

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 M Street Franklin, NE 68939	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613</p> <p>Licensure Reference Number 175 NAC 12-006.09B</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS- a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) reflected insulin injections for 1 (Resident 5) of 4 sampled residents. The facility census was 30.</p> <p>Findings are:</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual Version 3.0, dated October 2024, revealed the following:</p> <ul style="list-style-type: none"> -Enter the number of days that injections of any type were received in the last 7 days <p>Review of Resident 5's Quarterly Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 2/13/2025 revealed the following:</p> <ul style="list-style-type: none"> -Admission to the facility on [DATE] -diagnosis of Diabetes Mellitus -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, which indicated the resident is cognitively intact. -injections were not marked <p>Review of Resident 5'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) dated 12/12/2024 revealed the following:</p> <ul style="list-style-type: none"> -focus the resident has Diabetes Mellitus -goal the resident will be free from hyperglycemia and hypoglycemia <p>(continued on next page)</p>

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-interventions included diabetes medication as ordered</p> <p>Review of Medication Administration Record dated from 2/7/25-2/13/25 revealed that Resident 5 received insulin injections 7 times.</p> <p>During an interview on 03/18/25 at 1:51 PM, the Director of Nursing (DON) confirmed that injections were marked zero on the most current Quarterly MDS dated [DATE] and should have been marked as 7 times given.</p> <p>During an interview on 03/20/25 at 8:52 AM, the DON confirmed that they use the RAI manual to ensure MDS accuracy.</p>

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5)</p> <p>Based on record review and interview, the facility failed to assess a resident's skin condition and provide treatment for impaired skin conditions for 1 (Resident 6) of 4 sampled residents for skin conditions. The facility census was 30.</p> <p>Findings are:</p> <p>An observation on 3/17/25 at 2:38 PM of Resident 6 revealed multiple open areas and scabs to the resident's arms and legs. Areas were small and did not have any signs of infection.</p> <p>During an interview on 03/17/25 at 2:39 PM Resident 6 revealed that both of (gender) legs and arms were itchy and stated (gender) scratched the areas.</p> <p>Record review of Resident 6's weekly skin assessments dated from 2/27/2025-3/13/2025, revealed no open areas, scratches or scabbed areas.</p> <p>Record review of Resident 6's progress notes dated from 2/1/2/-3/19/25 did not reveal any documentation regarding the resident's skin condition.</p> <p>Record review of Resident 6's undated Admission Record revealed the resident was admitted to the facility on [DATE].</p> <p>Record review of Resident 6'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 the following:</p> <ul style="list-style-type: none"> -on 1/24/24 the resident's daughter reported that the resident picks at skin. -focus and goal dated 12/1/21 the resident is at low risk for skin breakdown and the resident will not develop any skin impairments -intervention dated 8/7/2023 weekly skin assessments to be completed <p>During an interview on 03/19/25 at 3:29 PM, the Infection Preventionist (IP) confirmed that Resident 6 has multiple open areas and scabbed areas to arms and legs and it was not mentioned on the skin assessments.</p> <p>During an interview on 03/20/25 at 7:55 AM Nursing Assistant (NA) - B confirmed that Resident 6 picks at (gender) arms and legs and everywhere but NA - B didn't know of anything that was being done for the areas.</p> <p>(continued on next page)</p>		

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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>During an interview on 03/20/25 at 8:43 AM Medication Aide (MA) - C confirmed that Resident 6 takes a bath 2 times a week and staff sometimes puts lotion on her arms and legs. It was further confirmed that MA - C had seen the scabs and open areas and had told a nurse.</p> <p>During an interview on 03/20/25 at 9:24 AM the Director of Nursing (DON) confirmed that Resident 6's skin assessments did not mention any open areas or scabs, and that no treatments were being done and that there should have been. The DON further confirmed there was no documentation that Resident 6's provider had been notified, and that the provider should have been notified. It was further confirmed that Resident 6 does have ongoing skin issues and that the open areas and scabs are in various stages of healing.</p> <p>Review of facility policy titled Clinical Management dated 8/26/21 revealed weekly skin checks are to be completed on every resident within the facility every week.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>45641</p> <p>Licensure Reference Number 175 NAC 12-006.04(B)(i)(6)</p> <p>Based on interview and record review, the facility failed to ensure dementia care training was completed prior to nursing staff taking care of residents with a diagnosis of dementia. The facility census was 30.</p> <p>Findings are:</p> <p>A record review of the facility's Human Resources (HR)-Training policy dated 09/2024 revealed each employee should have received an initial orientation that included Alzheimer's care (brain disorder that causes a gradual decline in memory) and dementia (decline in mental ability) care.</p> <p>A record review of the facility's Employee Listing dated 03/14/2025 revealed:</p> <p>Nursing Assistant (NA)-I started 12/23/2024</p> <p>NA-J started 09/30/2024</p> <p>NA-K started 10/03/2024</p> <p>NA-L started 03/04/2025</p> <p>Medication Aide (MA)-H started 03/04/2025</p> <p>A record review of personnel and HR files for NA-I, NA-J, NA-K, NA-L, and MA-H did not reveal dementia care training had been completed.</p> <p>A record review of the facility's Training Hours dated 03/18/2025 for NA-I, NA-J, NA-K, NA-L, and MA-H did not reveal dementia care training had been completed.</p> <p>A record review of the facility's Daily Shift Assignments sheets dated 02/17/2025 - 03/17/2025 revealed:</p> <p>NA-I worked on own 02/21/2025, 02/28/2025, 02/29/2025, 03/12/2025, 03/13/2025, 03/15/2025, and 03/14/2025</p> <p>NA-L worked on own 03/16/2025 and 03/17/2025</p> <p>MA-H hasn't worked on own</p> <p>NA-K worked 02/18/2025, 02/24/2025, 03/01/2025, 03/02/2025, 03/04/2025, and 03/07/2025</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>NA-J worked on own 02/17/2025, 02/18/2025, 02/19/2025, 02/22/2025, 02/23/2025, 02/24/2025, 02/26/2025, 02/27/2025, 03/03/2025, 03/04/2025, 03/06/2025, 03/08/2025, 03/09/2025, 03/10/2025, 03/12/2025, and 03/17/2025</p> <p>A record review of the facility's undated, un-named list of residents with a dementia related diagnosis was 6 residents.</p> <p>In an interview on 03/18/2025 at 1:47 PM, the Business Office Manager (BOM) confirmed the facility had not been completing any kind of dementia care training on hire and before taking care of dementia care residents. The BOM confirmed that NA-I, NA-J, NA-K, NA-L had not had dementia care training and had taken care of resident with a dementia related diagnosis alone and should not have.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45641</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Based on interview and record review, the facility failed to ensure the low temperature (temp) dish machine reached the minimum required temperature of 120 degrees Fahrenheit (F) during the wash cycle to prevent foodborne illness. This had the potential to affect all of the residents in the facility. The facility census was 30.</p> <p>Findings are:</p> <p>A record review of the facility's Dishwasher Temperature Policy with a reviewed date of 03/2020 revealed for a low temp dishwasher (chemical sanitization), the wash temperature shall be 120 degrees F. The sanitizing solution shall be 50 parts per million (PPM) of chlorine on dish surfaces in the final rinse. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift. Results shall be recorded.</p> <p>A record review of the facility's Dietary Sanitation Policy Statement with a reviewed date of 05/2021 revealed for a low temp dishwasher (chemical sanitization), the wash temperature shall be 120 degrees F. The final rinse should be 50 PPM hypochlorite (chlorine) for at least 10 seconds.</p> <p>A record review of the National Sanitation Foundation (NSF) Operational Requirements as manufactured by American Dish Service sticker on the facility's low temp dish machine dated 12/2001 revealed for the model of low temp dish machine the facility had, a wash temp of 120 degrees F minimum and 50 PPM available chlorine rinse was required.</p> <p>A record review of the facility's Dish Machine Washing And Rinsing Temp Log, Sanitizer Log, De-Lime Log dated February and March 2025 revealed all the recorded wash temperatures were 65 degrees F, and all the recorded rinse temperatures were 125 degrees F.</p> <p>A record review of the facility's Chemical Sanitizer Dish Machine Log dated February and March 2025 revealed all the recorded sanitizer concentration levels that were recorded was 200 PPM and it was only recorded once per day.</p> <p>A record review of the facility's Schedule Dietary - Cooks dated March 2025 revealed there where 2 shifts in the kitchen.</p> <p>An observation on 03/18/2025 at 9:25 AM revealed the facility's Cook-M prepared lunch and ran dishes through the facility's low temp dish machine. The temp during the wash cycle only reached 90 degrees F and the final rinse temp reached 122 degrees F. Cook-M did not observe the dish machine thermometer as the cycles ran and did not test the sanitizer level of the machine rinse cycle.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 03/18/2025 at 11:55 AM revealed Cook-M ran dishes through the facility's low temp dish machine and the maximum temperature achieved was 106 degrees F and the final rinse temperature reached 125 degrees F. Cook-M did not observe the dish machine thermometer as the cycles ran and did not test the sanitizer level of the machine rinse cycle.</p> <p>In an interview on 03/18/2025 at 12:18 PM, the Dietary Manager (DM) confirmed it was a low temp dish machine, and the DM was told by the machine and chemical company's representative that the wash temp should be 60 degrees F and the rinse temp should be 140 degrees F. The DM confirmed the dish machine temps and chlorine levels was only tested on ce per day.</p> <p>In an interview on 03/19/2025 at 10:09 AM, the DM confirmed the low temp dish machine was not reaching a wash temperature of 120 degrees F on the first couple of loads that were ran through. The wash temp should have been at least 120 degrees F. The DM confirmed the chlorine levels were only tested on ce per day and they should have been testing it every shift.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Based on observation, record review and interviews, the facility failed to complete a clean dressing change for Resident 2, wear gloves during blood glucose testing for Resident 5, ensure nebulizer kits were cleaned after treatments for Residents 13 and 27, ensure Resident 27's oxygen concentrator filter was clean, and failed to ensure Resident 27's wheelchair oxygen nasal cannula was stored to prevent cross contamination. The facility census was 30 at the time of survey.</p> <p>Findings are:</p> <p>A.</p> <p>Review of Resident 2's Quarterly Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 1/18/2025 revealed the following:</p> <ul style="list-style-type: none"> -admission to the facility on [DATE] -diagnosis of sepsis -Stage 4 pressure ulcer (full thickness tissue loss) that was present on admission <p>Record review of Resident 2'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 the following:</p> <ul style="list-style-type: none"> -wound management focus dated 9/28/2024 -intervention dated 9/28/2024 wound care per treatment order <p>Resident 2's physician order dated 2/20/25 revealed:</p> <ul style="list-style-type: none"> -Wet to moist gauze packing to coccyx wound-change daily and cover with ABD (a highly absorbent dressing) and hold with undergarment. <p>An observation on 3/19/25 at 1:53 PM of the Infection Preventionist (IP) completing wound care for Resident 2 revealed the following: the IP was wearing gloves and removed the wet brief, and then the saturated dressing. No hand hygiene was then performed, the IP did not change gloves. The wound was then cleansed, and a clean dressing was packed into wound per order. The area was covered with a clean dry dressing. The IP then applied the wet brief over the clean dressing.</p> <p>During an interview on 3/19/25 at 1:55 PM, the IP confirmed that hand hygiene and changing of the dirty gloves should have been performed after removing the soiled dressing and that the wet brief was placed over the resident's clean dressing and should not have been reapplied to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy titled Hand Hygiene dated September 2024 revealed that all staff will perform proper hand hygiene procedure to prevent the spread of infection to other staff, residents and visitors. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.</p> <p>Review of facility policy titled Clean Dressing Change dated 2/2020 revealed that after removing the existing dressing, remove gloves, wash hands and put on clean gloves.</p> <p>Review of facility policy titled Wound Treatment Management dated 2/2020 revealed that dressings will be applied in accordance with standards of practice.</p> <p>During an interview on 03/20/25 at 8:26 AM, RN - A, the corporate nurse confirmed that no one is supposed to put a dirty or a wet brief over a clean dressing, it was further confirmed that it is not standard practice to put a wet brief over a clean dressing.</p> <p>B.</p> <p>Review of Resident 5's Quarterly MDS dated [DATE] revealed the following:</p> <ul style="list-style-type: none"> -Admission to the facility on [DATE] -diagnosis of Diabetes Mellitus -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, which indicated the resident is cognitively intact. <p>Review of Resident 5's CCP dated 12/12/2024 revealed the following:</p> <ul style="list-style-type: none"> -focus the resident has Diabetes Mellitus -goal the resident will be free from hyperglycemia and hypoglycemia -interventions included diabetes medication as ordered <p>An observation on 03/18/25 at 7:37 AM revealed the IP in Resident 5's room, sitting on the resident's bed and not wearing gloves while completing an accucheck to measure the amount of glucose in the blood. The IP did not perform hand hygiene.</p> <p>During an interview on 3/18/25 at 7:38 AM, the IP confirmed that (gender) forgot to put on gloves during the accucheck and should have.</p> <p>Record review of the facility policy dated September 2024 and titled Personal Protective Equipment Policy revealed staff should wear gloves when in direct contact with blood, bodily fluids, mucous membranes, non-intact skin or potentially contaminated surfaces or equipment is anticipated.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy titled Nebulizer Therapy dated 1/20/2024 revealed that nebulizers kits are to be cleaned after each use and parts are to be disassembled after each treatment. Rinse the nebulizer cup and mouthpiece with tap water and air dry on an absorbent towel. Change nebulizer tubing every 72 hours.</p> <p>During an interview on 03/20/25 at 8:26 AM Registered Nurse (RN) - A corporate nurse confirmed that nebulizer treatment kits are supposed to be cleaned, rinsed out, taken apart and set out to dry after each use.</p> <p>45641</p> <p>D.</p> <p>A record review of the facility's Nebulizer Therapy policy with a reviewed date of 01/2023 revealed the staff was to disassemble and rinse the nebulizer with tap water and allow it to air dry after the treatment. The nebulizer kit was to be cleaned after each use, disassembled, rinsed, and allowed to air dry.</p> <p>A record review of the facility's Oxygen Storage policy dated 02/2024 did not reveal cleaning or storage instructions.</p> <p>A record review of Resident 27's Clinical Census dated 03/19/2025 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 27's Medical Diagnosis dated 03/19/2025 revealed the resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Dependence on Supplemental Oxygen, Heart Failure, and Tobacco Use.</p> <p>A record review of Resident 27's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/02/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 15 which indicated the resident was cognitively aware. The resident required setup or clean up assistance with eating, oral hygiene (cleaning), and upper body dressing. The resident required supervision or touching assistance with bathing, toileting, lower body dressing, personal hygiene (cleaning), and footwear. The MDS revealed that the resident was on oxygen therapy.</p> <p>A record review of Resident 27's Care Plan with an admitted [DATE] revealed interventions of administer nebulizer treatments per order and administer oxygen as prescribed or per standing order.</p> <p>A record review of Resident 27's Order Summary dated 03/19/2025 revealed the resident had an order for oxygen up to 5 liter per minute (l/m), DuoNeb (nebulizer medication) nebulizer treatments every 4 hours as needed, and wipe down the concentrator (a machine that purifies oxygen) and clean the filter weekly on Mondays.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 M Street Franklin, NE 68939	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident 27's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2025 revealed the resident was administered nebulizer treatments 02/06/2025, 02/07/2025, 02/08/2025, 02/11/2025, 02/14/2025, 02/15/2025, 02/17/2025, 02/18/2025, and 02/24/2025. The order to wipe down the concentrator and clean filter on Mondays was marked as done every Monday.</p> <p>A record review of Resident 27's MAR & TAR dated March 2025 did not reveal the DuoNeb nebulizer treatments had been given. The MAR & TAR revealed the order to wipe down the concentrator and clean filter on Mondays was marked as done every Monday and the last date it was completed was 03/17/2025.</p> <p>An observation on 03/17/2025 at 11:33 AM revealed Resident 27's oxygen nasal cannula (a tube that is placed in the nose to deliver oxygen) that was connected to the oxygen tank on the wheelchair was draped over the side of the wheelchair with the part that goes into the nose touching the seat of the wheelchair. The nebulizer kit was placed on top of the nebulizer machine with a residual (small, leftover) amount of medication in it, and the mask had facial oils and debris on it. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vents and the filter.</p> <p>An observation on 03/18/2025 at 9:01 AM revealed Resident 27's oxygen nasal cannula that was connected to the oxygen tank on the wheelchair was partially in a black mesh bag hanging on the back of the wheelchair with the part that goes in the nose hanging out of the bag. The nebulizer kit was placed on top of the nebulizer machine with a residual amount of medication in it, and the mask had facial oils and debris on it. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vents and the filter.</p> <p>An observation on 03/18/2025 at 3:25 PM revealed Resident 27's oxygen nasal cannula that was connected to the oxygen tank on the wheelchair was hanging on the back of the wheelchair. The nebulizer kit was placed on top of the nebulizer machine with a residual amount of medication in it, and the mask had facial oils and debris on it. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vents and the filter.</p> <p>An observation on 03/19/2025 at 6:56 AM revealed Resident 27's oxygen nasal cannula that was connected to the oxygen tank on the wheelchair was in the wheelchair with the part that goes in the nose touching the seat of the wheelchair. The nebulizer kit was placed on top of the nebulizer machine with a residual amount of medication in it, and the mask had facial oils and debris on it. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vents and the filter.</p> <p>An observation on 03/19/2025 at 8:14 AM revealed MA-C entered Resident 27's room to give the resident a nebulizer treatment. An observation with MA-C prior to the resident getting a nebulizer treatment revealed the nebulizer kit was on top of the nebulizer machine with a residual amount of medication in it and the mask had facial oils and debris on it. MA-C proceeded to give Resident 27 the nebulizer treatment without cleaning the kit.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 M Street Franklin, NE 68939	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 03/19/2025 at 9:39 AM with the Administrator revealed Resident 27's nasal cannula that was connected to the wheelchair oxygen tank and was laying on a brown stained reusable incontinence (lack of bowel/bladder control) under pad that was in the seat of the wheelchair and the part that goes in the nose was touching the dirty under pad. The nebulizer kit was placed on top of the nebulizer machine with a residual amount of medication in it and facial oils and debris on the mask and it was covered with a towel. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vent and filter.</p> <p>In an interview on 03/17/2025 at 11:33 AM, Resident 27 confirmed that the resident did take nebulizer treatments due to the resident was congested and was getting over Pneumonia.</p> <p>In an interview on 03/19/2025 at 8:14 AM, MA-C confirmed the nebulizer kit was on top of the nebulizer machine with a residual amount of medication in it and the mask had facial oils and debris on it. MA-C confirmed the nebulizer kit should have been cleaned after each treatment and had not been.</p> <p>In an interview on 03/19/2025 at 9:57 AM, MA-C confirmed that MA-C gave Resident 27 a DuoNeb treatment at 8:14 AM but had not marked it off as done on the TAR.</p> <p>In an interview on 03/19/2025 at 9:39 AM, the Administrator confirmed Resident 27's nasal cannula that was connected to the wheelchair oxygen tank was laying on a brown stained reusable incontinence under pad that was in the seat of the wheelchair and the part that goes in the nose was touching the dirty under pad. The Administrator confirmed the nasal cannula should have been in the black mesh bag on the back of the wheelchair and not touching the under pad in the wheelchair seat. The nebulizer kit was placed on top of the nebulizer machine with a residual amount of medication in it and facial oils and debris on the mask and it was covered with a towel, and the nebulizer kit should have been cleaned after the nebulizer treatment. The back of the oxygen concentrator had a coating of a gray fuzzy substance on the vent and filter, and it should have been clean.</p>		