

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Tabitha Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4720 Randolph Street Lincoln, NE 68510	

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 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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)Based on record reviews and interviews, the facility failed to assess Resident 6 for a change of condition. This affected 1 of 4 residents sampled for changes of condition. The facility census was 132.Findings are:A record review of Resident 6's admission Record dated 09/30/2025 revealed the resident was admitted to the facility on [DATE] from an acute care hospital and discharged [DATE] to an acute care hospital. Further review of the admission Record revealed the resident had diagnoses of a right leg trimalleolar fracture (a fracture of three of the four ankle bones) that was surgically repaired, localized edema (swelling caused by fluid retention in the tissues), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (CHF-a long-term condition in which the heart is unable to pump enough blood to meet the body's needs), an irregular heart rate, chronic kidney disease (CKD-a gradual loss of kidney function, resulting in the inability to filter waste and excess fluid from the blood), and acute kidney failure (a sudden [within hours or day] loss of the kidneys' ability to filter waste and excess fluids from the blood).A record review of Resident 6's 5-day Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 09/01/2025 revealed the resident had 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) score of 15.A record review of Resident 6's Skilled Nursing Facility Physician admission Orders electronically signed by the physician on 08/28/2025 revealed the resident was in the facility for a Medicare skilled stay.A record review of the Order Summary Report dated 09/30/2025 that listed Resident 6's Active Orders as of 09/05/2025 revealed an order for DRESSING/INCISION CARE: Keep splint C/D/I [clean/dry/intact] until f/u [follow/up] appt. scheduled for every shift with a start date of 08/26/2025.A record review of Resident 6's hospital Discharge Summary dated 08/26/2025 revealed the resident was admitted to the hospital on [DATE] with the right ankle fracture after having fallen at home, and surgery to repair the right ankle was done on 08/20/2025.A record review of Resident 6's admission Assessment dated 08/26/2025 revealed that on admission the resident had strong pulses in both wrists and in the left foot, and a weak pulse in the right foot. Further review revealed the resident also had edema (swelling caused by fluid retention) in both legs. There was no mention of a cast or splint present to Resident 6's right leg.A record review of Resident 6's Progress Notes from 08/26/2025 to 09/30/2025 revealed the following:A Communication note dated 08/26/2025 at 11:00 PM from nursing that did not address edema, the neurovascular status (NV status-checking for pulses, skin temperature, color, and sensation) of the right foot, or the cast/splint on the right leg.A Medicare note dated 08/28/2025 at 3:35 PM from nursing that did not address edema, NV status, or the cast/splint on the right leg.A Nutrition note dated 09/02/2025 at 11:12 AM from the registered dietitian that stated there was no edema documentation noted.A Medicare note dated 09/02/2025 at 3:51 PM from nursing that did not address edema, NV status, or the cast/splint on the right leg.A Labs note dated 09/03/2025 at 11:37 AM from nursing that stated blood had been drawn for labs.A Care Conference note dated 09/03/2025 at 12:12 PM as a late entry from nursing that did not address edema, NV status, or the cast/splint on the right leg. The note did state that the resident had a six pound weight gain since admission.A Medicare note dated 09/03/2025 at 8:33 PM that stated the cast was in place. The note did not address edema or NV status of the right leg.A Medicare note dated 09/05/2025 at 2:54 PM from nursing stated the resident had edema to both legs. The note did not address NV status or the cast/splint to the right leg.A Transfer to ER/Hospital note dated 09/05/25 at 4:28 PM that stated the resident was transferred to the hospital by ambulance due to a change in condition, elevated creatinine (a waste product in the blood that measured how well the kidneys were functioning), weight gain and lethargy (drowsiness and an unusual lack of energy and mental alertness).A Communication note dated 09/06/2025 at 11:17 AM that stated Resident 6 had been admitted to the hospital for acute kidney injury (AKI-also called acute kidney failure).There were no other Progress Notes that addressed Resident 6's physical condition. There were four Medicare notes between admission [DATE] and discharge 09/05/2025.A record review of Resident 6's weight record revealed the following weights, measured in pounds:08/26/2025-none recorded08/27/2025-305.008/28/2025-none recorded08/29/2025-305.008/30/2025-309.008/31/2025-311.009/01/2025-309.509/02/2025-311.009/03/2025-316.409/04/2025-315.009/05/2025-316.4This was a gain of 11.4 pounds in ten days. There was no documentation of the medical</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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Further review of the admission Record revealed the resident had diagnoses of a right leg trimalleolar fracture (a fracture of three of the four ankle bones) that was surgically repaired, localized edema (swelling caused by fluid retention in the tissues), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (CHF-a long-term condition in which the heart is unable to pump enough blood to meet the body's needs), an irregular heart rate, chronic kidney disease (CKD-a gradual loss of kidney function, resulting in the inability to filter waste and excess fluid from the blood), and acute kidney failure (a sudden [within hours or day] loss of the kidneys' ability to filter waste and excess fluids from the blood).A record review of Resident 6's 5-day Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 09/01/2025 revealed the resident had 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) score of 15.A record review of Resident 6's Skilled Nursing Facility Physician admission Orders electronically signed by the physician on 08/28/2025 revealed the resident was in the facility for a Medicare skilled stay.A record review of the Order Summary Report dated 09/30/2025 that listed Resident 6's Active Orders as of 09/05/2025 revealed an order for DRESSING/INCISION CARE: Keep splint C/D/I [clean/dry/intact] until f/u [follow/up] appt. scheduled for every shift with a start date of 08/26/2025.A record review of Resident 6's hospital Discharge Summary dated 08/26/2025 revealed the resident was admitted to the hospital on [DATE] with the right ankle fracture after having fallen at home, and surgery to repair the right ankle was done on 08/20/2025.A record review of Resident 6's admission Assessment dated 08/26/2025 revealed that on admission the resident had strong pulses in both wrists and in the left foot, and a weak pulse in the right foot. 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