STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Licensure Reference Number NAC 175-12 006.09(G)(i)7 Based on record review and interviews, the facility failed to document a recapitulation (a complete summary of resident stay in nursing facility from admittance to discharge) for a resident-initiated discharge for 1 (Resident 50) of 6 sample resident. The facility identified a census of 59. Findings are: A record review of a Discharge summary and Plan of Care dated 06/08/2025 of Resident 50 revealed no documentation of a recapitulation summary of residents stay at facility. An Interview with the Social Service Director (SSD) on 06/24/2025 02:30 PM revealed that the recapitulation has not been part of the facilities discharge process, and that the facility utilized a Discharge Summary and Plan of Care. The SSD confirmed they were unaware of the regulatory requirement for the Recapitulation Summary and stated they would work to incorporate it in the discharge process in the future.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Licensure Reference Number NAC 175-12 006.09(F) Based on record review and interviews, the facility failed to implement a Comprehensive Care Plan (a detailed, individualized guide that outlines a residents medical, functional, and psychosocial needs) addressing the need for repositioning bars based on assessed physical needs. A review of 1 (Resident 23) out of 3 sampled residents. The facility identified a census of 59. Findings are: A record review of the facilities Positioning Rails and Monitoring Policy dated 10/08/2024 revealed positioning rails are to only be implemented when clinically indicated. A record review of a Minimum Data Set (MDS, a federally mandated assessment tool for nursing homes reveals) a Brief Interview for Mental Status (BIMS) score of 11 idicating the resident is moderately cognitive impairment. An observation on of Resident 23's bed 6/23/2025 at 10:00 AM revealed 2 bed canes (a type of bed rail), 1 on each side of the bed. An interview with Resident 23 on 6/23/2025 10:00 AM revealed the (gender) did not know why bed canes were on (gender) bed. Resident revealed the repositioning bars were on the bed when (gender) was admitted . A record review of a Resident 23's Care Plan revealed no documentation for the use of the repositioning bars. An interview with the Assistant Director of Nursing (ADON) at 9:15 AM confirmed that resident 23s Care Plan did not include the use of bed canes and that it should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to assess a wound and obtain wound care orders for Resident 67. The sample size was 6 with the facility identifying a census of 59. Findings are: A record review of Resident 67's admission Summary revealed Resident 67 was admitted to the facility on [DATE] after a surgery to the right ankle for intravenous (IV) antibiotics, wound care, and physical therapy services. Resident 67 had an admission diagnosis of Osteomyelitis (a bone infection, most often caused by bacteria) and Cellulitis (a bacterial infection of the skin and underlying tissues) to the right ankle. A record review of Resident 67's Physician Orders revealed no documented evidence of wound care orders to the right lower leg or Resident 67's weight-bearing status (the amount of weight that can safely be placed on a body part during healing after an injury or surgery). A record review of a progress note on 6/21/25 revealed that Resident 67 is alert and oriented to person, place, time, and situation. The note revealed that Resident 67 is able to make their needs known. An interview with Resident 67 on 6/23/25 at 9:30 AM revealed that their dressing had not been changed since they arrived because the facility stated they had no wound care orders. Resident 67 stated that no one has taken off their dressing to look at their wound. Resident 67 stated that they also thought they were supposed to be non-weight bearing but that the facility has been doing toe touch transfers. An interview with RN-A on 6/24/25 at 12:25 PM confirmed that there had been no dressing change or visualization of the wound since Resident 67 has been admitted on [DATE]. RN-A confirmed that the facility had no wound care orders at that time. RN-A further revealed that they thought Resident 67 was to be non-weight bearing but would need to clarify. RN-A confirmed that there is no weight bearing status order in Resident 67's order set. An interview with NA-F on 6/23/25 at 11:35 AM revealed they were not totally sure how Resident 67 transferred but thought they were non-weight bearing. An interview with the Rehab Services Director (RSD) on 06/25/25 at 9:26 AM revealed that Resident 67 is on their caseload and that they had orders that Resident 67 was to be non-weight bearing. The RSD revealed that they receive their orders from the Physical Therapist. The RSD later produced a document from Resident 67's discharge paperwork that revealed Resident 67 was to be non-weight bearing upon discharge from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number NAC 175 12-006.11(E) Based on observations, interviews, and record review, the facility failed to store, prepare, and serve food in a manner to prevent potential for foodborne illness. This included not wearing gloves while touching food, not wearing beard covers in the food preparation area, not using water from a clean source for food preparation or steam table. This had the potential to affect all 59 residents who resided within the facility. Findings are: A. An observation on 6/23/25 at 10:58 AM in the walk-in cooler of the kitchen revealed: - 1 Sunkist orange juice concentrate 3-liter container, more than 75% used, no open date. - 1 Sunkist apple juice concentrate 3-liter container labeled 5/17, approximately 25% used. An observation on 6/23/25 at 11:18 AM in the dry goods storage area revealed: - 1-gallon jugs (128 fluid ounces) of Pearl [NAME] Company Original syrup, including 1 unopened jug with a best by date of 12/29/24 and 1 opened partial jug with an opened date of 3/20/24 and best by date of 12/29/24, and three unopened jugs with a best by date of 11/9/24. - Seven unopened 46-oz boxes of Grove brand pineapple juice, all labeled with an expiration date of 5/30/25. A record review of a facility policy titled, Food Safety Requirements, last revised 3/26/25, revealed that food should be labeled, dated, and monitored so it is used by its use-by date. An interview with the Dietary Manager (DM) on 6/23/25 at 11:36 AM revealed the following: - The 5/17 written on the apple juice concentrate referred to the date the item was received in the kitchen, and that there was no open date written on either container of concentrated juice. - The DM had consulted the juice manufacturer's website and found that the shelf life for the concentrated juice if opened was 10 days. The DM stated that the accepted practice is for kitchen staff to label the containers with an open date and follow the manufacturer's recommendations, and that the juice should have been discarded. An interview with DM on 6/23/25 at 11:36 AM confirmed the food items listed above were not safe or suitable for resident use and should have been used or discarded prior to the best by dates, and that opened items should have been labeled with an open date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Observations on 6/23/25 at 10:53 AM in the kitchen food preparation area revealed the DM and Cook-B were not wearing any covering over their lip and chin facial hair. An observation on 6/23/25 at 10:57 AM revealed that Dietary Aide-D (DA-D) had facial hair on their upper lip and chin but was not wearing a beard cover. An observation on 6/23/25 at 11:15 AM revealed that Dietary Aide-C (DA-C) walked through dry storage area to dining room. DA-C had facial hair on their upper lip and chin but was not wearing a beard cover. Record review of a facility policy titled, Food Safety Requirements, last revised 3/26/25 revealed that dietary staff must wear hair restraints, including beard covers, to prevent hair from contacting food. A record review of a facility policy titled, Maintaining a sanitary tray line, last revised 3/26/25 revealed staff shall wear hair restraints when preparing or handling food. An interview with DM on 6/23/25 at 11:36 AM revealed that beard covers were worn by kitchen staff for hair longer than ¼ in length, and that the staff members with hair or beards longer than that should have been wearing beard covers. DM confirmed that staff members Cook-B, DA-C, DA-D, and themselves (DM) should have worn beard covers while in the kitchen. C. An observation on 6/23/25 at 11:36 AM in the kitchen revealed Cook-B putting a clean grill scraper (a stainless-steel blade with plastic handle) into an uncovered stainless-steel pan with a charcoal block, next to several cleaning chemicals under a sink where dirty dishes were washed. A record review of a facility policy titled Food Safety Requirements, last revised 3/26/25, revealed, clean dishes shall be kept separate from dirty dishes. A record review of the 2017 Nebraska Food Code Section 7-201.11 revealed that toxic materials should be stored so they cannot contaminate food, equipment, and utensils. An interview with Cook-B at that time revealed the location observed under the sink was where the grill cleaning tools were always kept. An interview with DM on 6/23/25 at 11:40 AM confirmed that the grill cleaning tools were kept in that location. DM stated they were unaware the grill tools should not be kept in that location but agreed that accidental contamination could occur. D. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285094	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Centennial	510 Centennial Circle North Platte, NE 69101

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 6/23/25 at 11:34 AM revealed Cook-B making a half sandwich of pulled pork on a hamburger bun. Cook-B touched the bun with an ungloved left hand and cut in half from top to bottom, scooped meat onto the opened bun, and then placed the top of the bun onto the meat without wearing gloves. Cook-B used a metal scoop to put macaroni and cheese in a small bowl, put the bowl on the plate with the half sandwich, then put into the serving window. Cook-B continued with the lunch service for additional residents. A record review of a facility policy titled Food Safety Requirements, last revised 3/26/25 revealed that staff shall not touch food with bare hands. The policy also revealed that gloves would be worn when directly touching ready-to-eat foods. A record review of a facility policy titled, Maintaining a sanitary tray line, last revised 3/26/25 revealed staff shall wear gloves when handling food items, especially when handling ready-to-eat foods. An interview with Cook-B on 6/23/25 at 11:38 AM revealed that Cook-B performed frequent handwashing instead of wearing gloves because they had been instructed in the past by another staff member that it was acceptable to do so. An interview with the DM at this time revealed that they had questioned the practice of not wearing gloves while touching ready-to-eat food in the past, but they were told by a superior the practice was allowed. E. An observation of food preparation on 6/25/25 at 9:53 AM revealed Cook-E dispensing water from the faucet in the handwashing sink into pitchers. The water from the handwashing sink was transferred into two separate pans for making boiled carrots and 2 more containers for instant mashed potatoes. At 10:35 AM water from the handwashing sink was added to the steam table. A record review of the 2017 Nebraska Food Code Section 5-205.11 revealed that a handwashing sink may not be used for another purpose besides handwashing. An interview with Cook-E on 6/25/25 at revealed they were not aware that the Nebraska Food Code stated the handwashing sink may only be used for handwashing. Cook-E stated the sink that was supposed to be used for clean water was on the opposite side of the kitchen. An interview with DM revealed the handwashing sink was being used for water because the hot water routinely took too long to reach the other faucets in the kitchen. Following education regarding the Food Code, they confirmed the practice could result in cross contamination.