STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E300	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oglala Sioux Lakota Nursing Home	7835 Elders Drive, State Highway 87 Rushville, NE 69360

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.006.09(I)(i)(3) Based on record review and interviews, the facility failed to implement interventions to prevent falls for 3 (Residents 1, 2, and 3) of 3 sampled residents. The facility census was 42. Findings Are: A record review of facility policy Falls-Clinical Protocol, with a revision date of March 2018 revealed that for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. The policy also stated that based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. A. A record review of Resident 1's Clinical Resident Profile revealed the resident was admitted to the facility on [DATE] and had a diagnosis of dementia. A record review of Resident 1's significant change 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 1/16/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 0/15, which indicated the resident had severe cognitive impairment. The MDS also revealed the resident required substantial staff assistance for their bed mobility and was dependent on staff assistance for their transfers and locomotion. Resident 1 had not had any falls since their prior assessment. A record review of Resident 1's Care Plan, dated 2/4/25 revealed the resident was at high risk for falls related to frequently declining health, physical condition change, life expectancy less than 6 months, and weakness. (continued on next page)

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	A record review of Resident 1's Progress Notes revealed the following: -The resident had a fall in the evening on 1/8/2025, was sent to the hospital on 1/9/2025 due to left thigh pain and had left hip surgery due to a fracture. -The resident had a fall on 1/20/2025 with no new injuries. The documentation further revealed that the resident had an increase in their pain medication following this fall. Further record review of Resident 1's Care Plan revealed no new interventions had been put into place following their fall on 1/8/2025. A record review of facility provided Fall Huddle Report documents revealed no evidence of a fall huddle being completed for either of Resident 1's falls in January 2025. A record review of the facility's Weekly Risk Management document dated January 1st-9th, 2025 revealed Resident 1 had a fall on 1/8/2025, the interventions for the fall section was blank. An interview on 2/4/2025 at 2:20 PM with the Director of Nursing (DON) confirmed the facility had not implemented any fall interventions following Resident 1's fall on 1/8/2025. B. A record review of Resident 3's Clinical Resident Profile revealed the resident was admitted to the facility on [DATE] and had a diagnosis of dementia. A record review of Resident 3's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 12/15, which indicated the resident had moderate cognitive impairment. The MDS also revealed the resident ranged from independent to set up assist for all activities of daily living. The resident had fallen two or more times since their previous assessment. A record review of Resident 3's Care Plan, dated 5/1/2024 revealed the resident was at risk for falls related to muscle weakness. A record review of Resident 3's Progress Notes revealed the following: -On 10/25/2024 the resident was found on the floor in their room by housekeeping, there was also a moderate amount of baby powder on the floor. -On 10/26/2024 the resident was found on the floor by a nurse aide and housekeeping, the resident stated they had forgotten to lock their wheelchair brakes during a self-transfer. -On 11/12/2024 at 9:38 AM staff documented Provider aware of resident fall. There was no documentation in the progress notes of what time this fall had occurred. -On 11/12/2024 at 9:53 AM the resident was found sitting on the floor against their bed. -On 11/12/2024 at 12:09 PM the resident was found sitting on the floor at their bedside, the resident stated their feet had slid out from under them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/13/2024 the resident was found on the floor by their bed, the resident stated they were trying to propel their wheelchair and fell over. -On 11/17/2024 the resident had a fall while self-transferring in their room. -On 12/15/2024 the resident was found sitting on the floor next to their bed, the resident stated they had forgotten to lock their wheelchair brakes. -On 12/19/2024 at midnight, the resident was sitting on the floor next to their bed, the resident stated they had missed their wheelchair. -On 12/19/2024 at 8:00 AM the resident was found on the bathroom floor; the resident was attempting to self-toilet. -On 1/2/2025 the resident was found sitting on the floor in their room. -On 1/6/2025 the resident was found on the floor in their room. A record review of the facility's Weekly Risk Management document dated November 7th-13th, 2024 revealed Resident 3 had an additional fall on 11/12/2024, which was at 12:15 AM. Further record review of Resident 3's Care Plan revealed no evidence of new interventions being put into place following the resident's falls on 10/26/2024, 11/12/2024, 11/13/2024, 12/15/2024, 12/19/2024, 1/2/2025, or on 1/6/2025. A record review of facility provided Fall Huddle Report documents for Resident 3's falls occurring between October 2024 and January 2025 revealed fall huddles were completed for the falls that occurred on 10/25/2024, 11/12/2024 at 12:09 PM, 11/17/2024, and 12/19/2024. There was no evidence of new interventions put into place via the huddles for the falls on 11/17/2024 or 12/19/2024. Further record review of the facility's Weekly Risk Management documents revealed the following falls were reviewed for Resident 3: -The resident had a fall on 10/25/2024 and a new intervention had been put into place. -The resident had a fall on 10/26/2024 and the interventions section was blank. -The resident had falls on 11/12/2024 at 12:15 AM and at 9:43 AM, both falls' interventions sections were blank. -The resident had a fall on 11/12/2024 at 12:00 PM and a new intervention had been put into place. -The resident had a fall on 11/13/2024 and a new intervention had been put into place. -The resident had a fall on 12/15/2024 with no new interventions put into place. -The resident had a fall on 1/2/2025 and the interventions section was blank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had a fall on 1/6/2025 and the interventions section was blank. The documents contained no evidence that the facility had revealed Resident 3's falls that had occurred on 11/17/2024 and 12/19/2024. An interview on 2/4/2025 at 2:20 PM with the Director of Nursing (DON) confirmed the facility had not implemented any fall interventions following Resident 3's falls that occurred on 10/26/2024, 11/12/2024 at 12:15 AM and 9:53 AM, 12/19/2024 at midnight, 1/2/2025, or on 1/6/2025. 49766 C. A record review of a Clinical Resident Profile indicated the facility admitted Resident 2 on 10/13/2022 with a diagnosis of Dementia. A record review of Resident 2's quarterly MDS with an Assessment Reference Date (ARD) on 12/26/2024 revealed Resident 2 had a BIMS of 0/15, which indicated severe cognitive impairment and also noted severe cognitive impairment with daily decision-making skills. The MDS also revealed Resident 2 had one fall without injury and two falls with minor injury since the last assessment. A record review of Resident 2's Care Plan revealed Resident 2 had a care focus area with a date initiated of 10/26/2022 and was at high risk for falls due to wandering, confusion, balance problems, use of an antidepressant, incontinence, and fall history. A record review of Resident 2's Progress Notes indicated Resident 2 had a fall on 12/13/2024 and 12/31/2024, no interventions were included in the note. A record review of a Fall Huddle Report with a date of 12/31/2024 revealed Resident 2 was self-transferring to the bathroom and fell . What interventions can you implement to prevent further falls? section was left blank. A record review of the facility's Risk Management Meeting Minutes with a date of 12/12/2024-12/18/2024 identified Resident 2's cause of fall on 12/13/2024 as gait imbalance during a transfer. There were no new interventions identified. A record review of the facility's Risk Management Meeting minutes with a date of 12/25/2024-12/31/2024 identified Resident 2's cause of fall on 12/25/2024 as gait imbalance, impaired memory, and weakness. There were no new interventions identified. Further record review of Resident 2's Care Plan revealed no new interventions were placed after Resident 2's fall on 12/13/2024 and 12/31/2024. An interview on 2/4/2025 with Nurse Aide (NA) - A revealed their dependence on the care plans being up to date to know what interventions have been put in place for a resident to prevent falls or other accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 2/4/2025 with the Director of Nursing (DON) confirmed there were no new interventions developed for Resident 2's Progress Notes, Fall Huddle Report, Risk Management Meeting minutes, or Care Plan following Resident 2's falls on 12/13/2024 and 12/31/2024.