STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sutton Community Home, Inc.	1106 North Saunders Avenue Sutton, NE 68979

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 (F) Based on record review and interview, the facility failed to revise the Care Plan (Comprehensive -CCP - written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care), to add interventions for a fall for one Resident (Resident 6) and to update Care plan with new interventions for 2 Residents (Resident 1, and Resident 3) of 6 sampled residents. The facility census was 22.Findings are: A. A record review of the admission record revealed that Resident 6 was admitted to the facility on [DATE] with the diagnosis of Anxiety Disorder (the body's natural response to stress, characterized by feelings of unease, worry, or fear), Atrial Fibrillation (an irregular, often rapid heart rhythm (arrhythmia) where the heart's upper chambers (atria) quiver out of sync with the lower chambers), Dementia with psychotic Disturbance (involves cognitive decline combined with delusions (false beliefs) or hallucinations (seeing or hearing things not there) , Urinary Tract Infections (bacterial infection in any part of your urinary system (kidneys, bladder, ureters, or urethra), and Major Depression (a serious mood disorder characterized by a persistent feeling of profound sadness, hopelessness, and a loss of interest in daily activities) . A record review of the Brief Interview for Mental Status (BIMS) (a test used to get a quick snapshot of a residents cognitive function, scored from 0-15, the higher the score, the higher the cognitive function), dated 4/1/2026 revealed Resident 6 BIMS score was a 6 meaning severely impaired. A record review of the progress notes dated 6/6/26 revealed Resident 6 was on the floor near the bathroom with a laceration to head and Resident stating that Resident 6 must of hit the door jam and then the floor. It was noted that Resident 6 has dementia. Resident 6 was transported to the hospital. A record review of the progress notes dated 6/6/26 revealed a nurse from the hospital called facility to inform the facility that Resident 6 had a mildly displace 5th rib and that Resident 6 was having delusions. A record review of a Post-Fall assessment form with no date revealed: -investigate, and record fall for proper interventions, circumstances, resident outcomes, and staff response to the fall in Risk Management on Point Click Care (PCC) (a comprehensive network for long-term and post-acute care providers to manage patient history, medical assessments, and care planning). (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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	285277	A. Building B. Wing	06/24/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-implement immediate interventions -document interventions in the notes tab under Risk Management -enter fall and interventions in Care Plan on PCC with fall date and date interventions was implemented. -be sure intervention matches what caused the fall A record review of the Care plan dated 6/6/26 for Resident 6 revealed: 6/6/26 unwitnessed fall with injury with no new intervention in place to prevent further falls. An interview on 6/25/26 with the Assistant Director of Nursing confirmed that there were no new interventions to prevent further falls for Resident 6 and there should be new interventions in place. B. A record review of Resident 1's admission Report identified an admit date of 11/01/2023 with diagnosis of difficulty walking related to prior stroke (blood flow to the brain is blocked or severely restricted). The Brief Interview for Mental Status (BIMS-a test to get a quick snapshot of a resident's cognitive function, scored 0-15, the higher the score, the higher the cognitive function) revealed Resident 1 had a score of 15, which indicated the resident is cognitively intact. A review of Resident 1's Progress Notes dated 05/19/2026 at 2:45 PM revealed Resident 1 was observed on her knees on top of a blanket. No apparent injury was noted and Resident 1 was assisted up safely. A record review of Resident 1's Progress Notes dated 05/20/2026 at 1:30 PM revealed a follow up note for the 05/19/2026 fall and further revealed Resident 1 was encouraged to remove blankets from her lap before standing and encouraged to use a lighter blanket while in the recliner. Review of Resident 1's Care Plan initiated on 03/01/2024 revealed Resident 1 is a high risk for falls and fell on [DATE]. No new interventions for 05/19/2026 fall were identified in the care plan. During an interview with the Assistant Director of Nursing (ADON) on 06/24/2026 at 11:08 AM when discussing Resident 1's Care Plan in the electronic medical record, confirmed Resident 1 did not have updated interventions for fall on 05/19/2026 and should have. C. A review of an admission Record revealed the facility admitted Resident 3 on 04/08/2026 with diagnoses repeated falls and an age-related cognitive decline. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Brief Interview for Mental Status (BIMS-a test to get a quick snapshot of a resident's cognitive function, scored 0-15, the higher the score, the higher the cognitive function) revealed Resident 1 had a score of 13, which indicated the resident has moderate cognitive impairment. A review of Resident 3's Progress Notes dated 05/09/2026 at 8:20 AM revealed the resident had a fall last night when trying to use the restroom. No documented fall on 05/08/2026. Review of Resident 3's Care Plan initiated on 04/08/2026, revealed Resident 3's care plan was updated on 05/13/2026 which included 05/10/2026 Gripper tape on the floor in front of toilet. The intervention was added to the Care Plan three days after the intervention was to start and five days after the fall on 05/08/2026. During an interview with the Assisted Director of Nursing (ADON) on 06/24/2026 at 11:15 AM when discussing Resident 3's Care Plan in the electronic medical record (EMR) confirmed Resident 3 did not have revised interventions on Resident 3's care plan for 05/08/2026 fall until five days had past and should have been documented same day as fall.