STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - 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** 45641 Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review; the facility failed to ensure interventions were followed for 1 (Resident 22) of 1 sampled resident to prevent potential accidents. The facility census was 83. Findings are: A record review of Resident 22's Clinical Summary Report dated 9/12/2024 revealed the resident was admitted to the facility on [DATE]. The resident had diagnoses of chronic diastolic congestive heart failure (CHF), age-related osteoporosis (weak bones), Post COVID-19, Type 2 diabetes mellitus with diabetic polyneuropathy (uncontrolled blood sugar that affects the nerves in the arms, hands, kegs, and feet), weakness, and cigarette nicotine dependence. A record review of Resident 22's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to develop a resident's care plan) dated 7/30/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 15 of 15 which indicated the resident was cognitively aware. The resident was dependent on staff for all activities of daily living (ADLs) except eating and oral hygiene (cleaning). The resident had arthritis and asthma. The resident was a current tobacco user. The MDS did not reveal the resident had skin problems or burns. A record review of Resident 22's St. [NAME] de [NAME] LTC (long term care) Care Plan dated 7/22/2024 revealed the resident had a problem of at risk for injury due to smoking cigarettes. At times does not get cigarette properly disposed. Apron in front during smoking sessions, takes walkie talkie outside to call nursing back when finished. There were interventions of: smokes safely, monitor for proper disposal of cigarettes, wear smoking apron over legs, feet, and foot pedals when outside smoking. Supervised for safely lighting the cigarette, cigarette ring holder. Keeps smoking material in medication room or nursing treatment cart. Resident to use designated smoking areas when going outside to smoke. Smoking Assessment quarterly (every 3 months) and as needed (PRN). Assess respiratory status after smoking PRN. There were also comments of: -4/28/2020 - had a lit cigarette in foot pedal when coming in from smoking. (continued on next page)

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
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	-2/16/2022 - resident dropped cigarette into right slipper burning a hole in slipper and sock. Did receive a burn to the right inner foot. -8/31/2022 - resident caught smoking in the room. -12/19/2023 - resident found smoking in the room. -7/11/2024 - resident complained of pain in hands and fingers and had difficulty holding cigarettes. -7/16/2024 - resident complained of pain in hands and fingers. -7/22/2024 - resident had a drop in blood pressure after smoking several cigarettes. -7/24/2024 - staff limited resident to 2 cigarettes. -7/30/2024 - Occupational Therapist reported burn to right middle finger. -7/30/2024 - noted old burn marks between second and third fingers on the right hand. Areas are scabbed, no redness or infection. Resident had a hard time holding cigarettes between fingers, so it slides down. Ordered a Cigarette ring holder for resident to try. A record review of Resident 22's Transfer/Discharge/Active Orders dated 9/12/2024 revealed the resident had an order for staff to apply a smoking apron on resident during smoking 3 times per day but did not reveal a smoking assistive device or that supervision was required. A record review of Resident 22's Quarterly Smoking assessment dated [DATE] revealed there was no change in the smoking assessment, Resident 22 smoked safely with minimal supervision and a smoker's apron. The resident kept smoking material in the resident's room. A record review of Resident 22's Risk Assessment/Screening LTC dated 7/29/2024 revealed there was no change in the smoking assessment, Resident 22 smoked safely with minimal supervision and a smoker's apron. The resident was to limited to smoking to 1-2 cigarettes due to becoming hypotensive (low blood pressure), nursing to keep smoking material in the treatment cart. An observation on 9/9/2024 at 12:56 PM revealed Resident 22 had a burn on their right hand between the index and middle fingers. An observation on 9/10/2024 at 11:47 AM revealed a Nursing Assistant (NA) assisted Resident 22 in a wheelchair down the hall and out of the North center exit of the building with a smoking vest on. The resident had a burn on their right hand between the index and middle finger. The NA assisted the resident with getting the ashtray close, left the resident, and returned to the resident's hallway. The resident got a cigarette and lighter out and lit the cigarette. The resident then got a white extension piece out and struggled but did get it placed it on the filter end of the cigarette. The resident continued to smoke the cigarette, holding it by the paper portion not the holder, between their index and middle finger of their right hand. The resident was in the smoking area alone and there were no staff outside or inside that could see or supervise the resident from 11:47 AM until 12:18 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	An observation on 9/11/2024 at 11:35 AM revealed Resident 22 was sitting alone outside smoking at the end of the North center hall. The resident had a different cigarette adaptive device that weaved around the fingers and held the cigarette away from the fingers. There was an NA that was in and out of the area, would get on the computer, and watch a different resident eat. Resident 22 was observed struggling with getting a cigarette in the adaptive device enough that the resident gave up and placed the cigarette between the index and middle finger, light it, and continued to smoke. The resident then dropped the cigarette on the table, the ashtray was smoking, and the resident dropped a cigarette on the ground below the resident, and the resident just lit another cigarette. The NA that was in and out of the area did not respond to any of the previous mentioned concerns. In an interview on 9/10/2024 at 12:56 PM, Resident 22 confirmed the resident smoked and had a recent burn between the index and middle finger of the right hand. The resident confirmed the cigarette slid down between the fingers and the resident had a new adaptive device, but it was missing, and the resident had to use an old one. In an interview on 9/10/2024 at 3:55 PM, Resident 22 confirmed the resident got burns from smoking about every 3-4 days when a cigarette would slide down between the resident's fingers. Resident 22 used to get burned clothes a lot, but now the resident had a smoking apron. The resident confirmed the resident had only 1 burn since the smoking apron when the resident dropped a cigarette between the chest and the apron, so now the resident had the staff tighten the apron more around the neck. The resident's newest adaptive device had been missing 4-5 days and the staff was aware but couldn't find it. In an interview on 9/12/2024 at 12:26 PM, Licensed Practical Nurse (LPN)-B confirmed the staff did not supervise Resident 22 when smoking. LPN-B confirmed the resident had a burn on the right hand between the index and middle finger and the resident did not report it to the staff. In an interview on 9/12/2024 at 1:06 PM, Occupational Therapist (OT)-C confirmed Resident 22 should have a black, ring style adaptive smoking device, but it was stretched out and the staff has had to try and tape it to stay on. OT-C confirmed the resident had poor hand dexterity (use of hands), was unable to load cigarettes in the devices, and the resident has had multiple burns. In an interview on 9/12/2024 at 1:15 PM, LPN-A, who was a charge nurse, confirmed Resident 22 was allowed to smoke with minimal supervision. Minimal supervision meant the staff could observe from a distance. LPN-A confirmed the facility did not have enough staff to supervise the resident one-on-one while smoking and the staff should at least be in the lounge right inside the building by the smoking area to supervise the resident while smoking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613 Licensure Reference Number 175 NAC 12-006.10 Based on observation, record review, and interview; the facility failed to ensure that residents were free of significant medication errors while administering insulin (a medication used to reduce the amount of blood sugar in the blood of residents with diabetes) to 1 (Resident 56) of 1 residents sampled. The facility census was 83 at the time of survey. Findings are: Record review of the facility's policy titled Medication Safety with a last reviewed date of 7/22/24 revealed that the short acting insulin administration schedule was based around meal delivery times. Record review of undated Admission Record revealed that Resident 56 was admitted into the facility on [DATE]. Record review of Resident 56's list of diagnoses revealed a primary diagnosis of incomplete quadriplegia (paralysis that affects all of a person's limbs) due to spinal cord lesion between 1st and 4th cervical vertebra. Also listed were respiratory failure and Type 2 Diabetes Mellitus (a condition that occurs when the body does not produce enough insulin or doesn't use insulin properly). Record review of Resident 56's quarterly Minimum Data Set (MDS -a federally mandated comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 8/7/24 revealed in section C a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 15, which indicates the resident was cognitively intact. Insulin injections were marked as administered 7 days during the look back period (standard 7 day time frame for assessment). Record review of Resident 56's undated 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 Resident 56 required extensive assist with ADL's related to quadriplegia from a motor vehicle accident (MVA) and contractures. Also revealed Resident 56 has the potential for hypo/hyperglycemia. Interventions included to monitor for signs and symptoms of hypoglycemia, and to give insulin as ordered. Record review Resident 56's of physician orders revealed the following: -Insulin Lispro PEN (DPS/humaLOG) Sliding Scale Insuline (SSI) (Moderate) Unit(s) -0 Unit(s) if Blood Glucose (BG) 60 - 149 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2 Unit(s) if BG 150 - 199, -4 Unit(s) if BG 200 - 249, -6 Unit(s) if BG 250 - 299, -8 Unit(s) if BG 300 - 349, -10 Unit(s) if BG 350 - 399, -12 Unit(s) if BG 400 - 999, -SubCutaneous, 4 times/day with meal/bedtime. -time critical medication. -if BG below 70 initiate hypoglycemia protocol; if BG above 400 notify physician. Observation on 9/9/24 at 1:16 PM revealed Licensed Practical Nurse (LPN) - H entered into Resident 56's room to obtain the resident's accucheck (blood glucose) and give the insulin after resident had returned to their room after eating lunch in the dining room. The resident's accucheck was 225 and LPN-H gave the resident 4 units of humalog insulin per the resident's sliding scale orders. Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 56 revealed that LPN-H completed the accucheck and gave 4 units of insulin on 9/9/24 at 1:19 PM. Interview on 9/11/24 at 11:27 AM with LPN - H confirmed that on 9/9/24 the resident's accucheck and insulin were completed late and should have been done before the resident ate lunch. Record review of Resident 56's most recent Hemoglobin A1c (lab levels used to monitor how well diabetes is being managed) dated 12/20/2023 was 6.7 which was out of the normal range of 4.0-6.0. Record review of Resident 56's accuchecks for July, August, and September 2024 revealed a range in blood sugars from 94 - 253. Interview on 9/12/24 at 8:48 AM with LPN - A, the unit coordinator, confirmed that the expectation was that accuchecks and insulin were to be done before the resident ate the meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.18(B) and (D) Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene (cleaning) and glove changes when going from a contaminated process to a clean process during wound care for 2 (Residents 3 and 77) of 5 sampled residents, failed to ensure 1 (Resident 38) of 6 sampled resident's mechanical in-exsufflator (a machine used to help produce a cough) circuit was changed monthly, and failed to rinse the nebulizer (neb)(a machine used to deliver liquid medication to the lungs) kit after each use and change weekly for 1 (Resident 56) of 6 sampled residents to prevent cross-contamination. The facility census was 83. Findings are: A. A record review of Resident 3's Transfer/Discharge/Active Orders dated 9/12/2024 revealed the resident had a wound care order on the right anterior (in front) foot wound for staff to apply a Mepilex (border dressing); Xeroform (petroleum-based gauge wound dressing) dressing on Mondays, Wednesdays, and Fridays. Cleanse with soap and water; 3M no sting skin preparation (prep). An observation on 9/11/2024 at 10:54 AM revealed Licensed Practical Nurse (LPN)-F completed hand hygiene, applied gloves, got supplies out of a cabinet in the room, removed existing Mediplex and Xeroform on Resident 3's right anterior foot, and discarded. LPN-F then cleansed the wound with soap and water, dried, wiped wound with a 3M no sting prep stick, and applied a new Xeroform and a new Mepilex. The observation did not reveal LPN-F changed gloves or performed hand hygiene when going from the contaminated process to the clean process. In an interview on 9/11/2024 at 10:54 AM, LPN-F confirmed LPN-F did not change gloves or perform hand hygiene when going from the contaminated process to the clean process during Resident 3's wound care on the right anterior foot wound. B. A record review of Resident 77's Transfer/Discharge/Active Orders dated 9/12/2024 revealed the resident had orders for wound care for the posterior (behind) neck wound and staff was to cleanse with soap and water, dry thoroughly after cleaning. Apply dry Therabond (absorbent silver-plated nylon three-dimensional fabric wound dressing), waffle side down, to wound. Cover with 4x8 white Mediplex lengthwise daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	An observation on 9/11/2024 at 7:26 AM revealed Registered Nurse (RN)-G performed tracheostomy (trach) care and posterior neck wound care on Resident 77. RN-G got supplies, performed hand hygiene, applied gloves, gown, and mask. RN-G cleansed trach stoma site with normal saline (NaCL)(sterile mixture of water and salt) on swabs, removed trach tie, removed posterior neck dressings, cleansed neck wound with soap and water, applied Therabond, applied Mepilex, applied new trach tie and 4 inch by 4 inch (4x4) split sponge around trach. RN-G then placed the resident's cervical collar (a neck brace) on the resident. RN-G removed mask, gown, and gloves and performed hand hygiene. The observation did not reveal that RN-G performed glove changes and hand hygiene when going from the contaminated process to the clean process during wound care. In an interview on 9/11/2024 at 11:08 AM, RN-G confirmed RN-G should have performed glove changes and hand hygiene when going from the contaminated process to clean process during Resident 77's wound care. C. A record review of the facility's Cough Assist Mechanical In-Exsufflator (M.I.E) policy with a last review date of 1/6/2023 revealed the staff was to complete circuit (tubing, mask, and filter) changes monthly and as needed (PRN). The staff was to date the filter when the circuit was changed. A record review of Resident 38's St. [NAME] de [NAME] LTC (long term care) Care Plan dated 9/10/2024 revealed the resident had a problem area of altered respiratory status related to respiratory failure, frequent pneumonia, excessive oral secretions (extreme amount or thickness of moth saliva), and apnea (stops breathing), and continue M.I.E. The comments revealed 6/20/2024 the resident went on hospice, and the hospice company delivered the M.I.E. The Care Plan did not reveal the frequency (how often) of circuit changes. A record review of Resident 38's Transfer/Discharge/Active Orders dated 9/12/2024 revealed the resident had orders for M.I.E 2 times per day (BID) at a pressure setting -35 +40 centimeters of water pressure (cmH2O). The Transfer/Discharge/Active Orders dated 9/12/2024 did not reveal the M.I.E. circuit was to be changed. A record review of Resident 38's Worklist Current Visit dated 7/14/2024 to 9/12/2024 did not reveal that the resident's M.I.E.'s circuit had been changed. An observation on 9/9/2024 at 11:14 AM revealed Resident 38's M.I.E.'s circuit and filter were not dated, the mask was in a plastic bag and the mask had facial oils on it. An observation on 9/10/2024 at 11:40 AM revealed Resident 38's M.I.E.'s circuit and filter were not dated, the mask was in a plastic bag and the mask had facial oils on it. An observation on 9/11/2024 at 8:05 AM with LPN-D revealed Resident 38's M.I.E.'s circuit and filter were not dated, the mask was in a plastic bag and the mask had facial oils on it. In an interview on 9/11/2024 at 8:05 AM, LPN-D confirmed Resident 38's M.I.E. mask had facial oils on it and LPN-D cleaned it before administering the M.I.E. treatment. LPN-D also confirmed the M.I.E. circuit was to be changed weekly, the filter should be dated but was not, and LPN-D was not sure the last time the circuit had been changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	In an interview on 9/12/2024 at 12:38 PM, LPN-A, who was the unit manager for the 400-hall, confirmed Respiratory Therapy used to change Resident 38's M.I.E. circuit but that had been changed to nursing. LPN-A confirmed the M.I.E. circuit had not been changed since the resident went on hospice on 6/20/2024 and the hospice company delivered their M.I.E., and it should have been changed monthly. 45613 D. Record review of an undated Admission Record revealed that Resident 56 admitted into the facility on [DATE]. Record review of an undated list of diagnoses for Resident 56 revealed a primary diagnosis of incomplete quadriplegia (paralysis that affects all of a person's limbs) due to spinal cord lesion between 1st and 4th cervical vertebra, and also a diagnosis of respiratory failure. Record review of Resident 56's quarterly Minimum Data Set (MDS -a federally mandated comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 8/7/24 revealed in section C a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 15, which indicated the resident was cognitively intact. Record review of Resident's 56's undated 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 that the resident has a potential for infection related to respiratory failure. Interventions included DuoNeb twice daily and to report any signs of respiratory distress. Observation on 9/9/24 at 1:42 PM of a neb treatment kit dated 8/27, laying on Resident 56's nightstand with a liquid noted in the chamber. There was a clear plastic treatment bag used for infection control purposes dated 8/20 hanging on the resident's wall. Observation on 9/10/24 at 10:01 AM of neb treatment kit dated 8/27, laying on Resident 56's nightstand with liquid noted in the chamber. There was a clear plastic treatment bag used for infection control purposes was dated 8/20 hanging on the resident's wall. Observation on 9/11/24 at 11:29 AM of neb treatment kit dated 8/27, laying on Resident 56's nightstand with liquid noted in the chamber. There was a clear plastic treatment bag used for infection control purposes dated 8/20 hanging on the resident's wall. Interview on 9/11/24 at 11:31 AM with LPN - H confirmed that the neb kit should have been changed weekly and it was not done, it was further confirmed that the neb kit should have been rinsed out after each use and had not been done and the infection control bag had not been changed and it should have been. Record review of Resident 56's physician orders revealed: -Change nebulizer kit every Tuesday at 4:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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 - Few	-Albuterol/ipratropium inhaler (DuoNeb) 2.5/0.5/3 milliliters (ml) solution twice daily. During an observation on 9/12/24 at 10:41 AM with LPN - A, the unit coordinator it was confirmed that the infection control bag was dated 8/20 and that there was liquid medicine in the chamber and it had not been rinsed out. Interview on 9/12/24 at 10:42 AM with LPN-A, the unit coordinator confirmed that the clear plastic bag used for infection control purposes that was hanging on the resident's wall had not been changed and that there was still liquid medicine in the neb kit and it had not been rinsed out. Interview on 09/12/24 at 10:43 AM with Resident 56 confirmed that (gender) took the breathing treatments in the morning and in the evening and that the neb treatment was done that morning and no one rinsed out the kit out after the treatment. Record review of facility's policy titled Aerosol Therapy with a last reviewed date of 2/23/24 revealed aerosol med nebulizers will be rinsed using a saline, sterile or tap water following treatments. Return nebulizer to treatment bag when not in use. Aerosol med nebulizers and treatment bag will be changed weekly and prn if damaged or soiled. Nebulizers kits and treatment bags will be dated.