STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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. 51122 License Reference Number 175 NAC 12-006.02 (H) Based on record review and interview, the facility failed to submit their investigation of an incident within 5 working days as required for 1 (Resident 1) of 2 sampled residents. The facility identified a census of 37. Findings Are: A record review of a facility document titled Abuse, Neglect, or Misappropriation and dated 10/23/24, revealed Resident 1 had a fall with injury on 10/15/24 at 10:00 PM. The document further revealed the investigation was submitted to the State Agency on 10/23/24. An interview on 1/6/25 at 1:15 PM with the Administrator confirmed the facility did not submit their investigation of Resident 1's fall with injury that occurred on 10/15/24 to the State Agency within 5 working days as required.

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49766 Licensure Reference175 NAC 12-006.09(I) Based on record reviews and interview, the facility failed to develop new interventions for falls for 1 (Resident 2) of 3 sampled residents. The facility identified a census of 37. Findings Are: A record review of a facility policy, Falls and Fall Risk, Managing, with a last revised date of March 2018 indicated if falls recur despite initial interventions, staff will implement additional or different interventions. A record review of an Admission Record indicated the facility admitted Resident 2 on 5/27/2022 with diagnoses of history of falling, dystonia (a brain condition that causes uncontrollable muscle movement,) hemiplegia (weakness on one side of the body,) muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. A record review of Resident 2's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), with an Assessment Reference Date of 11/8/2024 indicated Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 15/15, indicating Resident 2 had no cognitive impairment. The MDS also indicated Resident 2 required use of a walker and wheelchair; supervision with transfers; and partial assistance with dressing. It also revealed Resident 2 was taking an antipsychotic (a class of drugs that treat symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking,) diuretic (a water pill,) and opioid (narcotic pain) medications. A record review of Resident 2's undated Care Plan revealed the following related to Resident 2's falls: - Resident 2 was at risk for falls related to chronic pain, impaired mobility, and poor safety awareness. - Resident 2 had fallen on 9/5/2024, 10/2/2024, 10/7/2024, 11/1/2024, 11/26/2024, 12/2/2024, 12/24/2024, and 12/25/2024. The care plan did not reflect Resident 2's falls that occurred on 9/23/2024 or 1/3/2025. - Duplicate interventions for Resident 2's falls on 10/7/2024, 12/2/2024 of Physical Therapy (PT)/Occupational Therapy (OT) evaluations, educating Resident 2 on the hazards of walking backwards, using the grabber to reach for items, and call for assistance were placed. - No interventions were placed on the Care Plan for Resident 2's falls on 9/23/2024, 11/26/2024, 12/25/2024, or 1/3/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of an Incident Audit report with an incident date of 9/23/2024 indicated Resident 2 had spilled something on the floor and attempted to clean it up independently when Resident 2 lost their balance and fell to the floor. Resident 2 was educated to use staff for assistance. An Occupational Therapy (OT) evaluation for strengthening was placed. A record review of an Incident Audit report with an incident date of 10/7/2024 indicated Resident 2 had a fall while trying to undress due to losing their balance. A rehabilitation form was sent to therapy to assist with dressing and balance. A record review of an Incident Audit report with an incident date of 11/26/2024 indicated Resident 2 was encouraged to call for assistance with moving item in the room. All frequently used item were within safe reach. A Physical Therapy (PT) evaluation was for safety awareness and sequencing for safe ambulation was sent. A record review of an Incident Audit report with an incident date of 12/2/2024 indicated following Resident 2's fall an order for PT/OT evaluation with focus of fall prevention and safety awareness was placed. A record review of an Un-witnessed Fall document with a date of 12/25/2024 indicated Resident 2 had self-reported a fall in their room after stepping backwards causing their heel to step on the footrest of their wheelchair. The intervention placed was to educate/discuss with Resident 2 regarding walking backwards. The note also reflected that Resident 2 was currently working with PT/OT for balance and safety. A record review of an Un-witnessed Fall document with a date of 1/3/2025 indicated Resident 2 had an unwitnessed fall on 1/2/2025. Resident 2 reported they were reaching for a tissue when the box slide from the bed and Resident 2 also slid out of bed. The intervention placed was to ensure all frequently used items are within reach, educated on call light use for assistance, and PT/OT for sequencing and safety/fall prevention. An interview on 1/6/2025 at 12:25 PM with the Registered Nurse Consultant (RNC) confirmed the following: - No interventions for Resident 2's falls on 9/23/2024, 11/26/2024, 12/25/2024, and 1/3/2025 were placed on their care plan. - The intervention for Resident 2's fall on 9/23/2024 was to use the reacher/grabber for items on the floor, which was a duplicate intervention. - The intervention for Resident 2's fall on 11/26/2024 was to ensure items were in reach, which was a duplicate intervention. - The intervention for Resident 2's falls on 10/7/2024, 12/2/2024, 12/25/2024, and 1/3/2025 were duplicate interventions for PT/OT evaluation, noting Resident 2 was currently still working with PT/OT during their fall on 12/25/2024. - The intervention for Resident 2's fall on 1/3/2025 was to ensure items were within close reach, which was a duplicate intervention.