STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285067	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holdrege Memorial Homes, Inc	1320 11th Avenue Holdrege, NE 68949

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 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** 50348 Licensure Reference Number 175 NAC 12-006.09D6 (7) Based on observation, record review, and interview, the facility failed to ensure that a Metered Dose Inhaler (Nebulizer), (a machine that turns a liquid medication into a vapor for inhalation) was cleaned after each use to prevent the potential for cross contamination for 1 (Resident 58) of 1 sampled resident. The facility census was 71. Findings are. A record review of the facility's undated policy titled Administering Medications through a Metered Dose Inhaler (Nebulizer) revealed the following: - the purpose of the policy was to provide guidelines for the safe administration of inhaled medications, - the resident has the right to have their medications in the right dose, - when the dosing is complete, rinse the nebulizer equipment in warm water. A record review of Resident 58's Face Sheet dated 7/10/24 revealed the resident was admitted into the facility on [DATE] with a diagnosis of Asthma (a disease that causes the breathing passages to swell and /or close off). A record review of Resident 58's Order Summary dated 7/10/24 revealed the resident had an order for: -Ipratropium-Albuterol (medications that open airways and assist to expel mucous) solution for nebulization; 0.5 mg (milligrams) -3 mg (2.5 mg base)/3mL (milliliter) give 1 vial 3 times a day at 7:00 AM, 1:00 PM, 7:00PM An observation on 7/9/24 at 10:48 AM of Resident 58's end table revealed that there was a clear liquid in the nebulizer chamber. An interview on 7/9/24 at 10:49 AM with Resident 58 revealed the facility staff do not rinse out the nebulizer when the treatment is completed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 07/10/24 8:02 AM revealed Resident 58's nebulizer on the table in Resident 58's room with a clear liquid forming drops around the chamber. An interview on 7/10/24 at 8:53 AM with Licensed Practical Nurse (LPN)-N confirmed the nebulizers are not rinsed after each use. An interview on 7/10/24 at 4:14 PM with the facility Director of Nursing confirmed the facility expectation is for the staff to rinse the nebulizer after the medication has been administered per the policy.

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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** 50348 Licensure Reference Number 175 NAC 12.006.18(B) Based on observations, interviews, and record reviews: the facility failed to store oxygen tubing and CPAP (Continuous Positive Airway Pressure) (a machine that is used to keep airways open while sleeping) mask/tubing in a manner to prevent the potential for cross contamination for 5 (Residents 7, 23, 59, 53, 42) of 6 sampled residents. The facility census was 71. Findings are: A record review of the undated facility policy titled Storage of Medications and Treatment Supplies revealed: -When not in use oxygen tubing should be placed in the bag that is attached to the resident's oxygen concentrator. -No mention of CPAP supply storage was located on the policy. A. An observation on 7/9/24 at 8:53 AM revealed that Resident 7's oxygen tubing was not in use and was underneath the handle of the oxygen concentrator at the end of the bed. A bag was attached to the concentrator and was empty. A record review of Resident 7's Order summary dated 7/08/24 revealed the following order: -Oxygen per nasal cannula at 0-5 liters as needed to keep oxygen saturations above 90% as needed. B. An observation on 7/9/24 at 9:15 AM revealed that Residents 23's CPAP mask and tubing was not in use and was draped over the CPAP machine located on the bedside table. There was not a bag located for storage of the CPAP mask and tubing. The observation also revealed oxygen tubing that was not in use and was under the handle of a oxygen concentrator. There was not a bag located for the storage of the oxygen tubing. A record review of Resident 7's Order summary dated 7/9/24 revealed the following orders: -Administer oxygen at 1-4 liters per nasal cannula as needed for shortness of breath and anxiety. Keep oxygen saturations greater than 90% as needed. - Administer the CPAP with 2 liters of oxygen attached to machine, use while napping and at night C. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation 7/9/24 at 8:33 AM revealed that Resident 59's oxygen tubing was connected to a concentrator and not in use. The tubing was under the handle of a concentrator at the end of the resident's bed. An observation on 7/10/24 at 9:25 AM revealed Resident 59's oxygen tubing was under the handle of a concentrator at the end of the resident's bed. A review of Resident 59's Order Summary dated 7/9/24 revealed the following: -Administer oxygen at 3 liters per nasal cannula at bedtime. An interview on 7/10/24 at 11:27 AM with the Director of Nursing (DON) confirmed the facility expectation was to store oxygen and CPAP supplies in a bag to prevent cross contamination when not in use. The DON revealed the facility staff have been educated about this facility practice. The DON did confirm Resident 7's and Resident 59's oxygen tubing was not stored per policy to prevent cross contamination. The DON confirmed Resident 23's CPAP mask and tubing was not stored per policy. 42861 E. A record review of the document titled Resident Face Sheet revealed Resident 53 had been readmitted into the facility on [DATE] with a primary diagnosis of Covid-19 (a mild to severe respiratory illness that is caused by a coronavirus) infection with hypoxia (low levels of oxygen in your body tissues). A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's physical and mental functional capabilities) dated 5/28/24 revealed Resident 53 had a BIMS (Brief Interview for Mental Status, 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, while scores of 00 or 99 indicate total confusion) score of 14. An observation on 7/8/24 at 2:24 PM revealed Resident 53 had oxygen tubing on (gender) face however the nasal prongs were not in Resident 53's nostrils but resting on (gender) chin. The observation revealed that the oxygen tubing was not dated. An observation on 7/10/24 at 09:04 AM revealed Resident 53's oxygen tubing to be coiled up and tucked under the handle of the oxygen concentrator and not stored in a bag or in a manner to prevent cross contamination. An interview on 7/10/24 at 9:07 AM with Registered Nurse (RN) I, after an observation of Resident 53's oxygen tubing, confirmed that the oxygen tubing should be stored in a bag when not in use. F. A record review of the document titled Resident Face Sheet revealed Resident 42 had been accepted into the facility on [DATE] with a primary diagnosis of Heart Failure and a secondary diagnosis of hypoxemia. (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 the MDS dated [DATE] revealed a BIMS score of 15. An observation on 07/09/24 at 10:03 AM, during an interview, revealed Resident 42 to be on oxygen (O2) continuously and the O2 tubing currently in use which was connected to the concentrator had not been dated. The observation also revealed Resident 42 had a portable oxygen tank attached to the wheelchair with O2 tubing attached and hanging from tank with the nasal cannula touching the wheelchair tire. During the observation/interview, Resident 42 voiced not requiring oxygen prior to hospital stay and admission into the facility and voiced hopes of weaning from oxygen. An observation on 7/9/24 at 2:49 PM revealed Resident 42's oxygen tubing was connected to the portable tank and was remained wrapped around the dial of the flow meter and was not being stored in a bag or in any manner to prevent the potential for cross contamination. An observation on 7/10/24 at 08:55 AM, while accompanied by RN-I, revealed that Resident 42's oxygen tubing was connected to the portable oxygen tank and wrapped around the flow meter with the nasal cannula touching the back of the wheelchair and the tank. An interview on 7/10/24 at 09:07 AM with RN-I, confirmed that oxygen tubing should be stored in a bag when not in use and voiced (gender) would change the tubing right away. The record review revealed that the facility policy titled Storage of Medications and Treatment Supplies did not address use or storage of oxygen tubing with portable oxygen tanks. An interview on 7/10/24 at 4:21 PM with the DON confirmed that the facility expectation was that oxygen tubing connected to portable oxygen tanks should be stored in a bag when not in use.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42861 Licensure Reference Number 175 NAC 12.006.4(B)(ii)(1) Based on interview and record review the facility failed to ensure 12 hours of continuing education had been completed for 3 Nursing Assistants (NA-A, NA-C and NA-D) of 5 reviewed employees that had been employed more than one year. This had the potential to affect all residents in house. The facility identified a census of 71. Findings Are: A record review of continuing education hours for NA (Nurse Aide)-A, hired on 3/21/2011, revealed a total of zero hours had been completed for the last one year, covering 3/21/23 through 3/21/24. A record review of continuing education hours for NA-C, hired on 7/6/2022, revealed a total of 11.75 hours had been completed for the last one year, covering 7/6/23 through 7/6/24. A record review of continuing education hours for NA-D, hired on 4/3/2023, revealed a total of 9.25 hours had been completed for the last one year, covering 4/3/23 through 4/3/24. A record review of the undated facility policy titled Training Requirements revealed it contained the following guidelines related to training and education hours; 4. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. 6. It is the responsibility of each employee, volunteer or contract staff to complete required training. a. The facility offers a variety of training methods and times to accommodate individuals. b. An individual's failure to complete required training, within the time requirements, will forfeit their annual evaluation increases until all training has been completed. 8. The Staff Development Coordinator maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. An interview on 7/10/24 at 8:47 AM with NA-F revealed (gender) did not know how many hours of continuing education was required for NA's annually but voiced I think it is 72 hours. An interview on 7/10/24 at 8:47 AM with NA-G revealed (gender) did not know how many hours of continuing education was required for NA's annually. NA-G voiced (gender) thought it was 40 hours. NA-G voiced that opportunities for education were through Relias as well as facility in-person meetings which occur at least monthly. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 7/9/24 at 11:34 AM with the facility DON (Director of Nursing), after review of the continuing education hours for NA-A, NA-C, NA-D and NA-E, confirmed that the requirement for the annual 12 hours of continuing education for NA's was annually from their hire date and that hours had not been monitored or met. The DON confirmed that staff were continuing to work and provide cares that staff were not removed from the working schedule if hours had not been completed but that annual pay increases were not given until education hours were completed. On 7/10/24 at 08:15 AM the BOM (Business Office Manager) confirmed that the facility did not have a Staff Development Coordinator and that the Payroll Coordinator runs an audit report from Relias (a provider of education, training, and workforce enablement solutions for human services and healthcare organizations) quarterly and reviews the education hours for NA's and then will notify the supervisors of the staff needing to complete their education hours. The BOM also revealed that the Payroll Coordinator monitors this around the time of the staff's evaluation due date and if education hours are not completed, staff pay increases do not go into effect until the education hours are completed.