

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Litzenberg Memorial County Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 26th Street Central City, NE 68826	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938</p> <p>Licensure Reference Number 175NAC 12-006.09(F)(i)</p> <p>Based on record review and interviews; the facility failed to ensure that the medical record contained documentation that the written summary of the baseline care plan (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) was provided to the resident/resident representative as required for 2 of 9 residents (Residents 23, and 26). This had the potential to prevent the resident/resident representative from identifying additional care and goals required for the resident; and the facility failed to ensure that the baseline care plans were completed with the necessary information to care for 1 of 3 newly admitted residents (Residents 132). The facility census was 30.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the facility policy titled Comprehensive Care Plan and Care Conferences dated 12/4/23 revealed that the purpose is to develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual, and psychosocial well-being. The procedure section for Baseline Care Plan revealed to review admission information to develop an initial care plan that includes specific interventions including but not limited to: Initial goals, PASRR (Preadmission Screening and Resident Review is a federal required evaluation of all applicants for serious mental illness and/or intellectual disability to help ensure that individuals are not inappropriately placed in nursing homes for long term care) recommendations, physician orders, transfer interventions, fall prevention, pain, pressure ulcer prevention, infections and resident specific care. Provide the resident and/or resident representative with a written summary of the baseline care plan. The summary includes initial goals of the resident, summary of medications and dietary restrictions and services and treatments to be administered. Use the Care Conference Note to document that the meeting occurred with the resident and representative and any significant discussion that occurred.</p> <p>Record review of the Admission Record for Resident 23 revealed that Resident 23 admitted into the facility on [DATE] with diagnoses of Dementia, Hip Fracture, and Anxiety. Resident 23 had a Power of Attorney for Health.</p> <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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 23 dated 4/30/24 revealed that Resident 23 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 9 (a score of 8-12 indicates moderate cognitive impairment).</p> <p>Record review of the Baseline Care Plan dated 1/26/24 for Resident 23 revealed that it contained the signature of Resident 23 on the last page of the care plan. No date was documented for the signature. The Baseline Care Plan contained no documentation of any discussion of the care plan with the resident or the resident representative.</p> <p>Record review of the medical record for Resident 23 revealed no Care Conference Note or any other note documenting that a baseline care plan review meeting occurred with the resident or resident representative. The medical record contained no documentation that a written summary of the baseline care plan was provided to the resident or resident representative.</p> <p>Interview on 8/13/24 at 10:43 AM with the facility Director of Nursing Services (DNS) revealed that the DNS reviews the baseline care plan with the resident usually on the day of admission. The DNS revealed that they review the goals, orders, medications for identified conditions, and the care to be provided. The DNS revealed that the DNS has the resident sign the baseline care plan at that time. The DNS revealed that most residents do not want a copy of the baseline care plan. The DNS confirmed that the DNS does not document the discussion of the baseline care plan with the resident and does not document any offering of a copy of the baseline care plan to the resident.</p> <p>Interview on 8/13/24 with the Facility Administrator confirmed that the facility needs to document the baseline care plan discussion in the medical record and the provision of a copy of the baseline care plan to the resident and representative.</p> <p>Policy does not state they have to document that meeting occurred and any thing significant. Does not say to document a offered copy. Would keep becuase the policy does say to document that it happened but it is very weak since the DNS states they do and that is how the signature is obtained. Seems more a documentation tag vs not providing the careplan and having the meeting. Would have liked an interview with the resident/family.</p> <p>B.</p> <p>Record review of the Admission Record for Resident 26 revealed that Resident 26 admitted into the facility on [DATE] with diagnoses of Pneumonia, Diabetes, and Unsteadiness on feet. Resident 26 had a Power of Attorney for Health.</p> <p>Record review of the MDS Assessment for Resident 26 dated 7/29/24 revealed that Resident 26 had a BIMS score of 15 indicating Resident 26 was cognitively intact.</p> <p>Record review of the Baseline Care Plan dated 7/23/24 for Resident 26 revealed that it was signed by the representative of Resident 26 on the last page of the care plan. No date was documented for the signature. The Baseline Care Plan contained no documentation of any discussion of the care plan with the resident or the resident representative.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the medical record for Resident 26 revealed no Care Conference Note or any other note documenting that a baseline care plan review meeting occurred with the resident or resident representative. The medical record contained no documentation that a written summary of the baseline care plan was provided to the resident or resident representative.</p> <p>Interview on 8/13/24 at 10:43 AM with the facility Director of Nursing Services (DNS) revealed that the DNS reviews the baseline care plan with the resident usually on the day of admission. The DNS revealed that they review the goals, orders, medications for identified conditions, and the care to be provided. The DNS revealed that the DNS has the resident sign the baseline care plan at that time. The DNS revealed that most residents do not want a copy of the baseline care plan. The DNS confirmed that the DNS does not document the discussion of the baseline care plan with the resident and does not document any offering of a copy of the baseline care plan to the resident.</p> <p>Interview on 8/13/24 with the Facility Administrator confirmed that the facility needs to document the baseline care plan discussion in the medical record and the provision of a copy of the baseline care plan to the resident and representative.</p> <p>Same as above</p> <p>50253</p> <p>C.</p> <p>Record review of the Progress Notes for Resident 132 revealed they had been admitted to the facility on [DATE] from a hospital following surgery to repair a fractured femur (upper long bone) of the right leg.</p> <p>Record review of Res 132's Baseline Care Plan revealed Resident 132 was not placed on Enhanced Barrier Precautions (EBP, an infection control strategy used in nursing homes to reduce the spread of multidrug-resistant organisms) at the time of admission following a surgical repair of the right leg.</p> <p>Observation on 8/7/24 at 9:20 AM in the room of Resident 132 revealed staff did not use EBP after Resident 132 had finished breakfast and staff assisted the resident to a new position in the bed.</p> <p>Record review of the Resident 132's Care Plan revealed a revision to the Care Plan was initiated on 8/7/24 to include the required EBP related to surgical wound care.</p> <p>Interview DATE TIME? with the Director of Nurses (DNS) the resident had not been placed on EBP from the time of admission until 8/7/24 was because I forgot new surgical patients had to be on EBP.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>49382</p> <p>Licensure Reference Number 175NAC 12-006.09(H)(iv)(1)</p> <p>Based on observations, record review, and interviews; the facility failed to prevent urinary catheters from becoming contaminated during personal cares and transportation of a resident in a wheelchair for 2 (Resident 3 and 27) of 3 sampled residents. Facility stated census of 30.</p> <p>Findings are:</p> <p>Review of a facility policy titled, Catheter: Care, Insertion& Removal, Drainage bags, Irrigation, Specimen dated 7/30/2024 revealed:</p> <p>-All closed collection systems that become contaminated by inappropriate technique, leaks or other means are immediately replaced.</p> <p>A.</p> <p>Review of an Admission Record revealed the facility admitted Resident 3 on 5/22/2024 with diagnoses of Multiple Sclerosis (a chronic disease of the central nervous system), and Neuromuscular dysfunction of the Bladder (a condition where the nerves and the muscles of the bladder don't work well together).</p> <p>The Comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 5/29/2024 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 15 indicating the resident was cognitively intact. The resident was documented as having an indwelling Foley catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine into a plastic collection bag).</p> <p>In an observation on 8/13/2024 at 10:10 AM Nurse Assistant-C (NA-C) was observed to be assisting Resident 3 get dressed. NA-C removed Resident 3's Foley catheter bag from the frame of the bed. The NA-C took the Foley catheter bag and tubing and threaded it through one leg of the residents' shorts. The NA then dropped the Foley bag onto the bare floor on the right side of the bed. NA-C left the Foley bag on the floor during the remainder of the time while assisting the resident with dressing of the lower half of Resident 3's body and performing catheter cares.</p> <p>In an interview on 08/13/2024 at 11:20 PM with the Director of Nursing Services (DNS), the DNS confirmed that the Foley catheter bag should not meet soiled or dirty surfaces like the resident's floor.</p> <p>B.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed the facility admitted Resident 27 on 5/24/2024 with diagnoses of Kidney Failure (a condition where the kidneys cannot filter waste from the blood), obstructive uropathy (a condition where the flow of urine from the bladder is blocked), and urinary tract infection (an infection in any part of the urinary system).</p> <p>The Comprehensive Minimum Data Set MDS with an ARD of 5/29/2024 revealed Resident 27 had a BIMS score of 8 indicating the resident was moderately cognitively impaired. The resident was documented as having an indwelling Foley catheter.</p> <p>In an observation on 8/07/2024 at 11:05 AM Resident 27 was observed to be sitting in [gender] wheelchair in the commons area. The residents Foley catheter tubing was observed to be coming out of the pants by the ankle on the left side going past the pedal of the wheelchair and on to the floor then up into a cloth bag attached to the underside frame of the wheelchair.</p> <p>In an interview on 8/07/2024 at 11:10 AM with Licensed Practical Nurse-A (LPN-A), LPN-A confirmed that Resident 27 had an indwelling Foley catheter and a history of urinary tract infections. The LPN stated that catheter bags and or tubing should not be on or come in contact with the floor.</p> <p>In an interview on 8/13/2024 at 11:20 PM with the Director of Nursing Services (DNS), the DNS confirmed that the Foley catheter tubing should not meet soiled or dirty surfaces like the floor.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>50253</p> <p>License Reference Number 175 NAC 12-006.09(J)</p> <p>The facility failed to ensure the physician ordered and recommended amount of Glucerna was provided to residents who had triggered for malnutrition or those at risk of malnutrition. This affected 1 (Resident 15) of 3 sampled residents. The facility census was 30.</p> <p>Findings are:</p> <p>Record review of Resident 15's Mini Nutritional Assessment (MNA, a tool is used to assist registered dieticians (RD) in the assessment of the nutritional needs of individuals whom they are required to give dietary recommendations in institutional settings. A score of 14 is the maximum. Scores of 0-7 indicate one is malnourished. Scores of 8-11 points indicate one is at risk of malnutrition. A score of 12-14 indicates normal nutritional status.) completed by the facility RD dated 5/21/2024 at 10:24 AM revealed a score of 5 which indicated Resident 15 was malnourished. Resident 15 had an admission weight of 172.5 on 5/10/24 and current weight of 167.5 on 5/21/24.</p> <p>Record review of the Dietary Notes written by the RD on 5/21/2024 revealed Resident 15 was a new admission with diagnoses of malnutrition, cellulitis, lymphedema, diabetes, urinary tract infection, and confusion, all of which could or would have an effect on the nutritional status of an individual. The resident's weight was 172.5.</p> <p>Record review of Resident 15's MNA completed by RD dated 6/18/2024 at 8:33 AM revealed a score of 7 which indicated Resident 15 continues to be malnourished.</p> <p>Record review of the Dietary Notes written by the RD on 6/18/2024 revealed Resident 15's nutritional status was starting to improve, but Resident 15 had been started on an antibiotic. Resident 15 was at high risk for weight loss and meal intakes were not greater than 75% of nutritional needs. The RD recommended a liberalized regular diet and 8oz Glucerna/Equivalent twice daily to meet the necessary calories and protein needed.</p> <p>Record review of Resident 15's MNA completed by RD dated 7/2/2024 at 8:22 AM revealed a score of 7 which indicated Resident 15 continues to be malnourished.</p> <p>Record review of the order summary dated 7/3/2024 revealed a Physician Order for Resident 15 to receive Glucerna Supplement 8 ounces twice daily.</p> <p>Record review of Resident 15's MNA completed by RD dated 7/30/2024 at 11:09 AM revealed a score of 9 which indicated Resident 15 was now at risk for malnutrition.</p> <p>Record review of the Medication Administration Record (MAR) for Resident 15 for the month of July 2024 revealed Resident 15 was to receive the nutritional supplement Glucerna 8 ounces (equivalent to 240 milliliters (mL)) twice a day starting on 7/3/2024. Nursing staff were to chart in milliliters both in the morning and in the evening when the supplement was given.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the July 2024 MAR documentation revealed the following amounts of Glucerna was given:</p> <ul style="list-style-type: none"> -The morning charting indicated 100 ml was given on the following dates: 19, 20, and the 21st. -The morning charting revealed 120 ml was given on the following dates: 17, 18, 22, 23, 24, 25, 26, 27, 28, 29, and the 30th. -The morning charting revealed just a checkmark indicating the resident received the supplement on the following dates: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and the 16th. -The evening charting indicated 100 ml was given on the following dates: 16, 20, 21, and the 30th. -The evening charting revealed 120 ml was given on the following dates:18, 19, 22, 23, 24, 25, 26, 27, 28, and the 29th. -The evening charting revealed the resident refused the supplement 7/31/2024. <p>Record review of the August 1st through August 12 of 2024 MAR documentation revealed the following amounts of Glucerna was given:</p> <ul style="list-style-type: none"> -The morning charting revealed 100 ml was given on the following dates: 1, 2, 3, 4, 5, 6, 7, 11, and the 12th. -The morning charting revealed 180 ml was given on the following dates: 8, 9, and the 10th. -The evening charting revealed 100 ml was given on the following dates: 1, 2, 3, 4, 5, 6, and the 11th. -The evening charting revealed 180 ml was given on the following dates: 8, 9, and the10th. -The evening charting revealed 8 ounces (240 ml) was given on the following date 8/7/24. <p>Observation on 8/7/2024 at 8:00 AM revealed Resident 15 sitting at the dinning room table Resident 15 finished [gender] entire breakfast and supplement (240 milliliters) prior leaving the dining room.</p> <p>Observation on 8/12/2024 at 1:00 PM revealed Resident 15 had finished [gender] entire noon meal the supplement (240 milliliters).</p> <p>In an interview on 8/12/2024 at 10:25 AM with the facility Registered Dietician (RD). Confirmed the Resident 15 is to have 8 ounces, or 240mL of Glucerna twice daily for caloric and protein needs due to malnutrition. Asked to review what has been charted on the MAR for clarification of the daily intake, the RD indicated confusion as to what was being charted and was going to follow-up with the nursing staff. Perhaps it means 100% of the supplement instead of 100 ml?</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/12/2024 at 10:40 with Licensed Practical Nurse-A (LPN-A) revealed [gender] gives the Glucerna to Resident 15 in the original 8-ounce container with a straw at mealtime. LPN-A further revealed Resident 15 routinely drinks the entire bottle. The Glucerna is then charted in the MAR. LPN-A always notates the consumption of the supplement as a percentage, which has always been 100% when LPN-A gave the supplement. When asked if nursing staff are to chart in ml or percentages or with just a checkmark, LPN-A stated it gets confusing because there are too many ways to chart the supplements. It depends on which nurse adds the order onto the MAR as to how it will appear.</p> <p>In an interview on 8/12/2024 at 10:50 with Licensed Practical Nurse-J (LPN-J) revealed there are several ways to chart the supplements. LPN-J was dispensing supplements at breakfast on 8/12/2024 and revealed, I only gave 100 ml of the Glucerna because I misread the order. I am just being honest.</p> <p>In an interview on 8/12/2024 at 11:05 PM with the facility Director of Nursing (DNS) confirmed it is difficult to understand how much of the supplement was being given to Resident 15 and what was being consumed. DNS further confirmed that supplements may be given at mealtime or between meals dependent upon when each resident will consume the supplement.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49382</p> <p>Licensure Reference Number 175NAC 12-00.10(D)</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, record review, and interviews; the facility failed to have a medication error rate less than 5% with an observed medication error rate of 10.53%. This affected 3 residents,(Resident 3, 20, and 22), of 9 sampled Residents. The facility stated census was 30</p> <p>Findings are:</p> <p>Review of a facility policy titled Medication Administration and dated 5/21/2024 revealed to perform three checks including reading the label on the medication container and comparing with the medication administration record and to administer medications with in at least 60 minutes on each side of ordered time.</p> <p>A.</p> <p>Review of an Admission Record revealed the facility admitted Resident 3 on 5/22/2024 with diagnoses of Multiple Sclerosis (a chronic disease of the central nervous system), Chronic Respiratory Failure(a condition where there is not enough oxygen in the blood), and Hypertension(high blood pressure).</p> <p>In an observation of medication administration by Licensed Practical Nurse-B (LPN-B) on 8/08/2024 at 11:13 AM, LPN-B prepared and administered the following medications to Resident 3:</p> <p>-Modafinil (a stimulant medication), Oral Tablet 200 milligrams. Directions on the label of the medication packaging read to give half of a tablet by mouth one time a day around 2 PM. Directions in Resident 3 electronic medication administration record read to give one half of a tablet by mouth one time a day with a indicated administration time of 12:00 AM/PM.</p> <p>-Potassium Chloride (a mineral supplement) Extended-Release Tablet 20 milliequivalents. Directions on the label of the medication packaging read to give 2 tablets three times a day and do not crush or chew the tablets. LPN-B used a pill splitter to cut the medication in half per the resident's request. The tablet crushed into multiple small pieces. The LPN put the pieces in a plastic cup and administered them to the resident. The resident then took the second tablet in [gender] mouth and broke it into pieces with [gender] teeth.</p> <p>In an interview with LPN-B on 8/08/2024 at 11:50 AM, LPN-B confirmed that the label of the Modafinil medication administration time and the order in the electronic medication administration record did not match. LPN-B confirmed the medication error related to right time of medication administration. LPN-B confirmed the directions that the Potassium Chloride Extended-Release Tablet was not to be crushed or chewed and that when attempting to split the tablet it crumbled into multiple pieces and the [gender] should not have administered all the pieces to the resident. LPN-B revealed [gender] was unaware of the resident having difficulties swallowing the tablets due to size and would reach out to the provider alerting to resident needing a different form of the medication so it could be take correctly.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B.</p> <p>Review of an Admission Record revealed the facility admitted Resident 20 on 6/10/2022 with diagnoses of Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and Parkinson's Disease (a disease that is progressive and affects the nervous system).</p> <p>In an observation of medication administration by Licensed Practical Nurse-B (LPN-B) on 8/08/2024 at 11:13 AM, LPN-B prepared and administered the following medications to Resident 20:</p> <p>-Quetiapine (an antipsychotic medication) 50 milligrams. Directions on the label of the medication packaging read to give one tablet four times a day and once daily as needed. Directions in Resident 20 electronic medication administration record read to give one tablet four times a day. Resident 20 did not have an order to receive this medication once daily as needed.</p> <p>In an interview with LPN-B on 8/08/2024 at 11:50 AM, LPN-B confirmed that the label on the medication did not match the orders for the medication in the resident's electronic medical health record. LPN-B confirmed the as needed order for the medication had been discontinued in September of 2023.</p> <p>C.</p> <p>Review of an Admission Record revealed the facility admitted Resident 22 on 10/04/2023 with diagnoses of hypotension (low blood pressure).</p> <p>In an observation of medication administration by Licensed Practical Nurse B (LPN-B) on 08/08/2024 at 11:20 AM, LPN-B prepared and administered the following medications to Resident 22:</p> <p>-Midodrine Hydrochloric Acid (HCL) (a medication used to treat low blood pressure) 5 milligram tablet. Directions on the medication packaging read to give one tablet three times a day before meals. Directions in Resident 22's electronic medication administration record read to give one tablet three times a day.</p> <p>In an interview with LPN-B on 8/08/2024 at 11:50 AM LPN-B confirmed that the medication packaging directions for administration of the medication and the electronic medication administration record did not match.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105</p> <p>Licensure Reference Number 175 NAC 12-006.04(A)(ii)</p> <p>Licensure Reference Number 175 NAC 12-006.18</p> <p>Licensure Reference Number 175 NAC 12-006.19</p> <p>Based on record review, observations, and interviews; the facility failed to ensure that pre-employment health history screens were reviewed to prevent the potential for transmission of contagious disease for 2 of 3 staff, which had the potential to affect all residents. The facility failed to ensure that the tub and shower room was maintained in a clean and sanitary manner, which had the potential to affect all residents. The facility failed to ensure that Enhanced Barrier Precautions (EBP) were implemented as needed upon admission of new residents requiring EBP, which affected 1 resident, (Resident 132) of 3 sampled residents. The facility failed to apply Personal Protective Equipment (PPE) in the correct sequence during care of a resident on transmission-based precautions, failed to perform hand hygiene and change gloves correctly during cares, failed to complete catheter cares per the professional standards, and the facility failed to change oxygen tubing as required. This affected 1 resident, (Resident 3) of 2 sampled residents. The facility failed to prevent Foley catheter tubing and catheter bag from coming into contact with contaminated surfaces. This affected 2 residents, (Resident 132 and Resident 15) of 2 sampled residents.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the undated and untitled list of facility employees revealed that Housekeeper had a hire date of 09/05/2023.</p> <p>Record review of Housekeeper timeclock revealed first employment day clock in was on 10/02/2023 for a full 7.5 hour day of work.</p> <p>Record review of the Medical History Questionnaire for Housekeeper revealed that it was signed by Housekeeper yet remained undated. The box on the form stating this medical history has been reviewed with this conditional employee was not checked yes, or no. The line for the Human Resource representative or designee signature for review was undated and blank.</p> <p>Record review of the undated and untitled list of facility employees revealed that Laundry Aide had a hire date of 09/06/2023.</p> <p>Record review of Laundry Aide timeclock revealed first employment day clock in was on 09/27/2023 for a full 7.5 hour day of work.</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 - Many</p>	<p>Record review of the Medical History Questionnaire for Laundry Aide revealed that it was signed and dated on 02/19/2024 by Laundry Aide. The box on the form stating this medical history has been reviewed with this conditional employee was not checked yes, or no. The line for the HR Representative or Designee signature for review was undated and blank.</p> <p>Interview on 08/13/24 at 9:45 AM with the Social Services Director (SSD) revealed that the Medical History Questionnaire form is part of the orientation packet. The SSD confirmed that the information on the Medical History Questionnaire form should be reviewed, dated, and accepted with a signature prior to the first day of employment.</p> <p>A review of a facility policy titled, Hiring and Screening dated 03/24/2022 revealed under section Health Assessment and Drug Screen: a pre-employment drug screen and health assessment will be conducted on all external job applicants who have accepted offers of employment. The health assessment is required prior to the first day of employment and employment is contingent upon successful completion of the drug screen and/or health assessment.</p> <p>50253</p> <p>B.</p> <p>Observation on 8/12/2024 at 09:15 AM of the tub and shower room. The room floor is comprised of 1x1 tiles which then go up the wall part of the way. Many tiles to the left (south side of the door in the tub room) as one enters have grey and dark grey grime on them. The grout lines are discolored, and a grey, dark grey, and brownish color compared to most the other of the grout lines of the other tiles that are white to verylight grey in color. There is a 2'x 6 drain in that area that has grey and brown build up. On the left side of the tub flooring, the tiles have a buildup and accumulation of what appeared to be soap scum and hard water like deposits that are grey to dark grey in color with hair. To the right side of the tub nearer the wall the floor is unkempt with many hairs of various color and length, dirt particles, and brown and grey in color. Inside the tub, the side walls are covered what appears to be hard water deposits especially under and around the control knobs and the waterspout. There is a hair left on the drain stopper. Above the tub, there is a water reservoir. Under the lip of the water reservoir there is a black, grey, and brown residue.</p> <p>Observation on 8/12/2024 at 9:15 AM as the tub and shower chair are being disinfected and cleaned. The shower chair is submersed completely but the safety harness is only partially submersed as the straps that go around a resident's abdomen remain above the water.</p> <p>Interview on 8/12/2024 at 9:25 AM with Medication Aide-E (MA-E) stated [gender] makes sure the disinfectant is in the water by observing how murky the water is when the tub is filling for the disinfecting process. If the water isn't very murky, MA-E will check the siphoning tube seated inside the disinfectant solution to be certain the container is not empty. MA-E is not certain how hot the water must be to wash the tub or to perform the disinfectant step.</p> <p>C.</p> <p>Record review of the Progress Notes for Resident 132 revealed they had been admitted to the facility on [DATE] from a hospital following surgery to repair a fractured femur (upper long bone) of the right leg.</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 - Many</p>	<p>Record review of Res 132's Baseline Care Plan revealed Resident 132 was not placed on Enhanced Barrier Precautions (EBP, an infection control strategy used in nursing homes to reduce the spread of multidrug-resistant organisms) at the time of admission following a surgical repair of the right leg.</p> <p>Observation on 8/7/24 at 9:20 AM in the room of Resident 132 revealed staff did not use EBP after Resident 132 had finished breakfast and staff assisted the resident to a new position in the bed.</p> <p>Record review of the Resident 132's Care Plan revealed a revision to the Care Plan was initiated on 8/7/24 to include the required EBP related to surgical wound care.</p> <p>Interview on 8/13/2024 at 04:10 PM with the Director of Nurses (DNS) the resident had not been placed on EBP from the time of admission until 8/7/24 was because I forgot new surgical patients had to be on EBP.</p> <p>49382</p> <p>D.</p> <p>Record review of a Centers for Disease Control document labeled Sequence for putting on Personal Protective Equipment (PPE), not dated revealed Step 1 place on the gown fully covering the torso from neck to knees and wrap around and fasten in the back. Step 2. place gloves on and extend them to cover the wrist of the gown.</p> <p>Review of an Admission Record revealed the facility admitted Resident 3 on 5/22/2024 with diagnoses of Multiple Sclerosis (a chronic disease of the central nervous system), and Neuromuscular dysfunction of the Bladder (a condition where the nerves and the muscles of the bladder don't work well together).</p> <p>The Comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 5/29/2024 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 15 indicating the resident was cognitively intact. The resident was documented as having an indwelling Foley catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine into a plastic collection bag).</p> <p>Review of Resident 3's Care Plan dated 08/07/2024 revealed a Focus that the resident required Enhanced Barrier Precautions due to having an indwelling Foley Catheter with an intervention of don (put on) gown and gloves when performing high contact care activities and doff (take off) gown and gloves inside the resident's room and perform hand hygiene.</p> <p>In an observation on 8/13/2024 at 10:10 AM while care was being provided to Resident 3 the following was observed:</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 - Many</p>	<p>Nursing Assistant-D (NA-D) performed alcohol-based hand hygiene and entered Resident 3's room. NA-D obtained disposable gloves from a box hanging on a wire rack on the resident's closet door and applied the gloves to both of their hands. The NA then obtained a blue disposable gown from the same rack and applied the gown covering their torso and tied the gown in the back. The NA did not apply the gown and then the gloves in order as recommended.</p> <p>In an interview completed on 08/13/2024 at 10:50 AM with NA-D confirmed [gender] should have put the gown on first and not the gloves when applying PPE.</p> <p>In an interview completed on 08/13/2024 at 10:30 AM with the Director of Nursing Services (DNS) the DNS confirmed that staff are to don their gown and then their gloves when it comes to applying personal protective equipment.</p> <p>E.</p> <p>Review of a facility document titled Hand Hygiene Clinical Skill Checklist dated 10/2023 revealed Hand hygiene is performed at the Moments of Hand Hygiene which includes but is not limited to after glove removal. Under Procedure it is listed to scrub hands for at least 20 seconds, dry hands thoroughly and discard wet paper towels. Turn off the faucet with a dry paper towel and discard. when performing Hand Washing.</p> <p>In an observation completed on 8/13/2024 at 10:18 AM while care was being provided to Resident 3 the following was observed:</p> <p>Nursing Assistant-C (NA-C) with gloved hands emptied Resident 3 Foley catheter drainage bag into a clear plastic container. The NA then took the container into the bathroom and emptied the contents into the toilet. The NA rinsed the plastic container with water and emptied the water into the toilet then placed the container on the back of the toilet on clean dry paper towels. NA-C then removed their gloves from their hands and placed new gloves on both hands. The NA did not complete hand hygiene with an alcohol-based gel or by Hand Washing between glove changes.</p> <p>After completion of cares for Resident 3 NA-C entered the bathroom in the resident's room and removed their gloves. The NA then turned on the sink, wetted hands, applied soap to hands, and rubbed hands with the soap on them for 10 seconds. The NA then rinsed both hands running the water up onto their forearms of both arms and down hands. NA-C obtained paper towels from the dispenser hanging on the wall and dried their hands. The NA then used the same paper towels to turn off the water faucet and disposed of the paper towels in the trash can.</p> <p>In an interview completed on 8/13/2024 at 10:50 AM with NA-C, confirmed [gender] should have completed hand hygiene between glove changes, completed hand washing for 20 seconds, and turned the faucet off with a clean dry paper towel.</p> <p>In an interview completed on 8/13/2024 at 10:30 AM with the DNS confirmed that hand washing is to be completed for a 20 second minimum, hand hygiene is to be completed between glove changes, and that a clean paper towel should be used to turn off the faucet then hand washing is completed.</p> <p>F.</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 - Many</p>	<p>Review of a facility policy titled Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, and Specimen dated 07/30/2024 revealed under Procedure: Catheter Care-Indwelling Catheter to perform hand hygiene and apply gloves, Position the resident exposing the perineal area, remove gloves and perform hand hygiene and don gloves, expose the urethral meatus with the non-dominant hand for a female gently retract the labia to fully expose the catheter insertions site, stabilize the catheter using the non-dominant hand and use a clean disposable wipe to clean the perineal area and the portion of the catheter in contact with the perineum or meatus. Use a clean section of the wipe for each stroke.</p> <p>In an observation completed on 8/13/2024 at 10:20 AM while catheter cares were being provided to Resident 3 the following was observed:</p> <p>With gloved hands NA-C obtained 4 disposable wipes from a package and placed the disposable wipe package on the resident's bed with the exposed wipes placed on top of the package. The NA did not prepare a clean surface to place the disposable cloths on. NA-C then placed [gender] left hand to Resident 3's outer labia and grasped onto the catheter tubing with two fingers stabilizing the tube. The NA then used a disposable wipe to wipe from where they were pinching the tube down the catheter tubing about 3 inches. The NA did not separate the labia exposing the insertion site of the catheter and begin cleansing from that point down the catheter tubing. The NA then placed the disposable cloth in their right hand and let go of the tubing with their left hand. With their left hand the NA picked up another disposable wipe and wiped down the catheter tubing starting at the resident's labia and down the tubing 3-4 inches and placed the disposable cloth in their gloved right hand. NA-C then threw away the disposable wipes. NA-D requested Resident 3 to roll onto the side so they could perform cares to the residents back side. With gloved hands NA-C obtained and used a disposable wipe to cleans the resident's buttock. The NA took the wipe and wiped in a back-and-forth horizontal pattern. The NA did not use a different section of cloth for each wipe. NA-C with the same gloved hands as from performing catheter cares obtained a tube of cream from the resident's bedside stand drawer. The NA squeezed the tube getting some of the cream on their gloved right hand and spread the cream to the resident's buttock in a circular motion. The NA did not remove gloves, perform hand hygiene, and apply new gloves prior to applying the cream. The NA then had the resident roll onto their back. NA-C then removed their gloves and then applied new gloves. The NA did not complete hand hygiene between glove changes.</p> <p>In an interview completed on 8/13/2024 at 10:50 AM with NA-C confirmed [gender] should have completed hand hygiene between glove changes, should have changed gloves when going from soiled to clean task, and should have cleansed the catheter from the insertion site down the catheter tubing, provided a clean surface and ensured the trash can was within reach prior to providing care.</p> <p>In an interview completed on 8/13/2024 at 10:30 AM the DNS confirmed that the NA should have changed gloves and completed hand hygiene when going from soiled to clean care and cleansed the catheter tubing from the insertion site down not the labia.</p> <p>G.</p> <p>Review of a facility policy titled Oxygen Administration, Safety, Mask Types dated 07/08/2024 revealed Disposable equipment should be changed weekly and marked with a the date and individuals initials.</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 - Many</p>	<p>Review of Resident 3's electronic medical record revealed the resident had an order/direction that oxygen tubing and bag is to be changed weekly on Thursdays.</p> <p>In an observation completed on 8/08/2024 at 2:40 PM in Resident 3's room revealed 3 Ziploc disposable baggies were attached to Resident 3's oxygen tubing that went from the concentrator to the resident. One bag was labeled 7/04/2024, another 7/11/2024, and the third 7/12/2024. Located on the actual oxygen tubing was a piece of white tape with 7/18 written on it.</p> <p>In an observation completed on 8/13/2024 at 9:40 AM in Resident 3's room revealed 3 Ziploc disposable baggies were attached to Resident 3 oxygen tubing that went from the concentrator to the resident. One bag was labeled 7/04/2024, another 7/11/2024, and the third 7/12/2024. Located on the actual oxygen tubing was a piece of white tape with 07/18 written on it.</p> <p>In an interview completed on 8/13/2024 at 9:40 AM with Licensed Practical Nurse A (LPN-A), LPN-A stated that the residents oxygen tubing and Ziploc bags are changed on Thursdays. LPN-A confirmed the 3 Ziploc bags with different dates attached to the oxygen tubing dated 7/18 and that the resident should have tubing and a baggies labeled/dated 08/08/2024.</p> <p>In and interview completed on 8/13/2024 at 10:30 AM with the Director of Nursing Services (DNS) the DNS confirmed that Resident 3 oxygen tubing and baggies should have been changed on 8/08/2024 and was not.</p>		