date of 11/12/2024 revealed Resident 7 was found on the floor of their room. Resident 7 stated they were coming back from the bathroom and tripped on their walker. Resident 7 was complaining of severe right hip. A record review of Resident 7's Progress Notes from 11/12/2024 revealed Resident 7's family member had called to notify the facility that Resident 7 had been admitted to the hospital due to a fractured pelvis. A record review of Resident 7's Progress Notes from 11/19/2024 revealed Resident 7's family member had called to notify the facility that Resident 7 would be undergoing a total hip replacement on 11/20/2024. A record review of Resident 7's state reported investigations revealed no evidence the facility had notified the state agency within two hours of the serious injury or that a five-day investigative report had been submitted to the state agency. An interview on 3/24/2025 at 12:55 PM with the Administrator confirmed the facility had not reported the serious injury or submitted a five-day investigative report the state agency. The Administrator revealed the facility's process is to report with 24 business hours when a fall with potential injury occurs.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49766 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Licensure Reference Number 175 NAC 12-006.09(H)(iii)(3) Based on record reviews and interviews, the facility failed to provide ongoing monitoring of an incision, follow physician's orders for care of the incision, and implement treatment and other interventions to promote healing and prevent infection for 1 (Resident 7) of 4 sampled residents. The facility identified a census of 24. Findings are: A record review of a facility policy, Wound Care, with a last revised date of October 2010, revealed the purpose of the policy was to provide guidelines for the care of wounds to promote healing. The policy revealed an assessment of the wound (including color, size, drainage, etc.) should be documented with wound care. Additionally, it revealed information should be reported in accordance with facility policy and professional standards of practice. A record review of a facility policy, Dressings, Dry/Clean, with a last revised date of September 2013, revealed a step of preparation is to verify that there is a physician's order for the procedure, which may be generated from a facility protocol. During the dressing change, the wound and surrounding skin should be assessed for swelling, redness, drainage, and tissue healing progress. Following the procedure, the assessment data obtained should be documented and information should be reported in accordance with facility policy and professional standards of practice. A record review of an Admission Record indicated the facility admitted Resident 7 on 9/27/2024 with diagnoses 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)] Type 2 Diabetes Mellitus (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels which can impair wound healing due to factors like high blood sugar levels, reduced blood circulation, and a weakened immune system, all of which hinder the body's ability to effectively heal wounds), high blood pressure, and repeated falls. Additional diagnoses, with an onset date of 11/26/2024, of fractures of the right acetabulum (hip) and pubis (pelvic) bones were added. A record review of Resident 7's Care Plan Report revealed the following: - A care focus area initiated on 10/9/2024 revealed Resident 7 had a potential for developing pressure ulcers due to urinary incontinence and limited mobility. An intervention initiated on 10/9/2024 to monitor, document, and report as needed any changes in skin status of appearance, color, wound healing, signs or symptoms of infection, wound size (length x width x depth), and stage was added. - A care focus area initiated on 10/10/2024 revealed Resident 7 had Diabetes Mellitus with an intervention to monitor, document, and report as needed any signs of infection to any open areas of redness, pain, warmth, swelling, or pus formation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 7's Progress Notes revealed the following: - On 11/12/2024 at 5:21 AM, Resident 7 was found on the floor and had complained of severe pain in their right hip. Resident 7 was transferred to the Emergency Department (ED) for evaluation. - On 11/12/2024 at 12:55 PM, the facility received a phone call from Resident 7's family member informing the facility that Resident 7 would be admitted to the hospital due to a fracture pelvis. - On 11/19/2024, Resident 7's family member called the facility to inform the facility Resident 7 would be undergoing a total hip replacement surgery on 11/20/2024. - On 12/31/2024, Resident 7 had seen the Orthopedic surgeon for a follow up and had recommended a revision surgery to the right hip. - On 1/3/2025, the Orthopedic surgeon's office informed the facility of a scheduled right hip revision surgery on 1/8/2025. A record review of Resident 7's Post-Operative Instruction, dated 1/11/2025 revealed instructions to keep the dressing clean, dry, and intact, remove the wound vac (Also known as Negative Pressure Wound Therapy is a treatment that uses a vacuum to promote wound healing) on 1/14/2025 and replace with a dry gauze dressing. There was no instruction included to provide dressing changes or frequency. Additionally, an order for wound care to the left buttock and right thigh to cleanse sites with bath wipes, apply zinc oxide twice a day and as needed with baths and pericare (cleansing of the genital areas). Additional record review of Resident 7's Progress Notes revealed the following: - From 1/8/2025-1/13/2025, there was no evidence of documentation of an assessment of the incisional site/wound area. - On 1/14/2025, the wound vac from Resident 7's right hip was removed as ordered and a dry gauze pad and silicone border foam dressing had been applied. Resident 7 was noted to have a 20 centimeter (cm) intact surgical incision to the right hip with 33 intact staples. The incision was noted to not be warm, and edges were well approximated (fit neatly together). A fax was sent to the Orthopedic surgeon to clarify how frequent the dressing to Resident 7's right hip should be completed. - On 1/15/2025, Resident 7's surgical incision was noted to have staples intact and the dressing to be clean, dry, and intact. - On 1/16/2025, Resident 7's surgical incision was noted to be closed with staples and have some drainage. There was no evidence of documentation regarding any present redness, pain, swelling, warmth, description of the drainage, appearance, color, wound size, other signs of infection, or an intervention implemented. - From 1/14/2025-1/20/2025, there was no evidence of documentation that clarification regarding the dressing change frequency had been received or additional attempts to obtain clarification had been made. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- There was also no evidence of documentation that the wound dressing had been changed or remained intact. - From 1/17/2025-1/20/2025, there was no evidence of ongoing monitoring of the incision site/wound. A record review of the facility's Change in Condition/Follow Up Log from 1/14/2025 revealed no evidence of ongoing monitoring of the incision site/wound and that on 1/16/2025 and 1/17/2025, Resident 7's right hip had no dressing and had been left open to air. A record review of Resident 7's Doctor's Orders and Progress Notes from 1/20/2025 revealed Resident 7 was seen for a follow-up for right hip fracture care. The physician had documented that Resident 7's hip looked good and was clean and dry without redness or streaking. Resident 7 had severe pain with movement and staples were ready for removal. The physician ordered for Resident 7's staples to be removed and follow-up with the Orthopedic surgeon. A record of an order clarification for dressing changes to Resident 7's right hip incision was received on 1/22/2025 and revealed dressings were to be changed once a day after cleansing. Additional record review of Resident 7's Progress Notes revealed the following: - On 1/20/2025, Resident 7's staples were removed, and a dressing had been applied. - On 1/21/2025, there was no evidence of ongoing monitoring of Resident 7's incision site/wound. - On 1/22/2025, a fax was sent to the physician and Orthopedic surgeon regarding concerns of Resident 7's surgical incision and drainage. There was no evidence of documentation regarding the status of the wound, including any present redness, pain, swelling, warmth, description of the drainage, appearance, color, wound size, or other signs of infection. An order for a wound culture was obtained. - On 1/24/2025, the Orthopedic surgeon informed the facility there were no concerns with the wound culture and provided orders for Hibiclens Antimicrobial Antiseptic Skin Cleanser twice a day and to follow-up at next appointment on 1/30/2025. - On 1/27/2025, it was noted that a call was received from Resident 7's physicians' nurse recommending Resident 7 be sent to the ED. The facility placed a call to the Orthopedic surgeon's office and was advised not to send Resident 7 to the ED and would follow up on 1/30/2025. - From 1/23/2025-1/30/2025, there was no evidence of ongoing monitoring of Resident 7's incision site/wound. A record review of Resident 7's Treatment Administration Record (TAR) for the month of January 2025 revealed the following: - There was no evidence the order for wound care to the left buttock and right thigh to cleanse sites with bath wipes and apply zinc oxide twice a day and as needed with baths and pericare had been implemented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- An order to remove dressing, cleanse area, and apply absorbent dressing one time a day was not started or completed until 1/23/2025. - An order to apply Hibiclens solution to Resident 7's right hip twice a day for a possible infection had been started on 1/24/2025. There was no evidence that the order had been completed on 1/25/2025 or 1/28/2025 in the morning. - A record review of Resident 7's Orthopedic surgeons' documentation from the follow-up visit on 1/30/2025 revealed Resident 7 had been doing very poorly, refusing to transfer and bearing very little weight, had chronic diarrhea, fatigue, constant pain in their right hip, and had been losing their will to live. Resident 7 was also noted to have had some drainage from their right hip incision. The incision was noted to be mostly healed with a couple small points of scant serous (a clear, thin, watery fluid, often described as plasma) drainage without redness. Additionally, the note revealed the Orthopedic surgeon had been very concerned as Resident 7 had not been eating, had chronic diarrhea, had tachycardia (fast heartrate), and did not look well. The second concern noted was that the incision and filth at the nursing home facility, being problematic and could put [Resident 7] at risk for chronic wound infection. The Orthopedic surgeon admitted Resident 7 to the hospital to obtain x-rays of the hip and place a wound vac on their incision. An interview on 3/20/2025 at 1:45 PM with the Infection Preventionist (IP) revealed the facility monitors post-operative incisions at least weekly and during dressing changes. The IP also revealed no attempts to obtain clarification for Resident 7's dressing order from 1/11/2025 had been attempted again after 1/14/2025 and was not obtained until 1/22/2025. Additionally, the IP confirmed Resident 7's order for wound care and the application of zinc oxide had not been added to the TAR or had evidence of it having been completed and dressing changes had not been implemented until 1/23/2025. The IP revealed that once Resident 7's staples were removed on 1/20/2025, the drainage became really bad and so the wound culture was completed on 1/22/2025. The IP also confirmed there was no documentation of ongoing monitoring of Resident 7's incision site/wound on 1/21/2025, or 1/23/2025-1/30/2025 and confirmed documentation should have included a full assessment and details of the site and drainage. An interview on 3/24/2025 at 9:10 AM with the Nursing Home Administrator (NHA) confirmed there was no documentation of ongoing monitoring of Resident 7's incision site/wound from 1/8/2025-1/13/2025 or from 1/17/2025-1/20/2025. The NHA also confirmed Resident 7's incision site had not been covered on 1/16/2025 or 1/17/2025 as ordered. The NHA revealed Resident 7 was having large amounts of drainage from their incision site and a wound culture was completed on 1/22/2025 and on 1/24/2025 Resident 7's had recommended Resident 7 be sent to the ED, but the Orthopedic surgeon was not concerned and wanted to follow-up on 1/30/2025, so Resident 7 had not been sent to the ED. At Resident 7's appointment on 1/30/2025, Resident 7 had been directly admitted from their appointment to the hospital.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 49766 Licensure Reference Number 175 NAC 12-006.09(I)(i)(1) Based on record reviews and interviews, the facility failed to develop and or implement appropriate interventions to prevent additional falls for 4 (Residents 2, 4, 6, and 7), which resulted in two residents (Resident 4 and 7) sustaining major injuries from subsequent falls. The facility identified a census of 24. Findings are: A record review of a facility policy, Assessing Falls and Their Causes, with a revised date of March 2018, revealed when a resident falls, an appropriate intervention taken to prevent future falls should be recorded in the resident's medical records. A. A record review of an undated facility policy, Abuse and Neglect Reporting defined neglect as a failure to provide care, treatment, goods or services necessary to avoid physical harm or mental anguish of a resident. The policy revealed an alleged case of neglect should be reported to the state agency within 24 hours and a completed internal investigation of the facility's conclusion and follow-through within five days to the state agency. There was no evidence of the requirement to report serious bodily injury to the State Agency within two hours as required. A record review of an Admission Record revealed the facility admitted Resident 7 on 9/27/2024 with diagnoses 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)], repeated falls, and a broken ankle. A record review of Resident 7's discharge 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) with an Assessment Reference Date (ARD) of 11/12/2024 revealed Resident 7 had impaired short-term memory and some difficulty in new situations with cognitive skills for daily decision making. Resident 7 also required supervision with toileting and set-up assistance with ambulation. A record review of Resident 7's Care Plan Report revealed a focus area for falls, initiated on 10/9/2024. The Care Plan revealed Resident 7 has had an actual fall with injury which contributed to their need for nursing home care. The following interventions were implemented: - Monitor, document, and report as needed to the physician signs and symptoms of pain; bruises; changes in mental status; and/or new onset of confusion, sleepiness, inability to maintain posture, or agitation with an initiated date of 10/9/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	- Neuro-checks (an assessment tool to determine a patient's neurologic function) as necessary with a date initiated of 10/9/2024. - Provide activities that promote exercise and strength building where possible and provide 1:1 activities, if bed bound with a date initiated of 10/9/2024. A record review of Resident 7's Care Plan Report revealed a focus area for impaired cognitive function, initiated on 10/10/2024. The Care Plan revealed Resident 7 has impaired cognitive function and impaired thought processes due to dementia. Intervention to cue, reorient, and supervise as needed was initiated on 10/10/2024. A record review of an Un-witnessed Fall report with a date of 11/10/2024 revealed Resident 7 was found on the floor in front of their bed with their walker nearby. Resident 7 stated they were trying to get to their bed and lost control of their walker and fell . A record review of an Un-witnessed Fall report with a date of 11/12/2024 revealed Resident 7 was found on the floor of their room. Resident 7 stated they were coming back from the bathroom and tripped on their walker. Resident 7 was complaining of severe right hip. Predisposing factors were identified as using walker and ambulating without assistance. A record review of Resident 7's Progress Notes from 11/12/2024 revealed Resident 7's family member had called to notify the facility that Resident 7 had been admitted to the hospital due to a fractured pelvis. A predisposing factor of ambulating without assistance was identified. A record review of Resident 7's Progress Notes from 11/19/2024 revealed Resident 7's family member had called to notify the facility that Resident 7 would be undergoing a total hip replacement on 11/20/2024. Additional record review of Resident 7's Fall Care Plan revealed no evidence of implemented interventions following Resident 7's falls on 11/10/2024 or 11/12/2024. An interview on 3/24/2025 at 1:45 PM with the Director of Nursing (DON) confirmed no interventions were placed following Resident 7's falls to prevent the potential for subsequent falls and injuries. B. A record review of an Admission Record revealed the facility admitted Resident 2 on 8/1/2023 with diagnoses of: dementia with behavioral disturbance, anxiety (a common mental health condition characterized by excessive and persistent worry, fear, and nervousness), osteoporosis (a condition that weakens bones, making them fragile and prone to fractures), and restless leg syndrome (a neurological disorder characterized by an overwhelming urge to move the legs, often accompanied by uncomfortable sensations, that worsens during periods of rest, especially at night.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 2's annual MDS with an ARD of 8/14/2024 revealed Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 4/15, which indicated that Resident 2 had severe cognitive impairment. The MDS also revealed Resident 2 had behaviors of wandering 4-6 days of the 7-day look-back period. Additionally, Resident 2 utilized a walker and required maximum assistance with transfers, ambulation, toileting, and hygiene. Additionally, it revealed Resident 2 had no fall alarms in use and had sustained one fall without injury since their last MDS assessment. A record review of Resident 2's quarterly MDS with an ARD of 11/14/2024 revealed Resident 2 had a BIMS score of 3/15, which indicated that Resident 2 continued to have severe cognitive impairment. Resident 2 utilized a walker for ambulation and required set-up assistance with transfers, ambulation, toileting, and hygiene. Additionally, it revealed Resident 2 had no fall alarms in used and had sustained two falls without injury since their last MDS assessment. A record review of Resident 2's Significant Change MDS with an ARD of 2/14/2025 revealed Resident 2 had a BIMS score of 3/15, which indicated that Resident 2 continued to have severe cognitive impairment. Resident 2 utilized a walker for ambulation and required partial assistance with toilet transfers, supervision for other transfers, and supervision during ambulation as well as substantial assistance for toileting and hygiene. Additionally, it revealed Resident 2 had no fall alarms in used and had sustained two falls without injury since their last MDS assessment. A record review of Resident 2's Care Plan Report revealed a focus area for Activities of Daily Living (ADL) self-care performance deficit due to dementia with an initiated date of 7/24/2024. The Care Plan revealed Resident 2 required extensive assistance by 1 staff member for toileting and transferring with initiated dates of 7/24/2024. A record review of Resident 2's Care Plan Report revealed a focus area for risk of falls due to confusion and incontinence with a last revised date of 11/20/2023. The following interventions were listed: - Anticipate and meet my needs with a last revised date of 11/20/2023. - Be sure my call light is within reach and encourage me to use it for assistance as needed. I require prompt response to all requests for assistance with a last revised date of 11/20/2023. - Place bed alarms per family request with an implemented date of 3/7/2024. - Therapy to evaluate wheeled walker for safety with me with an implemented date of 3/7/2024. - Therapy rearranged my room for easier maneuvering at night with a date of 3/21/2024. - Placed blue non-slip pad on recliners in residents' room with a date of 3/26/2024. - Check on me every 2-3 hours during the night with a date of 4/12/2024. - Encourage me to call for assistance with transfer and walking in room with a date of 7/16/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	- Check frequently to make sure my floor is dry and place a wet floor sign if needed or clean up spills/urine with a date of 9/17/2024. - Sent out for evaluation with a date of 10/10/2024. - Sent out for evaluation with a date of 11/3/2024. - Staff assistance and gait belt with ambulation as needed if gait view to be unsteady with a date of 3/10/2025. - Change resident to front wheeled walker for safety. Provide continual re-education on safety as needed with a date of 3/17/2025. - Bed alarm initiated with a date of 3/18/2025. Which was duplicated from 3/7/2024. A record review of an Un-witnessed Fall report with a date of 10/10/2024 at 10:30 PM revealed Resident 2 was found on the floor of their bathroom. Resident 2 was documented as confused, incontinent, had impaired memory, and had been ambulating without assistance. A record review of an Un-witnessed Fall report with a date of 11/3/2024 at 3:00 PM revealed Resident 2 had been found on the floor with their walker near the bathroom. Resident 2 sustained a hematoma (like a bruise, but the damage can lead to swelling, discoloration, and warmth) to the left side of their head. A record review of an Unwitnessed Fall report with a date of 3/18/2025 at 8:40 PM revealed Resident 2 was found next to their bed wrapped in blankets. Additional record review of Resident 2's Fall Care Plan revealed no facility-implemented interventions to prevent subsequent falls for Resident 2's falls on 10/10/2024 or 11/3/2024. An interview on 3/24/2025 at 1:50 PM with the DON confirmed there were no facility interventions to prevent subsequent falls developed or implemented for Resident 2's falls on 10/10/2024, or 11/3/2024. The DON also confirmed interventions to encourage resident to use their call light for assistance and providing education were not resident-appropriate interventions due to resident's impaired cognition with dementia. Additionally, the DON revealed that at some point [Resident 2's] bed alarm was discontinued so it was re-implemented on 3/7/2025. 51122 C. A record review of Resident 4's electronic medical record revealed Resident 4 was admitted on [DATE] with diagnoses of: encephalopathy (a change in how the brain functions, which can be temporary or permanent), diabetes, and dementia (a progressive decline that affects cognitive function). A record review of Resident 4's quarterly Minimum Data Set (MDS, a data tool used by nursing homes to report resident information to the federal government) dated 11/19/24, revealed in Section GG0170 that Resident 4 required partial/moderate assistance to walk 10 feet, 50 feet, and 150 feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285260	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chimney Rock Villa	106 East 13th Street Bayard, NE 69334

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 - Actual harm Residents Affected - Some	A record review of Resident 4's Progress Notes and Incident Reports revealed Resident 4 had the following falls: -On 12/6/24 at 10:35 AM, Resident 4 attempted to sit in a dining room chair, sat on the arm rest, then fell on their buttocks. -On 1/9/25 at 6:47 AM, Resident 4 rolled off the edge of the bed which was witnessed by staff as they entered the resident's room. Resident 4 sustained a skin tear on their left arm. -On 2/6/25 at 3:28 PM, Resident 4 was walking in the front living room, lost balance and fell into chair and then slid onto floor. Resident 4 sustained a skin tear to a finger and right hand. -On 2/7/25 at 6:30 AM, Resident 4 was observed on their back with a walker nearby in dining area. -On 2/19/25 at 6:40 AM, Resident 4 was walking without staff assistance in the living room when their walker caught on another resident's wheelchair. They left their walker then fell backward hitting their back and head. Resident 4 was transported to the hospital emergency department at 7:15 AM for treatment. Record review of a facility document titled ED to Hosp-Admission, dated 2/19/25 revealed that Resident 4 was transferred to a hospital and found to have a new subdural hematoma (a type of bleeding near the brain that can happen after a head injury) and subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect the brain) and urinary tract infection (bacterial infection that affects the urinary system). Resident 4 was admitted to the hospital the same day. Record review of Resident 4's care plan revealed that no fall interventions were implemented after 7/20/24 to prevent falls or injuries from a future fall. An interview on 3/24/25 at 4:45 PM with the Director of Nursing (DON) confirmed that no interventions were put into place for Resident 4 after the falls on 12/6/24, 1/9/25, 2/6/25, 2/7/25, and 2/19/25 to prevent future falls or reduce the chance of injury, and that there should have been interventions put into place. The interview also revealed Resident 4 had been in a wheelchair since the fall on 2/19/25. D. Record review of Resident 6's electronic medical record revealed Resident 6 was admitted on [DATE] with diagnoses of: paranoid schizophrenia (a mental health condition that affects thinking abilities, memories, and senses, with noticeable paranoia and delusions), heart failure, and dementia. A record review of the facility document, Incidents by incident type, dated 3/20/25, which listed resident falls between 9/1/24 and 3/20/25, revealed that Resident 6 had 2 unwitnessed falls, on 9/26/24 and 10/1/24. A record review of Resident 6's Progress Notes revealed the following: -On 9/26/25 at 10:10 AM, Resident 6 was found lying on their back in their room with their pants and brief off. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Resident 6 was later sent to the hospital emergency department to be evaluated for low blood pressure and a possible head injury. -On 10/1/25 at 12:21 AM, Resident 6 was found on the floor in their room after staff heard a loud noise and was found to be incontinent of bowel near their bathroom. A record review of Resident 6's Care Plan revealed that no interventions were added to prevent further falls or prevent injury from a future fall. The most recent intervention was recorded on the Care Plan on 6/11/24. An interview with DON on 3/24/25 at 1:31 PM confirmed that no interventions were put into place following Resident 6's falls on 9/26/24 and 10/1/24 and there should have been.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49766 Licensure Reference Number 175 NAC 12-006.07 Based on record reviews and interviews, the facility failed to ensure the Quality Assurance Performance Improvement Program [QAPIP, a facility process that identifies problems in the facility and works to correct the concerns] identified ongoing issues relevant to F689 and implement plans of action to identify and correct the deficient practice. This had the potential to affect all residents that reside within the facility. The facility identified a census of 24. Findings are: A record review of a facility policy, Quality Assurance and Performance Improvement Program with a revised date of February 2020, revealed the objectives of the QAPIP are to: 1) Provide a means to measure current and potential indicators for outcomes of care and quality of life, 2) provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, 3) reinforce and build upon effective systems and processes related to the delivery of quality care and services, and 4) establish systems through which to monitor and evaluate corrective actions. The key components of the QAPI plan are as follows: a. Tracking and measuring performance. b. Establish goals and thresholds for performance measurement. c. Identifying and prioritizing quality deficiencies. d. Systematically analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities. f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. Record reviews and interviews during the complaint survey conducted on 3/20/2025-3/25/2025 revealed a negative trend of falls, including some with major injuries from 9/26/2024-2/19/2025. A record review of the facility's QAPIP reports from 9/16/2024 revealed an attached incidents list. The incident list revealed two falls had occurred in August 2024. A record review of the facility's QAPIP reports from 10/21/2024 revealed an attached incidents list. The incident list revealed six falls had occurred from 9/18/2024-10/18/2024. There was no evidence that falls had been identified as a potential concern, or a corrective action plan had been developed or implemented. (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the facility's QAPIP reports from 11/18/2024 revealed an attached incidents list. The incident list revealed six falls had occurred in October 2024. There was no evidence that falls had been identified as a potential concern, or a corrective action plan had been developed or implemented. A record review of the facility's QAPIP reports revealed no evidence of QAPI meeting minutes for December 2024. A record review of the facility's QAPIP reports from 1/20/2025 revealed no evidence that falls had been discussed or identified as a potential concern. A record review of the facility's QAPIP reports from 2/17/2025 revealed no evidence that falls had been discussed or identified as a potential concern. A record review of the facility's QAPIP reports from 3/17/2025 revealed an attached incidents list. The incident list revealed five falls had occurred in February 2025. There was no evidence that falls had been identified as a potential concern, or a corrective action plan had been developed or implemented. An interview on 3/25/2025 at 10:30 AM with the Nursing Home Administrator (NHA) revealed their QAPIP team meets monthly, and each department head goes through their negative trends of identified concerns, these issues are then discussed. The QAPIP team decided of which identified concerns to work on by any negative trends and by severity level for potential harm outcomes to the residents. The NHA also revealed the QAPIP team identified falls were trending negatively at last months meeting, but did not develop or implement a corrective action plan.