STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285089	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage of Bel Air	1203 North 13th Street Norfolk, NE 68701

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. S483.45(f) Medication Errors. The facility must ensure that its- S483.45(f)(1) Medication error rates are not 5 percent or greater;This REQUIREMENT is not met as evidenced by Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review and interview; the facility staff failed to ensure a medication error rate of less than 5 percent (%). Observations of 25 medications administered revealed 2 errors resulting in an error rate of 8%. The medication errors were related to 1 (Resident 6) of 5 residents sampled. The facility identified a census of 98.Findings are:A. Review of the facility policy Medication Errors with a revision date of 2/18 revealed the facility was to ensure residents were free of medication error rates of 5% or greater. A medication error was defined as the observed or identified preparation or administration medications which were not in accordance with the prescriber's order or the manufacturers specifications regarding the preparation and administration of the medication. B. Review of the Prefilled Insulin Pen Competency Form used by the facility to competency test staff regarding insulin administration revealed the following procedural steps:-attach the capped needle onto the end of the pen by turning clockwise until tight. -to prime the pen, make sure the arrow is in the center of the dose window. -pull the dose knob out in the direction of the arrow until a 0 is seen. -turn the knob clockwise until the number 2 is seen. -hold the pen with the needle pointing straight up, tapping the clear cartridge holder so any air bubbles collect near the top. Push the injection button completely using the thumb. Keep pressing and continue to hold the injection button firmly. A stream of insulin should come out the tip of the needle. -upon completion of priming, a diamond must be seen in the center of the dose window. -turn the dose knob clockwise until the arrow is seen in the center of the dose window and the notches on the pen and dose knob are in line. -pull the dose knob out in the direction of the arrow until a 0 is seen in the dose window. Review of Resident 6's Medication Administration Record dated 7/2025 revealed the resident had orders for the following:-Lantus (long lasting insulin used to manage blood sugar levels) inject 50 units twice a day.-Humalog (rapid acting insulin used to control blood sugar levels) 20 units with meals three times a day. During an observation on 7/29/25 at 8:15 AM, Licensed Practical Nurse (LPN)-G, removed 2 insulin pens from a drawer of the medication cart for Resident 6. LPN-G detached the pen cap from the Lantus insulin pen and attached a needle cap. LPN-G turned the dose knob to 40 and indicated only 40 units remained in the pen and an additional 10 units would need to be administered from a second pen with Lantus insulin. LPN-G failed to prime the pen prior to administering the 40 units of insulin to the resident's right abdomen. LPN-G then removed the pen cap from the Humalog insulin pen and connected a needle cap. LPN-G, without priming the insulin pen, turned the dose knob to 10 units and administered the Humalog insulin to the resident's left abdomen. An interview conducted with LPN-G on 7/29/25 at 8:25 AM confirmed the insulin pens were not primed prior to administration of the Lantus Insulin and the Humalog insulins.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. S483.60(d) Food and drink Each resident receives and the facility provides- S483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; S483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.Licensure Reference Number 175 NAC 12-006.11D Based on observation, record review and interview; the facility failed to serve room trays at a palatable temperature. The sample size was 9 and the facility census was 98. Findings are: Review of the Nebraska Food Code effective 3/8/12 revealed the following:-refrigerated potentially hazardous food (time/temperature control for safety food) would be at a temperature of 41 degrees or below when received, and-potentially hazardous food that was cooked to a temperature and for a time specified and received hot would be at a temperature of 135 degrees or above. During an interview on 7/28/25 at 10:20 AM Resident 66 reported that they sometimes eat meals in their room and the food is cold most of the time. The following observations were made on 7/29/25:-at 12:04 PM the hot box (a specialized container designed to keep prepared food warm, safe, and at a palatable temperature during transportation) containing the lunch trays was moved from the kitchen to the resident hallway and plugged into the wall,-at 12:23 PM Nursing Assistant (NA)-P started serving the lunch trays and the temperature of the hot box was 167 degrees, and-at 12:35 PM Chef-O obtained the following temperatures on a test tray: Pork Roast-130 degrees, Macaroni and Cheese-130 degrees, and Carrots-124 degrees. Interview on 7/29/25 at 12:35 PM with Chef-O revealed the food temperatures obtained were too cold to serve the residents. Interview on 7/29/25 at 1:30 PM interview with the Certified Dietary Manager (CDM) confirmed the facility did not have a policy related to what temperature food should be served at, but the facility uses the Nebraska Food Code as a guideline. Further interview confirmed that hot foods should have been served above 135 degrees, and cold foods should have been served at 41 degrees and below. The CDM confirmed the facility served 9 room trays out of the hot box. Interview on 7/30/25 at 3:40 PM with the Administrator confirmed the hot food should be served at 135 degrees or higher and the food on 7/29/25 was not at a palatable temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. S483.60(i) Food safety requirements. The facility must - S483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observation, record review and interview; the facility failed to serve food in a manner to prevent potential food borne illnesses. The facility failed to ensure bare hands were not used to touch ready-to-eat food items. This practice had the potential to affect all residents in the facility who ate meals from the kitchen. The facility staff identified a census of 98. Findings are:A. Review of the 7/21/2016 version of the Food Code, based on the United States Food and Drug Administration Food Code and used as an authoritative reference for food service sanitation practices, revealed the following: 81-2,272.10*(Replaces 2013 Food Code 3-301.11 (B), (C), (D), and (E) Preventing Contamination from Hands). -Except when washing fruits and vegetables, food employees shall minimize bare hand and arm contact with exposed food. This may be accomplished with the use of suitable utensils such as deli tissues, spatulas, tongs, single-use gloves, or dispensing equipment. B. During observation of the noon meal on 7/29/25 from 11:45 AM to 12:35 PM the following was observed:-Culinary Lead-X picked up a cheese sandwich with bare hands, cut the sandwich in half and placed the sandwich on a serving plate with bare hands,-Culinary Lead-X then picked up a meat/cheese sandwich with bare hands, cut the sandwich in half and placed the sandwich on a serving plate with bare hands. C. An interview with the Dietary Manager (DM-Z) confirmed that staff should not have used bare hands to touch ready-to-eat food items.

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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(B)Based on observation, interview, and record review; the facility failed to implement the required Personal Protective Equipment (PPE-items such as gowns and gloves that are worn to protect care givers during the provision of care and to protect other residents from being exposed to potential communicable disease) during the provision of care for Resident 35. The facility census was 98.Findings are: A. Review of the facility policy [NAME] Senior Living (VSL) Policy for Enhanced Barrier Precautions (EBP) dated 4/12/24 revealed the following:-EBP referred to an infection control intervention designed to reduce transmission of multidrug resistant organisms (germ that is resistant to medications) (MDRO) that required the use of gowns and glove use during high contact resident cares,-EBP would be initiated on residents with an infection with a targeted MDRO.-PPE for EBP is only necessary when performing high-contact care activities in resident room and spa-room. -high-contact resident care activities included bathing and changing linens.B. Review of Resident 35's Minimum Data Set (MDS - a mandatory comprehensive assessment tool used for care planning) dated 6/18/25 revealed the resident required partial assist with bathing cares. Review of Resident 35's care plan revealed the resident:-had a history of MDRO, -EBP were in place,-resident required extensive 1 assist with bathing cares.Observation on 7/28/25 at 8:35 AM revealed an EBP magnet on the door entering Resident 35's room and stated:-Providers and staff must wear gloves and a gown for the following High-Contact Resident Care Activities including changing linens and bathing cares.An observation on 7/28/25 at 2:10 PM revealed the resident was in the bathing room receiving a whirlpool bath. Nursing Assistant (NA-L) was giving Resident 35 a whirlpool bath with no PPE on. An observation on 7/30/25 at 7:30 AM revealed NA-N had removed sheets, pillowcase and bedding from the resident's bed with no gown or gloves on. NA-N picked up the linens and hugged them against her uniform when exiting the room with no PPE on. An interview with Registered Nurse (RN-K) on 7/29/25 at 7:40 AM confirmed that Resident 35 was on EBP due to an MDRO in urine and staff should wear PPE when bathing the resident. An interview with NA-L on 7/29/25 at 8:00 AM confirmed that PPE was not worn when giving the resident a whirlpool on 7/28/25 and gown and gloves should have been worn.An interview on 7/30/25 at 7:45 AM with the Director of Nursing (DON) confirmed that staff should have had PPE on when changing the residents bed linens.