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	09/12/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.05 Nebraska State Statute 71-6023 Based on record review and interview, the facility failed to ensure the required information was included in the written notice of transfer for Resident 8 upon transfer to the hospital. This affected 1 of 1 resident sampled for hospitalization . The facility census was 47. Findings are: A record review of Resident 8's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). A record review of Resident 8's Clinical Census printed on 9/10/2024 revealed the resident was transferred to the hospital on 8/16/2024 and returned to the facility on [DATE]. A record review of Resident 8's Notice of Resident Transfer or discharge date d 8/16/2024 provided by the facility revealed the following: -Resident 8's name was not on the form. -Under the section The reason for the transfer/discharge is for the following reasons: the box next to The transfer is necessary for the resident's welfare and the resident's needs cannot be met by the facility (i.e. urgent medical need). Specify: was checked, but no specific need was given. -There was no contact information for the state long-term care agency or the state long-term care ombudsman on the form. An interview on 9/12/2024 at 8:38 AM the with Social Services Director (SSD) confirmed the specific medical reason for transfer, and the contact information for the state long-term care agency and the state long-term care ombudsman were not on the form.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49766 Licensure Refence 175 NAC 12-006.09(C)(ii) Based on interview and record reviews, the facility failed to complete a significant change Minimum Data Set (MDS, a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual resident) for 1 (Resident 20) of 12 sampled residents. The facility identified a census of 47 at the time of the survey. Findings are: A record review of a facility policy Change in a Resident's Condition or Status with a revision date of February 2021 revealed the following: -A significant change of condition is a major decline in the resident's status that impacts more than one area of the resident's health status. -If a significant change of condition occurs, a comprehensive assessment will be conducted as required by current Omnibus Budget Reconciliation Act (OBRA) regulations and as outlined in the Resident Assessment Instrument (RAI) Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities. A record review of the MDS RAI 3.0 Manual indicated a decline in two areas, including any decline in Activities of Daily Living (ADLs) and emergence of unplanned weight loss, warranted a significant change MDS to be completed. A record review of an Admission Record indicated the facility admitted Resident 20 on 9/15/2020 with a diagnosis of dementia. A record review of Resident 20's Quarterly MDS with an Assessment Reference Date (ARD) of 4/11/2024 revealed Resident 20 required partial assistance with oral hygiene and had no weight loss. A record review of Resident 20's Quarterly MDS with an ARD of 7/11/2024 revealed Resident 20 required full assistance with oral hygiene and had a significant weight loss. An interview on 9/12/2024 at 10:47 AM with the MDS Coordinator confirmed Resident 20 had a decline in ADL status and significant weight loss over the prior couple of months and that a significant change MDS should have been 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Based on record review and interview, the facility failed to complete and transmit a Discharge Minimum Data Set (MDS-a federally mandated comprehensive assessment of each resident's functional capabilities) for Resident 8 upon hospitalization . This affected 1 of 1 resident sampled for discharge. The facility census was 47. Findings are: A record review of Resident 8's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). A record review of Resident 8's Clinical Census printed on 9/10/2024 revealed the resident was transferred to the hospital on 8/16/2024 and returned to the facility on [DATE]. A record review of Resident 8's Progress Notes printed on 9/12/2024 revealed a note from 8/16/2024 at 3:49 PM that stated, Resident to be admitted into [hospital]. Further review revealed a note from 8/17/2024 at 11:30 AM that stated, Patient admitted overnight to [hospital] for dehydration. A record review of a list printed on 9/12/24024 of completed MDSs revealed no Discharge MDS had been completed when Resident 8 was hospitalized from 8/16/2024 to 8/17/2024. A record review of the Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.18.11 (an instruction manual for completing the MDS) revealed that a discharge MDS must be completed within 14 days after the discharge date . An interview on 9/12/2024 at 1:35 PM with the MDS Coordinator confirmed a discharge MDS had not been done when Resident 8 was hospitalized , and should have been.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(B) Based on record reviews and interviews; the facility failed to ensure the accuracy of the Minimum Data Set (MDS-a federally mandated comprehensive assessment of each resident's functional capabilities) for Resident 2 regarding a Positive Airway Pressure (PAP) device and for Resident 9 regarding anticoagulant use. This affected 2 of 12 residents reviewed for MDS accuracy. The facility census was 47. Findings are: A. A record review of Resident 2's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of muscular dystrophy (a group of genetic diseases that cause progressive weakness and loss of muscle mass). A record review of Resident 2's Order Summary printed on 9/10/2024 revealed an order for C PAP [continuous positive airway pressure - a machine that helps people breathe while they sleep by delivering a steady stream of air pressure through a mask or nosepiece] at bedtime for oxygen to use full face mask nightly. one time a day with a start date of 7/29/2021. A record review of Resident 2's Treatment Administration Record (TAR) for June 2024 revealed that the CPAP order was signed as administered every day in June, including during the look-back period (the time period over which the resident's condition or status is captured by the MDS assessment, in this case, from 6/7/2024 to 6/13/2024). A record review of Resident 2's Annual MDS dated [DATE] revealed that under Section O Special Treatments, Procedures and Programs, the box at row G1 Non-invasive Mechanical Ventilator and column b. While a Resident was not checked to indicate that the resident had used a PAP device during the look-back period. An interview on 9/12/2024 at 11:55 AM with the MDS Coordinator confirmed that Resident 2 had used a PAP device during the look-back period and that the box should have been marked to indicate they had. 49766 B. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities, indicated for section N0415-E1 to check if resident had taken an anticoagulant during the 7-day look back period and for section N0415-E2 to check if the was an indication noted for the anticoagulation medication taken by the resident during the observation period. A record review of Resident 9's Minimum Data Set (MDS,) a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents, with an Assessment Reference Date of 7/11/2024 under section N indicated Resident 9 was not taking an anticoagulant and had no indication for taking one. A record review of Resident 9's Order Summary with a date of 9/11/2024 revealed Resident 9 had an order for Xarelto, an anticoagulant, for atrial fibrillation. Resident 9 had been taking this medication since 10/3/2018. An interview on 9/12/2024 at 10:54 AM with the MDS Coordinator confirmed Resident 9 was taking an anticoagulant and that this should have been reflected on the MDS.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49766 Licensure Reference 175 NAC 12-006.09(E) Based on interviews and record reviews, the facility failed to develop a comprehensive care plan regarding behaviors and non-pharmacological interventions for 1 (Resident 40) of 12 sampled residents. The facility identified a census of 47 at the time of the survey. Findings are: A record review of a facility policy Care Plans, Comprehensive Person-Centered with a last revised date of March 2022 included a policy statement that read A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy also indicated, when possible, interventions should address the underlying sources of the problem, not just symptoms or triggers. A record review of an Admission Record indicated the facility admitted Resident 40 on 11/21/2023 with diagnoses of dementia, depression, and anxiety. A record review of Resident 40's Minimum Data Set (MDS, a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents), dated 6/27/2024 revealed Resident 40 had other behavioral symptoms, such as hitting or scratching self, pacing, rummaging, or disruptive sounds, 1-3 days during the 7-day observation period. A record review of Resident 40's Care Plan, which had a revision date of 4/1/2024, revealed the following: -Use of psychotropic medication related to behavior management with interventions to administer psychotropic medication as ordered with monitoring for side effects; consult pharmacy and physician to consider dosage reduction when appropriate; discuss with physician and family the ongoing need for use of medication; review behaviors, interventions, and alternate therapies attempted and their effectiveness. -Use of anti-anxiety medication related to adjustment issues with interventions to administer anti-anxiety medication as ordered with monitoring for side effects; educate the resident and family about the risks, benefits, and side effects; and monitor the resident for safety. -Has depression and anxiety with interventions to administer medications as ordered with monitoring for side effects; monitor for any risk for harm to self; monitor for depression symptoms; and monitor for risk of harming others. There was no evidence of behavioral symptoms specific to Resident 40 or interventions to address Resident 40's behaviors in Resident 40's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 40's Progress Notes revealed the following: -8/17/2024: Resident 40 yelling through shift. Nursing staff redirected resident, asked about pain, offered snacks and fluids, and assisted with toileting. -8/16/2024: Resident 40 continuously yelling throughout the night. Resident 40 currently sitting in recliner in TV room with staff at their side. Nursing staff redirected, offered snack, and assisted resident with toileting. -7/4/2024: Resident 40 yelling for help continuously throughout shift. Resident 40 was also kicking the door in the dining area, stating they were scared. Resident 40 was placed in the recliner in the TV room, which was effective. Resident 40 calmed down and went to sleep. An interview on 9/12/2024 at 10:05 AM with Medication Aide (MA) - I revealed Resident 40 had behaviors of refusing to lay in their bed and hallucinations of people are going to hurt them, especially more towards the evening. MA-I revealed interventions that are effective include offering a snack, toileting, offering 1:1 time, talking about likes from the past, and placing in recliner in the TV room. An interview on 9/12/2024 at 10:08 with Registered Nurse (RN) - C revealed Resident 40 had a fear of being alone and did better when in common areas. If left alone, Resident 40 would begin to yell. RN-C revealed effective interventions for Resident 40's behaviors included participation in activities, especially church on Sundays and placing the resident in the recliner in the common areas. An interview on 9/12/2024 at 10:54 AM with the MDS Coordinator confirmed Resident 40's care plan was not comprehensive as it did not include specific behaviors or interventions to address Resident 40's behaviors.

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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. 49766 Licensure Reference 175 NAC 12- 006.09(F)(iii) Based on interviews and record review, the facility failed to revise the activities of daily living (ADLs) care plan to reflect current status for 1 (Resident 20) of 12 sampled residents. The facility identified a census of 47. Findings are: A record review of a facility policy Care Plans, Comprehensive Person-Centered with a last revised date of March 2022 revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change, at least quarterly. A record review of Resident 20's quarterly Minimum Data Set (MDS,) a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents, with a date of 7/11/2024 revealed Resident 20 required moderate assistance with eating and was dependent for oral hygiene, toileting, dressing, and personal hygiene. A record review of Resident 20's Care Plan under the ADLs section, with a revision date of 4/30/2023, revealed the following: -Resident 20 required extensive assistance with bathing, dressing, and personal hygiene. -Resident 20 required supervision with eating. An interview on 9/12/2024 at 10:47 AM with the MDS Coordinator confirmed Resident 20's care plan was not reflective of Resident 20's current status and should have been updated to reflect Resident 20's current needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5) Based on record reviews and interviews, the facility failed to implement interventions to prevent constipation for Resident 22. This affected 1 of 1 resident sampled for bowel care. The facility census was 47. Findings are: A record review of Resident 22's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). A record review of Resident 22's quarterly Minimum Data Set (MDS-a federally mandated comprehensive assessment of each resident's functional capabilities) dated 6/20/2024 revealed a Brief Interview for Mental Status (BIMS-a screening tool used to assess cognition [relating to the mental process involved in knowing, learning, and understanding things]. The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points indicates severe cognitive impairment; 8 to 12 points indicates moderate cognitive impairment; and 13 to 15 points indicates that cognition is intact) score of 02, indicating the resident had severe cognitive impairment. A record review of Resident 22's Point of Care (POC) Response History for bowel continence from 8/1/2024 to 9/11/2024 revealed the resident was documented for No Bowel Movement (BM) from 8/19/2024 to 8/30/2024 (12 days), and from 9/5/2024 to 9/9/2024 (five days). A review of Resident 22's Order Summary printed on 9/10/2024 revealed the following orders for medications to treat constipation: -Senokot S (a combination laxative and stool softener) 1 tablet by mouth scheduled routinely two times a day for constipation. -Senokot S 1 to 2 tablets by mouth daily as needed for constipation. -Miralax (a laxative) powder 1 scoop by mouth every 24 hours as needed for constipation. -Milk of Magnesia (MOM - a laxative) 30 milliliters (mL) by mouth every 24 hours as needed for constipation. -Dulcolax (a laxative) suppository (a form of medication inserted into the rectum) 10 milligrams (MG) insert 1 suppository rectally every 24 hours as needed for constipation. -Fleet Oil (a laxative) enema (fluid inserted directly into the rectum) insert 1 dose rectally every 72 hours as needed for constipation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 22's Medication Administration Record (MAR) for August 2024 revealed the resident received the as needed MOM on 8/23/2024, when it was marked ineffective, and on 8/27/2024, when it was marked effective. There was no documentation of the resident receiving the as needed Senokot S, Miralax, Fleet Oil enema, or Dulcolax suppository. A record review of Resident 22's MAR for September 2024, up to 9/11/2024, revealed the resident had not received the as needed Senokot S, Miralax, MOM, Fleet Oil enema, or Dulcolax suppository. A record review of Resident 22's Progress Notes printed on 9/11/2024 revealed a note from 8/27/2024 at 2:54 PM that stated hospice staff had been in the facility and instructed facility staff to administer an as needed bowel medication, as the last documented BM was 8/18/2024. On 8/27/2024 at 3:42 PM, as needed MOM was given, and on 8/27/2024 at 4:54 PM it was documented effective, indicating the resident had a BM. An interview on 9/11/2024 at 8:50 AM with Registered Nurse (RN)-B confirmed Resident 22 was not documented for a BM from 9/5/2024 to 9/9/2024 for a total of 5 days. RN-B further confirmed that the resident was incontinent of bowel, and required the use of a full lift for transfers. An interview on 9/11/2024 at 10:07 AM with the Nurse Practitioner (NP)-K from hospice confirmed Resident 22 had constipation and would periodically go four to five days without a bowel movement. An interview on 9/11/2024 at 11:52 AM with the Director of Nursing (DON) confirmed that the eight days from 8/19/2024 to 8/26/2024 was too long to go without a bowel movement. An interview on 9/12/2024 at 9:28 AM with the DON confirmed the facility did not have a bowel protocol. The DON stated they had a night shift duty sheet for the nurses that gave them direction on what to do. A record review of the undated Night Shift Responsibilities list provided by the DON revealed the following: 2. Bowel report-(Note who is on day 2, 3, or more without bowel movement and give to oncoming day nurse) -Give 3+ days suppositories, Days will give day 2 MOM An interview on 9/12/2024 at 10:45 AM with the DON confirmed that when Resident 22's MOM was not effective on 8/23/2024, the resident should have been given a PRN dose of Dulcolax. The DON further confirmed there was no further documentation of BMs between 8/19/2024 and 8/27/2024.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference Number 175 NAC 12-006.09(I) Based on record reviews and interviews, the facility failed to develop and implement interventions to prevent elopement for 1 (Resident 23) of 1 sampled resident. The facility census was 47. Findings are: A record review of a facility policy Wandering and Elopements with a revision date of March 2019, indicated in the policy statement, the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Under policy interpretation and implementation, the policy indicated if a resident was identified at-risk for wandering or elopement, the resident's care plan would include strategies and interventions to maintain the resident's safety. A record review of Resident 23's Wandering Risk Scale with a date of 2/13/2024 revealed Resident 23 was at-risk to wander and had a history of wandering. A record review of Resident 23's Progress Notes written by the MDS Coordinator, with a date of 3/3/2024 revealed Resident 23 had eloped and was found outside by the garage around 7:30 AM. Resident 23 was brought back in and taken to the dining room for breakfast. The nurse was in the main dining room when an aide brought resident and reported the aide had found Resident 23 outside again. The progress note did not reveal any evidence of interventions being implemented to prevent elopement. A record review of Resident 23's Care Plan revealed no evidence an elopement or wandering care plan was initiated prior to Resident 23's elopement on 3/3/2024. An interview on 9/10/2024 at 2:55 PM with the MDS Coordinator revealed the MDS Coordinator was attempting to get ahold of Resident 23's Power of Attorney (POA) to get consent to place a Wander guard when Resident 23 was found outside again. The MDS coordinator revealed 15-minute checks were being completed to prevent Resident 23 from eloping again after the first elopement. The MDS coordinator confirmed Resident 23 was identified to be at risk-for wandering and elopement on 2/13/2024 and confirmed a care plan with intervention should have been developed and implemented when Resident 23 was initially found to be at-risk for wandering and elopement on 2/13/2024. The MDS Coordinator confirmed interventions to prevent elopement for Resident 23 were not developed or implemented until 3/3/2024, when Resident 23 had eloped. A record review of Oglala Sioux [NAME] Nursing Home - SNF Documentation Survey Report vs, a report of nurse aide documentation of the 15-minute checks, with a date of March 2024 revealed no evidence 15-minute checks had been completed on 3/3/2024 from 6:00 AM-6:00 PM for Resident 23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 9/11/2024 at 11:52 AM with the Director of Nursing confirmed the 15-minute checks were placed as part of Resident 23's fall interventions, should have been documented as completed in the nurse aide documentation, and the facility did not have any evidence 15-minute checks or other interventions were put in place on 3/3/2024 to prevent Resident 23 from eloping again.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49766 Licensure Reference Number 175 NAC 12-006.09(J)(i)(1) Based on observations, interviews, and record reviews; the facility failed to implement new interventions to prevent significant weight loss for 1 (Resident 20) of 4 sampled residents. The facility census was 47. Findings are: A record review of a facility policy Weight Assessment and Intervention with a revision date of March 2022 revealed the following: -Weight loss of 7.5% in three months is considered significant. A weight loss of greater than 7.5% is considered severe. -Weight loss of 10% over six months is considered significant. A weight loss of greater than 10% over six months is considered severe. -Care planning for weight loss is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. -Individualized care plans shall address the identified causes of weight loss, goals, and timeframes for monitoring and reassessment. A record review of Resident 20's quarterly Minimum Data Set (a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents), dated 7/11/2024 revealed Resident 20 had a significant weight loss, was not on a prescribed weight loss program, and required a mechanically altered diet. A record review of Resident 20's weights revealed Resident 20 weighed 98.7 pounds (lbs) on 9/2/2024 and weighed 109.5 lbs on 6/3/2024, which was a -9.86% weight loss in three months, which is severe. On 3/4/2024, Resident 20 weighed 113.3 lbs, which was a -12.89% loss over six months, which is a severe weight loss. A record review of Resident 20's Order Summary revealed an order for pureed textured food due to loose teeth with a start date of 4/2/2024. A record review of Resident 20's Care Plan revealed Resident 20 had a potential for a nutritional problem due to dementia with behavioral disturbance and Type 2 Diabetes Mellitus, and had a goal that Resident 20 would maintain adequate nutritional status as evidence by maintaining weight within 5% of baseline weight of 135 and consuming at least 75% of all meals daily through review date with a target date of 7/21/2024. Interventions included the following: - Monitor, document, and report any signs of difficulty swallowing with a created date of 7/2/2021. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- Obtain and monitor lab/diagnostic work as ordered, reporting results to the physician and follow up as needed with a created date of 9/28/2020. - Provide and serve supplements as ordered: 2cal 180 milliliters after meals and at bedtime with a last revised date on 9/12/2023. - Provide and serve diet as ordered, including mechanical soft texture with a last revised date on 8/1/2023. - Registered dietitian to evaluate and make diet change recommendation as needed with an update on 7/28/2023 that stated to include easy to chew foods. A record review of a Nutrition/Dietary Note with a date of 6/11/2024 from the Registered Dietitian recommended to continue current nutrition interventions, offer a snack as necessary, and monitor intake and weights with following-up per protocol. A record review of a Nutrition/Dietary Note with a date of 7/3/2024 from the Registered Dietitian recommended to continue current nutrition interventions, offer snack as necessary, and monitor intakes and weights with following-up per protocol. A record review of a Nutrition/Dietary Note with a date of 8/12/2024 from the Registered Dietitian noted a significant weight loss over 180 days. The Registered Dietitian to implement Two Cal and snack as soon as Resident 20 wakes up. A record review of a Nutrition/Dietary Note with a date of 9/6/2024 from the Registered Dietitian noted a significant weight loss over 180 days. No new interventions were implemented to mitigate Resident 20's severe weight loss. An interview on 9/12/2024 at 12:34 PM with the Director of Nursing confirmed no new interventions were put into place to mitigate Resident 20's severe weight loss and confirmed Resident 20's care plan had not been updated with interventions to prevent Resident 20's severe weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on record reviews and interviews, the facility failed to ensure Resident 2 had a Positive Airway Pressure (PAP) device order that included settings. This affected 1 of 2 residents sampled for respiratory care. The facility census was 47. Findings are: A record review of the facility's CPAP/BiPAP [bilevel positive airway pressure] Support policy last revised March 2015 revealed that preparation for using a PAP device should include checking the physician's order to determine the pressure settings for the machine. A record review of Resident 2's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of muscular dystrophy (a group of genetic diseases that cause progressive weakness and loss of muscle mass). A record review of Resident 2's Order Summary printed on 9/10/2024 revealed an order for C PAP [continuous positive airway pressure - a machine that helps people breathe while they sleep by delivering a steady stream of air pressure through a mask or nosepiece] at bedtime for Oxygen to use full face mask nightly. one time a day with a start date of 7/29/2021. A record review of a written order dated 1/26/2017 for Resident 2 revealed an order regarding the PAP device with no settings included. A record review of a written order dated 2/01/2017 for Resident 2 revealed an order regarding the PAP device with no settings included. A review of the website for ResMed (a CPAP machine manufacturer) revealed that Once you've been diagnosed with sleep apnea, you'll receive a prescription from a doctor in order to acquire a CPAP machine and start therapy. The prescription will list a pressure setting, which is determined by the prescribing physician based on the results of your sleep study. https://www.resmed.com/en-us/sleep-apnea/sleep-blog/diagnosed -with-sleep-apnea/#:~:text=Once%20you've%20been%20diagnosed , results%20of%20your%20sleep%20study An interview on 9/12/2024 at 9:44 AM with Licensed Practical Nurse (LPN)-A confirmed there were no settings included in the PAP device orders for Resident 2. An interview on 09/12/2024 at 10:52 AM with the Director of Nursing (DON) confirmed that there were no settings in the order for the PAP device for Resident 2.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49766 Based on interviews and record reviews, the facility failed to attempt a gradual dose reduction as required for psychotropic medications (medications that treat mental illness) for 1 (Resident 16) of 5 sampled residents. The facility identified a census of 47. Findings are: A record review of a facility policy Psychotropic Medication Use with a revision date of July 2022 indicated residents on psychotropic medications should receive a gradual dose reduction (GDR) in conjunction with non-pharmacological interventions, unless clinically contraindicated, in an effort to discontinue these medications. A record review of Resident 16's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment that includes medical, psychosocial, cognitive, and functional status to assist with developing care plans for individual residents), with an Assessment Reference Date of 6/6/2024 revealed Resident 16 had a Patient Health Questionnaire, a questionnaire that screen for symptoms of depression, score of 0, which indicated the resident had no symptoms of depression. A record review of Resident 16's Order Summary with a date of 9/10/2024 indicated Resident 16 had an order for sertraline, an antidepressant, for major depressive disorder, with an order date of 6/27/2024. It also revealed an order for Trazodone, an antidepressant and sedative, for sleep with an order date of 1/9/2024. A record review of a Gradual Dose Reduction Request with a date of 4/16/2024 for Resident 16 stated the resident was currently taking sertraline and trazodone. Under behavior summary, it stated no behaviors noted since 12/31/2024. Under new orders, the physician wrote no change. A record review of a Gradual Dose Reduction Request with a date of 8/8/2024 for Resident 16 stated resident was currently taking sertraline and trazodone. Under behavior summary, it stated no behaviors. Under new orders, the physician wrote no change. An interview on 9/12/2024 at 11:00 AM with the Director of Nursing confirmed the facility had no evidence of documentation from the physician that a gradual dose reduction was clinically contraindicated for Resident 16 and confirmed a gradual dose reduction should have been attempted.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49766 Licensure Reference Number 175 NAC 12-006.10(D) Based on observations, interviews, and record review; the facility failed to administer medication at the right time and to ensure the medication error rate was less than 5% for 3 (Residents 11, 43, and 98) out of 5 sampled residents. The medication error rate was 35.71%. The facility census was 47. Findings are: A record review of a facility policy Administering Medications with a revision date of April 2019 indicated medications are to be administered within one hour of their prescribed time. A record review of Resident 98's Medication Administration Record with a date of September 2024 revealed an order for cephalexin, an antibiotic, with a prescribed time of 7:00 AM. An observation on 9/11/2024 at 8:20 AM revealed Medication Aide (MA) - H had administered Resident 98's cephalexin at this time. A record review of Resident 43's Medication Administration Record with a date of September 2024 revealed orders for Miralax and omeprazole, both with prescribed times of 7:30 AM. An observation on 9/11/2024 at 8:48 AM revealed MA-H had administered Resident 43's Miralax and omeprazole at this time. An interview on 9/11/2024 at 8:50 AM with MA-H confirmed Resident 98's cephalexin and Resident 43's Miralax and omeprazole were administered late due to the MA running behind. A record review of Resident 11's Medication Administration Record with a date of September 2024 revealed orders for rivastigmine, acetaminophen, gabapentin, potassium chloride, stool softener, thermotabs, and oxcarbazepine, all with a prescribed administration time of 8:00 AM. An observation on 9/11/2024 at 9:10 AM revealed Resident 11 crying out in pain and yelling for help. An interview on 9/11/2024 at 9:10 AM with MA-I confirmed this was Resident 11 that was yelling and that MA-I was aware that Resident 11's medications were going to be administered late, stating we try not to bother Resident 11 in the morning as much as possible. An observation on 9/11/2024 at 9:15 AM revealed Resident 11 continued to be in pain and had asked MA-I to assist them with repositioning due to them hurting. An observation on 9/11/2024 at 9:22 AM revealed MA-I had administered Resident 11's for rivastigmine, acetaminophen, gabapentin, potassium chloride, stool softener, thermotabs, and oxcarbazepine at this time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC 12-006.11(E) Based on observations, interviews, and record reviews; the facility failed to ensure foods were disposed of or consumed prior to best-by and use-by dates, and failed to ensure food practices were conducted as required to prevent the potential for foodborne illness. This had the potential to affect all 47 residents who resided within the facility and ate foods prepared in the kitchen. A. An initial kitchen tour observation on 9/9/2024 at 9:16 AM revealed the following: In the dry food storage area: -Eleven 32-ounce containers of [NAME] Ready-care no sugar added 1.7 high calorie high protein nutrition drink with best by date of 5/7/24. -Three 4-ounce cups of 'Gelatein 20' high protein gelatin with an expiration date of 7/20/24. -Fourteen 28-ounce packets of Jell-O brand dry chocolate pudding mix with an expiration date of 6/12/24. -Twelve 4-ounce cups of prune juice, with a best by date of 7/3/24. -Forty 4-ounce cans of [NAME] nacho cheese dip with a best by date of 4/6/24. -4 packs of graham crackers wrapped in plastic stored in a plastic storage container with no date on it. -One 1-gallon container of premium sweet pickle relish with the lid on top crooked and the inside seal opened. -One 6-pound can of crushed pineapple with a large dent in the side. In the walk-in refrigerator: -9 loaves of sliced bread in unopened clear bags, not labeled with a date. -1 bag of hamburger buns in an unopened clear bag, not labeled with a date. -4 bags of 30 dinner rolls each, in unopened clear bags, not labeled with a date, and firm to the touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 half-full 12-ounce Gatorade bottle, on a top shelf above food items that were to be served to residents. An interview on 9/9/24 at 11:28 AM with the Dietary Manager (DM) confirmed the items observed during the initial kitchen tour should have been dated with an opened-on and use-by date and consumed or disposed of by the use-by or best-by dates. The interview confirmed the pickle relish and can of crushed pineapple should have been discarded since the containers were damaged. Record review of facility policy, Food Receiving and Storage, with a last revised date of October 2017 stated, All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). The policy also stated, partially eaten food may not be kept in the refrigerator. An interview on 9/9/24 at 11:28 AM with DM confirmed that the graham crackers, bread loaves, hamburger buns, and dinner rolls were not labeled with a date and that the Gatorade did not belong in a cooler with resident foods since it was partially consumed and it was unknown who it belonged to. B. Record review of facility policy, Food Preparation and Service, with a last revised date of April 2019 stated, The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff. An observation on 9/11/24 at 9:53 AM revealed Cook-N removed steak from the oven and measured the temperature. The pan of steak was then put onto the steam table. An observation on 9/11/24 at 11:58 AM revealed Cook-N placed food on plates from pans in the steam table for the residents' lunch without first obtaining temperatures of the foods. An interview on 9/11/24 at 11:58 AM with Cook-N revealed they were serving the main dining room plates, and the lunch plates for the special care unit had already been served without checking the temperature of the food held in the steam table. An observation on 9/11/24 at 11:58 AM revealed the food held in the steam table included steak, barbeque ribs, steamed baby carrots, and baked potatoes. An interview on 9/11/24 at 11:59 AM with Cook-M revealed that their routine process was to check the temperatures of the foods after being removed from the oven but not prior to being served. The interview also revealed the mechanically altered texture foods had not been checked for safe temperatures. An interview on 9/11/24 at 12:06 PM with the Dietary Manager (DM) confirmed the typical routine was to check food temperatures when the cooking process was complete and the food was placed on the steam table, but not prior to serving, regardless of hold time on the steam table. The DM confirmed that the food should have been checked for the required temperature prior to serving.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.18(B); 12-006.18(D) Based on observations, record reviews, and interviews, the facility failed to ensure a PAP (Positive Airway Pressure-a machine that delivers just enough air pressure to a mask worn over the nose or mouth to keep the upper airway passages open) mask was cleaned per facility policy to prevent infection for 1 (Resident 2) of 2 sampled residents for respiratory care, failed to implement enhanced barrier precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes. EBP involves wearing a gown and gloves during high-contact resident care activities, such as wound care, for residents known to be colonized or infected with a MDRO as well as residents at increased risk of MDRO acquisition [for example, residents with wounds or indwelling medical devices]) for 1 (Resident 22) of 2 sampled residents for pressure injury, and the facility failed to ensure hand hygiene was performed during wound care for 1 (Resident 22) of 2 sampled residents for pressure injury, and between peri-cares and medication administration for 1 (Resident 11) of 5 residents observed during medication administration. The facility census was 47. Findings are: A. A review of the facility's CPAP/BiPAP Support policy last revised March 2015 revealed: General Guidelines for Cleaning 7. Masks, nasal pillows and tubing: Clean daily by placing in warm soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. 8. Headgear (strap); Wash with warm water and mild detergent as needed. Allow to air dry. A record review of Resident 2's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility on [DATE] and had a primary diagnosis of muscular dystrophy (a group of genetic diseases that cause progressive weakness and loss of muscle mass). A record review of Resident 2's Annual Minimum Data Set (MDS-a federally mandated comprehensive assessment of each resident's functional capabilities) dated 6/13/2024 revealed a Brief Interview for Mental Status (BIMS-a screening tool used to assess cognition [relating to the mental process involved in knowing, learning, and understanding things]. The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points indicates severe cognitive impairment; 8 to 12 points indicates moderate cognitive impairment; and 13 to 15 points indicates that cognition is intact) score of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 2's Order Summary printed on 9/10/2024 revealed an order for C PAP [continuous positive airway pressure - a machine that helps people breathe while they sleep by delivering a steady stream of air pressure through a mask or nosepiece] at bedtime for Oxygen to use full face mask nightly. one time a day with a start date of 7/29/2021. An observation on 9/9/2024 at 11:36 AM of Resident 2's room revealed a PAP machine on the nightstand next to the bed. The mask for the PAP was lying on the nightstand and had light colored debris inside it. An observation on 9/10/24 at 9:01 AM of Resident 2's room revealed a PAP machine on the nightstand next to the bed. The mask for the PAP was lying on the nightstand and had light colored debris in it. The inside of the cushion had a yellow residue on the surface. The head strap had dark discoloration on the inner surface that fit next to the head. During an interview with Resident 2 on 9/9/2024 at 3:52 PM the resident stated the nurses are supposed to come clean the mask every day. A record review of Resident 2's Order Summary printed on 9/10/2024 revealed orders to clean the PAP device every Saturday, and rinse the mask and tubing daily, dry it, and place it in a bag. An interview on 9/10/2024 at 12:30 PM with Registered Nurse (RN)-C confirmed that the PAP mask had light colored debris in it and the strap had dark discoloration on the inner surface that fit next to the head. An interview on 9/12/2024 at 10:52 AM with the Director of Nursing (DON) confirmed that the facility policy was not being followed regarding washing the mask with soap and water daily. B. A record review of the facility's Handwashing/Hand Hygiene policy last revised October 2023 revealed hand hygiene should be performed after contact with blood, body fluids, or contaminated surfaces; and before moving from work on a soiled body site to a clean body site on the same resident. A review of the undated CDC.gov (Centers for Disease Control) EBP sign on Resident 22's door revealed that staff must wear a gown and gloves for high-contact resident care activities including personal hygiene, changing briefs, and wound care. A review of the facility's Enhanced Barrier Precautions policy last revised August 2022 revealed that EBPs were used during high-contact resident care activities when contact precautions (a set of measures used to prevent the spread of infectious agents that can be transmitted by direct or indirect contact with a patient or their environment) did not apply regardless of MDRO status of the resident. The policy review further revealed that examples of high-contact resident care activities included providing hygiene, changing briefs, and wound care, and that personal protective equipment (PPE - equipment used to prevent or minimize exposure to infection such as gown, gloves, masks, and eye protection) should be available outside the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 22's Admission Record printed on 9/12/2024 revealed the resident was admitted to the facility 12/2/2020 and had a primary diagnosis of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). A record review of Resident 22's quarterly MDS dated [DATE] revealed a BIMS score of 02, indicating the resident had severe cognitive impairment. A record review of Resident 22's Comprehensive Care Plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) revealed a focus for impaired skin integrity last revised on 3/27/2024, with a goal of no complications r/t [related to] skin integrity to coccyx [tailbone]. An observation on 9/9/2024 at 11:46 AM revealed a CDC.gov EBP sign on Resident 22's door. There were no gowns outside or inside the room. An observation on 9/9/2024 at 1:00 PM revealed a CDC.gov EBP sign on Resident 22's door. There were no gowns outside or inside the room. An observation on 9/10/2024 at 9:07 AM revealed a CDC.gov EBP sign on Resident 22's door. There were no gowns outside or inside the room. An observation on 9/10/2024 at 2:02 PM revealed Nurse Aide (NA)-D and NA-L holding Resident 22 in position on their right side. The resident's buttocks were exposed with the dressing to the coccyx visible. Both NAs were wearing gloves but no gowns. NA-D stated the resident had been incontinent of bowel and they had just finished cleaning them up. NA-L then sanitized their hands and left the room. An observation on 9/10/2024 at 2:03 PM revealed RN-B was in Resident 22's room and had sanitized their hands and put on gloves but no gown. RN-B removed the old dressing from Resident 22's coccyx, measured the wound, removed their gloves, sanitized their hands, and put on new gloves. RN-B cleaned the wound, then without changing gloves, applied a new dressing. RN-B removed their gloves, and with bare hands patted the bottom edge of the dressing down and wrote the date and their initials on it, then sanitized their hands. NA-D continued to hold Resident 22 on their right side throughout the dressing change while wearing gloves and no gown. An interview on 9/10/2024 at 2:12 PM with NA-D confirmed that the NA was aware of what EBP were, and that EBP required the use of a gown and gloves when performing personal cares on someone with an open wound. The NA stated they had not worn a gown because there were none available in Resident 22's room. An interview on 9/10/2024 at 2:14 PM with RN-B confirmed that Resident 22 was on EBP for an open wound. The RN confirmed that the RN did not wear a gown during the dressing change and should have. An interview on 9/11/2024 at 4:45 PM with Licensed Practical Nurse (LPN)-A confirmed that gloves should have been changed and hand hygiene performed between cleaning a wound and applying a new dressing. 49766 (continued on next page)

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	28E300	A. Building B. Wing	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. A record review of a facility policy Handwashing/Hand Hygiene with a revision date of October 2023 indicated hand hygiene is indicated before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. An observation on 9/11/2024 at 9:15 AM revealed Medication Aide (MA) - I had entered Resident 11's room to administer medications. MA-I applied gloves and proceeded to perform peri-cares for Resident 11. MA-I then removed their gloves and then proceeded to administer medications to Resident 11 without the benefit of performing hand hygiene prior. An interview on 9/11/2024 at 9:30 with MA-I confirmed MA-I had not performed hand hygiene and should have between peri-care and medication administration for Resident 11.