STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E303	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock County Hospital Long Term Care	100 East South Street Bassett, NE 68714

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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l) Based on observations, record review, and interview; the facility failed to identify causal factors for the development and/or revision of fall prevention interventions and to implement fall interventions for 4 (Residents 1, 2, 3, and 4) of 4 sampled residents. The facility census was 20. Findings are: A. Review of the Fall Prevention and Treatment Long Term Care policy dated 6/25revealed the purpose of the policy was to prevent any unintended falls. Each resident was assessed for fall risk and was to receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident was to be screened at admission, quarterly and with any significant change of status. The following procedure was identified:-upon admission, the nurse will complete the Morse Fall assessment along with the nurse assessment to determine the resident's level of fall risk. -the nurse would indicate on the resident's care plan what the residents fall risk was and then would initiate interventions on the baseline care plan in accordance with the resident's risk level.If the resident was at high risk for falls, the following protocols would be initiated:-the resident would be placed on the facility's Fall Prevention Program with a falling star on the resident's door and indicate fall risk on the care plan.-maintain a clear path to the bathroom.-keep the bed locked and lowered to the lowest position that allowed the resident's feet to touch the floor when sitting on the edge of the bed.-call light and frequently used items to be kept within reach.-adequate lighting.-monitor the resident's balance, cognition, gait, ability to rise, and/or sit.-ensure shoes or slippers with no slip soles.-increased frequency of rounds.-medication regimen review.-call pendants.-Physical Therapy or Occupational Therapy referrals. If the resident had a fall, the facility would: assess the resident with a full set of vitals; notify the physician and family; leave a message for the Director of Nursing (DON), do a risk management report; review and update the resident's care plan; document all actions and assessments; obtain witness statements in the case of injury; monitor the resident for 24 hours post fall and document any changes in the residents functional status, cognitive status and vitals; and communicate to all shifts that the resident had fallen and was at risk to fall again. B. Review of Resident 1's MDS dated [DATE] revealed the resident was admitted on [DATE] with diagnoses of diabetes, high blood pressure, Non-Alzheimer's dementia and insomnia. The following was assessed regarding the resident: -severe cognitive impairment. -behaviors which included rejection of cares and wandering. -substantial to maximal assistance with toileting and dressing. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-setup assist with transfers. -independence with bed mobility. -frequently incontinent of bowel and bladder. Review of an Incident Report dated 5/16/26 at 11:50 PM revealed the resident was found lying on the floor of the resident's room. The resident reported sliding out of bed. The resident was assisted per request to the bathroom and then to the recliner in the resident's room. New intervention developed for bed/chair alarms. Review of an Incident Report dated 5/21/26 at 3:00 AM revealed the resident was found on the floor in front of the recliner in the resident's room. A new intervention was identified to place fall alarms in areas the resident could not visualize. Further review of the report revealed no indication as to whether the bed/chair alarm was in place and functional or whether the alarm was sounding at the time the resident was found. There was no evidence causal factors for the fall were investigated/identified. During an interview on 6/8/26 at 11:05 AM, the DON indicated at the time of a fall, the Charge Nurse was responsible for completing an Incident Report and this should be completed by the end of their shift. The nurses are to look at causal factors and then implement an immediate intervention. The DON or designee would then do a follow up investigation and would review the Incident Report to determine if current interventions were appropriate or if a different intervention was needed. Confirmed with Resident 1's fall on 5/21/26 at 3:00 AM, the Incident Report does not clarify if the resident's alarm was in place or the causal factor for the resident's fall. The intervention to place the bed/chair alarms in areas the resident could not reach or visualize was developed because the resident had a history of dismantling electronics in the resident's room. C. Review of Resident 3's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 3/31/26 revealed the resident was admitted [DATE] with diagnoses of Non-Alzheimer's dementia, traumatic brain injury, and history of falling. The following was assessed regarding Resident 3: -cognition was moderately impaired. -behaviors which included wandering which occurred 1-3 days of assessment period. -required supervision/touching assistance with transfers and personal hygiene; partial to moderate assistance with toileting; and substantial to maximal assistance with dressing. -occasionally incontinent of urine. -frequent, moderate pain which affected ability to sleep and day to day activities. -no falls since the previous assessment. Review of an Incident Report dated 2/16/26 at 9:30 AM revealed the resident had an unwitnessed fall. The resident went to the bathroom by the Nurse's Station independently. The resident's shoe came off while toileting and caused the resident to fall. The report indicated an intervention to educate the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff that the resident might continue to require stand by assistance related to sitting, bathroom care, walking, turning, and sitting safely. The report further indicated the resident had impaired memory but failed to identify the resident's mental status, level of pain, or predisposing environmental factors. Review of an Incident Report dated 6/5/26 at 7:45 PM revealed the resident was found on the floor in front of a chair by the Nurse's Station. The resident identified reaching for something on the floor and falling out of the chair. The report indicated the resident had impaired memory and had attempted to transfer without assistance. An intervention was identified to check with the resident at 7:00 PM and to help the resident to bed early if desires. In addition, staff were to keep the area surrounding the resident neat and clean to prevent the resident from trying to pick items up off the floor. Review of an Incident Report dated 6/7/26 at 9:35 PM revealed the resident was heard calling out for assistance. The resident was found on the floor next to the resident's bed. The resident reported hearing a noise and got up to investigate. The report indicated the resident had impaired memory and was ambulating without assistance. An intervention was identified to keep the resident's walker in reach of the resident and to provide the resident with frequent reminders to keep the resident orientated to who, what, where and when. Further review of the report revealed no evidence as to where the walker was located at the time of the fall. During an interview on 6/8/26 at 12:00 PM, Nurse Aide (NA)-G verified the resident was at increased risk for falls. During the day shift, the staff would keep the resident in an area of constant supervision, normally next to the Nurses' Station. If the resident tried to get up or to reach down, the staff would redirect the resident and assist with cares. The resident was unable to remember cues or reminders and staff needed to provide the resident with close monitoring. An Interview with the DON on 6/8/26 at 12:30 PM confirmed the following regarding the residents' falls: -2/16/26 at 9:30 AM the resident was found on the floor of a public bathroom by the Nurses' Station. The resident recently had fall alarms discontinued and therapy had determined the resident could be independent with ambulation. The resident had indicated a shoe came off when in the bathroom as the cause of the fall. No interventions regarding assessment of the resident's footwear or need for different shoes. The staff were to provide the resident with reminders regarding safety when sitting, walking, transfers, and bathroom cares however, the resident had impaired cognition and memory loss so unable to determine if this was an effective/measurable intervention. -6/7/26 at 9:30 PM the resident had a fall next to the resident's bed. An intervention was identified to make sure the resident's walker was at beside and to provide frequent reminders to the resident as to who, what, when and where to help keep the resident orientated. Further review of the report revealed no documentation as to where the walker was at the time of the residents' fall. In addition, due to memory loss and impaired cognition, providing the resident with frequent verbal cues was not an effective and/or measurable intervention. C. Record review of Resident 2's fall report revealed that on 2/22/26 at 10:00 PM Resident 2 was noted to be lying on the floor on a blue mat next to the bed and the bed was in low position. The resident was oriented to person, no predisposing environmental or situational factors noted, the resident appeared to be more restless. New fall interventions put into place were: 1) residents' bed was moved against the wall, 2) bed bolsters to remind the resident not to get out of bed, 3) bed placed in the lowest position and 4) mats on floor in case the resident does roll out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's care plan revised 3/11/26 revealed the following: -The resident was admitted to the facility on [DATE]. -had impaired thought process, diagnosis of dementia. -was a high fall risk for falls. -was dependent on staff for transfers. -dependent on staff, 2 assist for bed mobility. -bed bolsters to remind resident to stay in bed. -place bed in low position at all times, except during cares. -place bed against the wall to prevent the resident from falling out of the bed on the right side. -fall mat by the resident's bed. An observation on 6/8/26 at revealed that the resident was laying in bed with eyes closed, bed was in the lowest position, fall mat was on the right side of the bed and a bolster was on the left side of the bed. The bed was not against the wall. An interview with RN-B on 6/8/26 at 11:30 AM confirmed that Resident 2's fall interventions were: 1) keep the bed in the lowest position when staff were not in the room, 2) fall mat on the right side of the bed and 3) bolster to the left side of the resident in bed. RN-B was unsure when the current fall interventions were put into place. RN-B confirmed that the bed was not against the wall per the resident's care plan and the bolster was only on the left side of the bed (not both per care plan). D. Review of Resident 4's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 4/7/26 revealed a Brief Interview for Mental Status score of 9 (moderate cognitive impairment). Resident had 2 or more falls with no injuries, was occasionally incontinent of urine and always continent of bowel. Review of Resident 4's care plan with a revision date of 4/15/26 revealed the following: -had impaired cognitive function related to diagnosis of dementia. -had short- and long-term memory loss and made poor decisions at times. -required extensive one assist with repositioning, dressing and transfers. -does not ambulate. -used a wheelchair for locomotion with staff taking to meals and activities (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 4's fall report revealed that on 3/26/26 at 7:10 AM the resident was on the floor on the mat. The resident was oriented to person, received no injuries, was confused, drowsy, incontinent of bowel movement and had impaired memory. New fall interventions put into place were: 1) do a visual check when staff walk by the room [ROOM NUMBER]) bolsters will be added to the bed to help from rolling out of bed. The facility did not identify the bowel incontinence as a causative factor. Record review of a fall reported dated 3/29/26 at 2:30 AM revealed Resident 4 was being assisted back to bed after being assisted to use the bathroom. The resident slid forward out of the wheelchair onto the floor. The resident was oriented to person and situation, no injuries were received, there were no predisposing environmental, physiological or situation factors. New fall intervention put into place where to change the resident in bed. Record review of a fall report dated 5/20/26 at 2:04 AM revealed Resident 4 was sitting on the floor off the fall mat, the call light was not on, and the bed was in low position. No injuries were received, the resident had gait imbalance and impaired memory, and the resident was attempting to get out of bed without assistance. Interventions were put into place to remind the resident to use call light for assistance. An interview completed with the DON on 6/8/26 at 1:15 PM confirmed that the facility did not identify bowel incontinence as a causative factor for the fall on 3/26/26. In review of the fall on 3/29/26 the resident used the bathroom for toileting cares, the resident would sit up on the edge of the bed when needing to use the bathroom and if staff were not in the room immediately the resident would attempt to get up. The intervention to change the resident in bed was not appropriate. In review of the fall on 5/20/26 the resident does not always use the call light and will request the roommate to turn the call light on. The intervention to remind the resident to use the call light for assistance was not appropriate.