STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285292	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litzenberg Memorial County Hospital	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observations, interviews, and record review; the facility failed to ensure staff performed hand hygiene and change gloves during wound cares for 1 (Resident 2) out 4 sampled residents. The facility also failed to ensure staff wore a gown, did not use contaminated gloves when accessing the clean wipes container, perform hand hygiene and change gloves during catheter cares for 2 (Residents 2 & 4) out of 3 sampled residents to prevent the potential for cross contamination. The facility had a census of 33. Findings are: A. Record review of Resident 2's admission Record dated 9/10/25 revealed admission to the facility was on 8/19/25. Interview on 9/9/2025 at 1:23 PM with Director of Nursing (DON) revealed Resident 2 was admitted to the facility with pressure wounds to both ankles. Record review of Resident 2's Diagnoses dated 9/9/25 revealed diagnoses of unspecified open wound right foot and unspecified open wound left foot. Record review of Resident 2's Braden Scale (The Braden Scale is a risk assessment tool that predicts a patient's likelihood of developing pressure ulcers –generally a score of 18 or less indicates at-risk status) revealed a score of 15, indicating mild risk on 8/19/25. Record review of Resident 2's Minimum Data Set (MDS, a comprehensive assessment of each resident's functional capabilities) dated 8/25/25 revealed: -Section C: 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) was 8/15, indicating moderate impairment. -Section G: Resident 2 needed supervision with eating, moderate assistance with oral hygiene, was dependent with toileting, required maximum assist with shower and upper body dressing, lower body dressing and footwear is dependent, personal hygiene needed moderate assistance, rolling right and left needed maximum assistance, and transfers needed maximum assistance. -Section M: at risk for pressure ulcers, had 2 Stage 3 ulcers present on admission, used pressure reducing devices in bed and wheelchair. Record review of Resident 2's Physician orders dated 9/9/25 revealed: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Alginate AG to open areas on right inner ankle and left outer ankle. Cover with self-adhesive dressing. Change every day and as needed for pressure ulcer. -Protein Modular 3 times a day for nutritional supplement 8 ounce can. Observation on 9/10/25 at 7:10 AM with Licensed Practical Nurse (LPN-A) during wound cares for Resident 2. LPN-A performed hand hygiene and applied a gown and gloves. LPN-A removed the old dressing from left outer ankle then cleansed with normal saline and gauze without hand hygiene or changing gloves. LPN-A cut a piece of Alginate AG dressing and applied to the wound bed and covered with an adhesive dressing. LPN-A then repositioned Resident 2 onto back and removed the right inner ankle dressing and then did not perform hand hygiene. LPN-A cleansed with normal saline and gauze and cut a piece of Alginate AG dressing and applied to the wound bed and covered with an adhesive dressing. LPN-A kept the same gloves on the entire time of wound cares. LPN-A then removed gown and gloves and performed hand hygiene. LPN-A did not date or initial the dressing. Interview on 9/10/25 at 7:25 AM with LPN-A confirmed [gender] should have performed hand hygiene and changed gloves throughout the dressing change. Interview on 9/10/25 at 11:00 AM with the DON confirmed the nurse should have performed hand hygiene and change gloves throughout the dressing change. Record review of Sandford's Wound Dressing Change policy dated 11/1/24 revealed: Purpose: To promote wound healing. To help wound remain free of infection. Procedure: - Follow Enhance Barrier Precautions (wash hands before entering and exiting the room, wear gloves and gown). -Position resident for comfort and to accommodate dressing change. -Put on gloves. -Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. -Remove gloves and discard in same plastic bag. Perform hand hygiene. -Create field with equipment/dressing wrappers. Use sterile technique if required. -Put on gloves. -Cleanse the skin and wound thoroughly with normal saline using gauze wipes, wound cleanser or ordered antiseptic Solution. Remove gloves and perform hand hygiene. -Put on gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remove dressing from inner wrapper, avoiding finger contact with the dressing. Position the dressing over the wound and press down gently on the skin. Secure dressing as directed. - Identify date and initials on dressing/tape. Record review of [NAME]'s Standard Enhanced Barrier and Transmission-Based Precautions policy dated 7/7/25 revealed: Purpose: To prevent the spread of infection and communicable diseases to residents, patients, employees, and visitors through infection prevention and control practices. Enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDRO's) to staff hands and clothing. Enhanced barrier precautions are also used for residents with chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers) and residents with indwelling medical devices (i.e., central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes and tracheostomies, even if the resident is not known to be infected or colonized with an MDRO. High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with resident in therapy gym (specifically when anticipating close physical contact while assisting with transfers and mobility), changing linens, indwelling medical device care or use (central line, urinary catheter, feeding tube, tracheostomy) and wound care. B. Observation on 9/8/25 at 11:00 AM revealed Resident 2 was sitting in a recliner in [gender] room, catheter tubing had slightly cloudy urine. Record review of Resident 2's MDS dated [DATE] revealed: -Section C: 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) was 8 indicating moderate impairment. -Section G: Resident 2 needs supervision with eating, moderate assistance with oral hygiene, dependent with toileting, maximum assist with shower and upper body dressing, lower body dressing and footwear is dependent, personal hygiene needs moderate assistance, rolling right and left needs maximum assistance, and transfers needs maximum assistance. -Section H: Indwelling catheter -Section M: at risk for Pressure ulcers, has 2 Stage 3 ulcers present on admission, uses pressure reducing devices used in bed and wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 2's physician orders dated 9/9/25 revealed: -Catheter 16 French with 30 CC (cubic centimeter) balloon to dependent drainage. Record review of Resident 2's Diagnoses dated 9/9/25 revealed a diagnosis of neuromuscular dystrophy dysfunction of bladder. Observation on 9/10/25 at 7:52 AM for Resident 2's catheter cares by Nurse Aide (NA)-C. NA-C performed hand hygiene with sanitizing gel and applied gloves and gown. NA-C emptied the catheter drainage bag without concerns. NA-C removed their gown and gloves. NA-C performed hand hygiene with sanitizing gel and applied gloves but no gown. NA-C assisted resident to lay on their back then took the brief off. NA-C took a cleansing wipe out of wipes container with contaminated glove and cleansed the right groin, then got another wipe with the same glove, cleansed the left groin. NA-C took out another wipe with the same gloves and cleansed the urethral meatus. NA-C took another wipe from the wipe's container with the same gloves and cleansed the peri-area. NA-C removed another wipe from the container with the same contaminated gloves and cleansed the catheter tubing going down the tubing approximately 4 inches. NA-C repositioned resident to [gender] side and cleansed buttock, getting into wipes from the container 2 times with contaminated gloves. NA-C assisted Resident 2 to the supine position and applied new brief with the same gloves. NA-C proceeded to dress resident and assist up for breakfast. An interview on 9/10/25 at 8:10 AM with NA-C confirmed [gender] should have worn a gown during catheter cares, perform hand hygiene and change gloves more often, and not get into the wipes with contaminated gloves. Interview on 9/10/25 at 11:00 AM with the Director of Nursing confirmed staff should have worn a gown during catheter cares, perform hand hygiene and change gloves more often, and not get into the wipes with contaminated gloves. Record review of the facility's Hand Hygiene Clinical Skill checklist dated 10/2023 revealed: Hand hygiene (i.e., alcohol-based hand sanitizer, soap and water) is performed at the Moments of Hand Hygiene which includes, but not limited to: -Before entering a room; -Before performing a clean task; -After bodily fluid/glove removal; and -After exiting a room. C. A record review of an admission Record printed on 09/10/2025 revealed that Resident 4 was admitted to the facility on [DATE] with a diagnosis of benign prostatic hyperplasia (BPH a non-cancerous enlargement of the male prostate gland that surrounds the tube that carries the urine from the bladder out of the body). This condition can cause issues with urination, requiring a thin tube (indwelling catheter) to be placed and left inside the bladder to drain the urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 4's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 07/02/2025 revealed in Section H: titled Bladder and Bowel under Appliances that Resident 4 had an indwelling catheter. The MDS also revealed Resident 4's Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score was 13, indicating that the resident was cognitively intact. A record review of Resident 4's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed that The resident has alteration in urinary elimination R/T (related to) BPH and had a foley catheter (indwelling foley catheter). The CCP also revealed the requirement for all staff to use Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices like catheters). A record review of Resident 4's Order Summary dated 09/09/2025 revealed an order for an indwelling catheter: 16 fr foley cath to dependent drainage. Change catheter PRN if dislodged or plugged and unable to clear with irrigation. as needed AND one time a day every 14 day(s) related to benign prostatic hyperplasia with lower urinary tract symptoms. An observation on 09/10/2025 at 9:25 AM revealed a nursing assistant (NA-D, a healthcare professional who provides basic care and support to the residents) performing catheter care on Resident 4. NA-D donned (applied) a gown, and gloves and then proceeded to gather supplies (disposable wipes). NA-D then assisted Resident 4 to the standing position, this was the preferred position as reported by Resident 4. NA-D then removed Resident 4's pants and brief (an absorbent, disposable undergarment designed for adults to have difficulty controlling their bladder and bowels). NA-D then performed perineal care (the cleaning of the area between the genitals and the anus) using one disposable wipe and the original gloves. NA-D then began to clean the meatus (the catheter insertion site) and the catheter tubing using the same wipe and gloves. NA-D did not remove contaminated gloves, perform hand hygiene and don clean gloves prior to cleaning the meatus and catheter tubing. NA-D did not retract the foreskin to clean/inspect the meatus. NA-D then emptied the catheter bag of urine and disposed of the urine in the toilet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's undated clinical skills checklist titled Catheter Care-Indwelling Catheter Clinical Skills Checklist and the facility's policy titled [NAME] Policy on Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen-AL, R/S and LTC. dated 04/06/2025 revealed the steps needed to preform catheter care for an indwelling catheter. 1. Perform the beginning five (assemble equipment, knock on door, identify resident, explain procedure, and provide privacy, perform hand hygiene). Steps 2-3 (perform hand hygiene, raise bed, position resident .) 4. Remove gloves, perform hand hygiene, and don gloves. 5. Expose the ureteral meatus with non-dominate hand. a. (Female instructions). b. Male: Retract the foreskin if not circumcised. Hold the penis at the shaft just below the glans. c. Observe meatus and surrounding tissue for inflammation, encrustation (a buildup of crystals and mineral deposits on or inside the catheter), swelling or discharge, ask the resident if burring or discomfort is present. 6. Stabilize the catheter using non-dominate hand. Do not pull on the catheter. 7. Provide perineal care. An interview with the Director of Nursing on 09/10/2025 at 9:50 AM confirmed that it is the facility's expectation for the staff is to remove contaminated gloves perform hand hygiene and apply clean gloves prior to cleaning the meatus and catheter tubbing. A record review of the results from a urinalysis test, a test used to detect urinary tract infections (UTIs) dated 09/07/2025 revealed that Resident 4 tested positive for a UTI. A record review of Resident 4's Order Summary revealed an order for the antibiotic Ertapenem Sodium Injection to be administered for 5 days with the active start date of 9/8/2025 for the treatment of a UTI.