STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northfield Retirement Communities Care Center	2100 Circle Drive Scottsbluff, NE 69361

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to submit a comprehensive investigative report to the State Agency for 2 (Residents 1 and 3) of 6 sampled residents who had a fall with major injury. The facility census was 55.Findings Are: A record review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program with revision date of April 2021 revealed the facility was to investigate and report any allegations within timeframes required by federal requirements. A.A record review of Resident 1's Facesheet dated 3/10/2026 revealed the resident was admitted to the facility on [DATE] and was discharged from the facility on 2/22/2026.A record review of Resident 1's Progress Notes dated 2/20/2026 revealed the resident had a fall on 2/19/2026 which resulted in a laceration to the left side of their head, a left wrist fracture, and a left femur fracture.A record review of a Investigation Report dated 2/24/2026 revealed in the Describe the incident section that Resident 1 had fallen on 2/19/2026 at 11:29 PM in their room and was by their bed on their left side. The resident had sustained a laceration to the left side of their head, a fractured left femur, and a fractured left wrist. In the What permanent measures were put into place to prevent reoccurrence section it stated: None, resident was admitted to the hospital. Family elected not to have surgery due to heart condition and upon return resident was unresponsive. In the What was the outcome of the facility investigation section it stated: Resident non-compliant with transfers. Tried to self-transfer and fell. Resident did not call for assistance.An interview on 3/10/2026 at 3:30 PM with the Director of Nursing (DON) confirmed that the Investigation Report dated 2/24/2026 was the investigative report the facility submitted to the State Agency for Resident 1's fall on 2/19/2026 and it did not contain information regarding interventions being put into place. The DON stated the facility had implemented interventions of repositioning and rounding on the resident greater than once per hour to ensure their safety and comfort following their return to the facility from the hospital and confirmed this information should have been included in the report. B.A record review of Resident 3's Facesheet dated 3/10/2026 revealed the resident was admitted to the facility on [DATE] and was discharged from the facility on 10/17/2025.A record review of Resident 3's Progress Notes dated 10/3/2025 revealed the resident had an unwitnessed fall in the sitting area which resulted in the resident needing sutures for a laceration on their nose.A record review of a facility provided document labeled October 2025 Reportable revealed Resident 3 had an incident occur on 10/3/2025 at 7:30 AM. In the section labeled Describe the Incident the description stated: 0725 Resident was observed on the floor with bleeding to the nose and forehead. 0750 Resident left the building with EMS (emergency medical service) for further workup in the ED (emergency department). 1120 Nursing staff received call from hospital and resident has been diagnosed with a fractured nose. In the section labeled Investigation Summary and Outcome the description stated, Fall committed will meet to discuss current interventions and decide what modifications need to be made. In the section labeled What permanent steps were put into place to prevent recurrence? the description stated, Staff will increase checks on rounds while resident is in bed and resident is not to be left in wheelchair without supervision.An interview on 3/10/2026 at 3:30 PM with the DON confirmed that the investigative report submitted to (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	the State Agency for Resident 3's fall on 10/3/2025 did not contain a thorough investigation into the resident's fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
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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 - 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Licensure Reference Number 175 NAC 12-006.09(I)(i)(1),(3), & (4)Based on record review, interview and observation, the facility failed to identify causal factors and implement interventions to prevent falls, and ensure resident safety for 4 (Resident 1, 5, 3, and 7) out of 7 sampled residents. The facility showed a census of 55.Findings are:

A.

Record review of Resident 1's Census dated 3/10/2026 revealed an admission date of 1/2/2026. A record review of Resident 1's Care plan revealed the following diagnoses:

-Unspecified systolic congestive heart failure,

-Unspecified atrial fibrillation,

-Unspecified combined systolic and diastolic heart failure,

-Atypical atrial flutter,

-Weakness,

-Dizziness and giddiness.

Record review of Resident 1's progress note at 12:04 PM on 1/2/2026 revealed the facility received report from the discharging facility and the resident required the assistance of 1 person and their walker for ambulation and transfers, and that the resident had confusion at times. A progress note from 12:30 on 1/2/2026 revealed resident does appear disoriented at times. Progress note written at 10:16 on 1/3/2026 revealed therapy recommended one staff member to provide assistance for mobility in Resident 1's room with use of 4 wheeled walker and gait belt, and use of manual wheelchair for mobility outside resident room.

A record review of Resident 1's Minimum Data Set (MDS)(a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate residents' physical, functional, and psychological capabilities) dated 1/9/2026 revealed a Brief Interview for Mental Status (BIMS) (a tool used to screen for cognitive impairment) revealed a score of 13 indicating the resident is cognitively intact. The MDS also revealed Resident 1 was taking anticoagulants.

Record review of Resident 1's undated care plan revealed a problem start date of 2/11/2026 for the category of 'Delerium; Resident experiencing delirium as evidenced by: Fluctuating cognition and alertness, Periods of confusion, reports of vivid dreams and difficulty distinguishing dreams from reality'.

Record review of a progress note from 7:20 PM on 1/31/2026 revealed a nurse was called into Resident 1's room to assess the resident after an unwitnessed fall.

Record review of Fall investigation packet revealed a brief description of the fall indicating Resident 1
(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	went to the bathroom alone and did not use their call light. Resident 1 fell in the bathroom, sustaining injury to the head, and aides found the resident on the floor after hearing the resident yelling. Record review of Resident 1's care plan revealed 1/31/2026 self-transfer, self-ambulation to BR, fell. Hematoma to back of head. To ER, admitted with brain bleed. Additional record review of Resident 1's care plan revealed a problem start date of 1/20/2026 for a category of 'falls' with approach start dates of 1/20/2026 for the following interventions: -See that Resident 1 has footwear on that does not slip, slide. -Make sure floor is free of glare, liquids, foreign objects. -Leave night light on in room. -Keep personal items and frequently used items within reach. -Dycem (a non-slip, and antimicrobial materials used for gripping, stabilizing objects, and controlling contamination) to recliner cushion. Further record review of Resident 1's care plan revealed following additional interventions: Approach start date 2/3/2026 -Sign in room to call for assistance. -Frequent checks. Record review of Resident 1's progress note revealed Resident 1 had a fall at 6:45 PM on 2/19/2026 with major injury. Fall Investigation Packet revealed Resident one was last seen between 6:00 and 6:15 PM when their dinner tray was taken by staff. The fall investigation packet revealed Resident was self-transferring when they lost balance. The fall investigation packet does not include a reason for Resident 1 self-transferring. The fall investigation packet shows a care plan update and staff educated to continue frequent checks, an immediate measure taken as 'bed alarm'. Root cause of fall is listed as: -Amount of assistance in effect. -Environmental factors/ items out of reach walker/ wheelchair by window. -Footwear. Further record review of Resident 1's care plan revealed no evidence of a 'bed alarm' being implemented. Another record review of Resident 1's care plan revealed: 2/19/2026 Did not have footwear on the did not slip, slide. Lost balance, fell on lt (left) side. Laceration to head. Sent to ER for c/o pain lt wrist, LT hip.Fell on left side. admitted for lt femur fx (fracture), lt wrist fx. Record Review of Resident 1's progress notes from 10:15 AM in 2/21/2025 revealed Received call (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from RWMC with report on patient (pt). Resident will be returning to facility via EMS. (Gender) will be coming back comfort cares. A progress note from 2/21/2026 at 2:02 PM revealed Resident has a 4-centimeter (cm) laceration to left side of scalp that has 6 staples. Resident is having labored breathing. A progress note from 10:16 AM on 2/22/2026 revealed At 0955 (9:55 AM) went to check resident, noted no lung sounds, no heart rate, and no Blood Pressure (BP). Charge nurse notified. Interview at 1:24 PM on 3/10/2026 with MDS Coordinator/RN (MDS) confirmed there is no way to look at charting to see what time a Resident was last brought to the bathroom. Interview at 2:14PM on 3/10/2026 with Medication Aide (MA)-C confirmed that Resident 1 was found in the bathroom on 1/31/2026 after falling because (gender) took (gender) to the bathroom without assistance. Resident 1 was last toileted around 4:00 PM on 1/31/2026. MA-C also confirmed Resident 1 was toileted about every 2 hours to help prevent falls because (gender) refused to use the call light due to embarrassment of being in the facility with (gender) family as apart of the staff. B. Record Review of Resident 5's census, dated 3/10/2026, revealed an admission date of 1/13/2026. Record review of Resident 5's undated care plan revealed the following listed diagnoses: -Unspecified dementia, unspecified severity, with psychotic disturbance, -Generalized anxiety disorder, - Restlessness and agitation. A record review of Resident 5's MDS revealed a BIMS score of 99 indicating severe cognitive impairment. A record review of a facility document Fall tracking and trends from June 2025 through March 2026 revealed Resident 5: -Fell at 1:15 PM on 1/17/2026. Leaned forward in wheelchair (w/c), fell, don't leave alone in dining room (DR). There was no injury noted. -Fell at 7:00 PM o 1/17/2026. In w/c, fell forward, hit head/dycem and gel cushion, w/c. There was a laceration to the head, and the resident was sent to the ER. -Fell at 3:10 PM on 1/22/2026. Self-transfer from recliner/ dycem to recliner cushion. There was no injury noted. -Fell at 6:45 PM on 1/25/2026. Self-transfer from w/c. fell/different/lower w/c per therapy. There was a skin tear to the left forearm. -Fell at 1:55 PM on 2/27/2026. In w/c, fire drill going on/slid from w/c / dycem again in w/c. There was no injury noted. Further record review of Resident 5's undated care plan revealed the resident needed extensive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with turning and positioning. The care plan also revealed the resident's cognition, mobility and safety awareness are impaired. Resident 5's care plan also revealed the following interventions with a star date of 1/20/2026: -Make sure the floor is free of glare, liquids, foreign objects. -Leave night light on in room. -Keep personal items and frequently used items in reach. -Keep bed in lowest position with brakes locked. -Dycem (a non-slip, and antimicrobial materials used for gripping, stabilizing objects, and controlling contamination) and gel cushion in wheelchair. -Don't leave Resident in DR (dinning room) alone. The following interventions had a start date of 1/27/2026: -Dycem to recliner. -Different lower wheelchair done by therapy. The following intervention has a start date of 2/11/2026: -Keep the call light in reach. Resident does not use the call light. Check routinely. The following intervention has a start date of 3/2/2026: -Therapy to check that dycem is in place in w/c. A record review of the pocket care plan (a documentation made daily for staff use regarding all facility residents and their care needs) for 3/10/2026 revealed no mention of Resident 5's fall interventions as listed above. Record review of the fall event reports from 1/17/2026, 1/22/2026, and 2/27/2026, revealed there were no immediate measures taken after the falls to prevent future falls and ensure safety. Record review of the fall event report from 1/25/2026 revealed first aid and rest as immediate measures taken. The NA fall investigation worksheet from 1/25/2026 revealed first down as the recommended intervention to prevent similar falls. Page 7 of the 'fall checklist' document revealed the root cause of this fall documented with a handwritten note that reads: I don't know. Record review of the NA investigation worksheet from 1/25/2026 revealed a recommendation of first down to prevent similar falls. Record review of the NA investigation worksheet from 2/27/2026 revealed a recommendation to make sure the resident is in the recliner as an intervention to prevent similar falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 5's progress notes revealed no mention of reevaluating interventions for appropriateness or attempts at different interventions to prevent falls and ensure safety. An interview at 1:24 PM with MDS confirmed that confused residents cannot be educated. An interview at 3:10 PM on 3/10/2026 with MA-C confirmed that the interventions in place for Resident 5 were unsuccessful in preventing falls. C. A record review of Resident 3's Facesheet revealed the resident was admitted to the facility on [DATE] and was discharged on 10/17/2025. A record review of Resident 3's undated Care Plan revealed the resident had a problem area related to falls. There were the following interventions for this problem area with a start date of 11/21/2023: -Keep bed in lowest position with brakes locked. -Keep personal items and frequently used items within reach. -Leave night light on in room. -Make sure the floor is free of glare, liquids, foreign objects. -See that Resident 3 has footwear on that does not slip, slide. -Staff to do frequent checks. There was the following intervention for this problem area with a start date of 6/13/2024: -Dycem placed on wheelchair related to Resident 3 sliding from wheelchair There was the following intervention for this problem area with a start date of 8/6/2024: -Resident 3 will try to put self on the floor when in the wheelchair. There was the following intervention for this problem area with a start date of 9/11/2024: -Place in common area after meals as Resident 3 allows. There was the following intervention for this problem area with a start date of 10/3/2024: -Staff to see that soda can is available and not on the floor. A record review of a facility document titled Fall Tracking and Trends from June 2025 through March 2026 revealed the following for Resident 3: -The resident was found on the floor by their wheelchair on 7/30/25 at 6:45 PM in the common area. The resident was trying to get out of their wheelchair. Staff were to put Resident 3 to bed after (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals. -The resident was observed on the floor in front of their recliner 8/23/2025 at 4:15 PM. Staff were not to put the resident in their recliner and were to put the resident in bed. -The resident fell out of their recliner while reaching for a banana on 9/7/2025 at 6:55 AM. Staff were to put food within the resident's reach. -The resident fell out of their wheelchair in the hall on 10/3/25 at 7:30 AM. Staff were not to leave the resident in their wheelchair and were to increase checks on rounds. A record review of Resident 3's Progress Note dated 07/30/2025 revealed the resident was observed in a kneeling position in front of their wheelchair in the common area. The resident stated they were trying to get up. There were no injuries noted. Further record review of Resident 3's undated Care Plan revealed there was an intervention added to the falls problem area with a start date of 8/5/2025 that stated, Staff to put in bed after meals. A record review of Resident 3's Progress Note dated 08/23/2025 revealed the resident was observed on the floor in their room in front of their recliner with no injuries noted. Further record review of Resident 3's undated Care Plan revealed there was an intervention added to the falls problem area with a start date of 9/3/2025 that stated, Staff do not put Resident 3 in their recliner. They slide out of it. Put them in bed. A record review of Resident 3's Progress Notes dated 9/07/2025 revealed the resident had fallen out of their wheelchair and sustained a laceration above their right eye. The resident was taken to the emergency room and returned to the facility with sutures above their right eye. Further record review of Resident 3's undated Care Plan revealed there was an intervention added to the falls problem area with a start date of 9/10/2025 that stated, Staff to place food within Resident 3's reach. A record review of Resident 3's Progress Note dated 10/03/2025 revealed the resident had an unwitnessed fall in the sitting area. The resident had a laceration to their nose, an abrasion to their forehead, and a skin tear to their left forearm. The resident was sent to the emergency room for evaluation. The resident later returned to the facility with sutures to the laceration on their nose. Further record review of Resident 3's undated Care Plan revealed there was an intervention added to the falls problem area with a start date of 10/14/2025 that stated, Do not leave alone in wheelchair, increase checks. A record review of a facility document Fall Checklist revealed Resident 3 had fallen on 10/3/2025 at 7:30 AM and on page 2 of the document it stated that dietary staff had witnessed the fall. In the Fall Scene Investigation Report section it revealed the resident stated they were trying to go home and that they had last been assisted with toileting at 7:00 AM. In the final portion of this section of the document, it states Action Taken: do not leave resident in wheelchair, increase checks. On the CNA (certified nurse aide) Fall Investigation page of the document, it stated that the resident was last assisted to the bathroom before their bath that morning, around 6:15 AM. The resident had last been (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

checked on 15 minutes prior to the fall and an intervention the staff could do to help prevent another similar fall like this was to make sure (gender) is being watched if in wheelchair more frequently. This page was signed and dated by staff. The document signed as reviewed by the Fall Risk Committee on 10/6/2025.

An interview on 3/10/26 at 12:30 PM with MDS confirmed the documentation in Resident 3's Fall Checklist for the fall that occurred on 10/3/2025 was inconsistent and it was unclear what had happened, and when. MDS confirmed that the document stated the resident was checked on 15 minutes prior to the fall and to increase checking frequency would be to place the on 1:1 supervision, which the facility had not implemented. MDS also confirmed the intervention of Do not leave alone in w/c, increase checks would not be a feasible intervention as the facility could not sustain 1:1 cares for residents. MDS also stated the CNA Fall Investigation page was signed by a dietary aide who would not have known when the resident had last been checked on or toileted. MDS confirmed the intervention that was added to Resident 3's Care Plan was not put into place until 11 days after the fall, and it should have been added no later than the day after the fall was reviewed by the fall risk committee, which was on 10/6/2025.

An interview on 3/10/26 at 2:30 PM with LPN-A confirmed Resident 3's Care Plan had conflicting guidance regarding whether to keep the resident in the common area or put the resident in bed after meals.

D.

A record review of Resident 7's Facesheet dated 3/10/2026 revealed the resident was admitted to the facility on [DATE].

A record review of a facility document Fall Tracking and Trends from June 2025 through March 2026 revealed:

- fell on 7/8/2025 at 6:50 PM. No injuries. Transferring, weak, lowered to floor. 2-staff to transfer- per therapy now a total lift.

- fell on 7/9/2025 at 4:00 PM. No injuries. Slid out of recliner. Keep footrest up when doing cares.

- fell on [DATE] at 2:30 AM. Fell out of bed, no injuries, keep bed in low position.

- fell on [DATE] at 7:30 AM. Found in doorway of room, had crawled to doorway, sent to ER r/t confusion, returned, bed in low position. ER found thyroid mass.

A record review of Resident 7's undated Care Plan revealed the resident had an amputation of the left leg, below the knee. The resident required extensive assist with turning and positioning and was dependent on staff and a mechanical lift for transfers. The care plan also revealed the resident had a history of falls and had an intervention of keep bed in lowest position with brakes locked with a start date of 7/10/2025.

A record review of Resident 7's Progress Note dated 12/17/2025 revealed the resident was observed sitting upright between their bed and bedside table and the bed was in a raised position. When asked what happened, the resident stated they had been sleeping and fell out of bed.
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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Further record review of Resident 7's undated Care Plan revealed an entry 12/17/25 fell out of bed and an intervention dated 12/22/2025 that stated, Keep bed in low position.

A record review of Resident 7's progress note dated 12/29/2025 revealed the resident was observed laying on the floor in the doorway of their room. The resident stated they had crawled to the doorway.

A record review of a facility document Fall Checklist dated 12/29/2025 revealed that 5 minutes prior to being observed on the floor in their room doorway, Resident 7 had been laying in bed.

Further record review of Resident 7's undated Care Plan revealed an entry 12/29/25 found in doorway of room on stomach, had crawled to the doorway. Unable to verbalize how (gender) fell, confused. Sent to ER and an intervention dated 12/31/2025 that stated Sent to ER r/t confusion, returned. Has thyroid mass. Bed to be in low position.

An observation on 3/10/2026 at 7:30 AM revealed Resident 7 lying in their bed. The bed was in a high position, approximately 2-3 feet from the floor.

An observation on 3/10/2026 at 8:35 AM revealed Resident 7 sitting up on the side of their bed with their legs dangling over the edge of the bed. Resident 7's right foot was several inches above the floor. There was an overbed table in front of the resident and the resident was eating their breakfast and watching TV. The Social Services Director entered the room at 8:36 AM and conversed with the resident, then left the room without lowering the bed.

An observation on 3/10/2026 at 9:21 AM revealed Resident 7 remained in the same position on their bed with the overbed table in front of them and the bed remained in the elevated position. Licensed Practical Nurse (LPN)- B entered the room and spoke with the resident for several minutes, then left the room at 9:30 AM without lowering the bed.

An observation on 3/10/2026 at 10:13 AM revealed Resident 7 lying in their bed on their back with a blanket over them. The bed had been lowered so the base of the mattress was about a foot above the ground.

An observation on 3/10/2026 at 11:13 AM revealed Resident 7 sitting upright on the edge of their bed with their legs dangling. Their right foot was a few inches from the floor and the overbed table was in front of them. The resident was reading a piece of paper and watching tv.

An observation on 3/10/2026 at 1:18 PM revealed Resident 7 sitting in the same position as prior observation with their foot a few inches from the floor.

An interview on 3/10/26 at 2:07 PM with LPN-B confirmed that when LPN-B went into Resident 7's room while the resident was eating their breakfast, the resident's bed was not in low position. LPN-B stated the bed was not ever in low position at mealtimes as the resident sits on the edge of their bed for all meals and it would not be comfortable for the resident to eat their meal if the bed was in low position.

An interview on 3/10/26 at 2:30 PM with LPN-A confirmed Resident 7's care plan had the intervention of keep bed in low position in the falls section entered on three different dates. LPN-A revealed that the facility's nurse aides did not have access to the residents' care plans and that the aides used a pocket care plan which contained pertinent information about each resident.
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285271	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northfield Retirement Communities Care Center	2100 Circle Drive Scottsbluff, NE 69361

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	A record review of the pocket care plan for 3/10/2026 revealed no information for Resident 7 in relation to their fall intervention of keeping their bed in low position. Further interview on 3/10/26 at 2:30 PM with LPN-A confirmed the pocket care plan reviewed by the surveyor was the document in use that day by the nurse aides and it did not reflect that Resident 7's bed was to be in low position. LPN-A stated the nurses also did not utilize the residents' care plans during their shifts. The nurses referred to a Therapy Communication binder which contained recommendations from the therapists and utilized a 24-hour report/census sheet which was updated nightly and contained information about each resident that the nurses needed to know. LPN-A confirmed that these documents also did not contain information about Resident 7's bed needing to be in low position.