STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Fullerton	202 North Esther Fullerton, NE 68638

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(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. Licensure Reference Number 175 NAC 12-006.11(E) Based on observations, record reviews, and interviews, the facility failed to ensure water temperatures in the dishwasher reached the required temperature during the wash cycle to ensure sanitization, failed to maintain cleanliness of the ice machine and convection oven surfaces, and failed to ensure hand hygiene was completed between glove changes in a manner to prevent the spread of foodborne illness. This had the potential to affect all residents. The facility census was 64.Findings are:A.A record review of the Ice Machine Monthly Cleaning for Year 2026 record revealed dates cleaned of 01/22/2026, 02/18/2026, and 03/24/2026.A record review of the undated Policy and Procedure Manual Cleaning Schedule copyright 2021 revealed that ice machines should be cleaned twice per month.An observation on 03/30/2026 at 9:15 AM revealed the white plastic piece above the ice in the ice machine had a black substance on it.An observation on 03/30/2026 at 9:18 AM revealed the top convection oven had thick streaks of brown greasy substance on the inner surfaces of both doors, the front edge, and the back of oven.An interview on 03/30/2026 at 2:40 PM with the Dietary Manager (DM) confirmed the inner surface of the top convection oven doors was coated with brown greasy substance, and that the white plastic piece above the ice in the ice machine had a black substance on it. The DM stated the ice machine had been cleaned recently and that they document that on a log.An observation on 03/31/2026 at 1:39 PM revealed the top convection oven had thick streaks of brown greasy substance on the inner surfaces of both doors, the front edge, and the back of oven.An interview on 03/31/2026 at 1:41 PM with the DM confirmed the top convection oven had not been cleaned.An interview on 04/01/2026 at 2:54 PM with the DM confirmed the DM was unaware that the cleaning schedule in the Policy and Procedure Manual said the ice machines should be cleaned twice per month. B.A record review of the data plate NSF Operational Requirements for MODEL HT-25 affixed to the front of the dishwasher revealed that for hot water sanitizing, the wash tank minimum temperature should be 160 degrees Fahrenheit (F).An observation on 03/30/2026 at 9:22 AM revealed the wash tank temperature of the dishwasher reached 142 F during a wash cycle.An interview on 03/30/2026 at 9:22 AM with [NAME] A confirmed that the facility used heat to sanitize and further confirmed that the wash tank temperature reached a high of 142 F during the wash cycle.An interview on 03/30/2026 at 2:40 PM with the Dietary Manager (DM) confirmed the wash tank temperature on the dishwasher was lower than 150 FAn observation on 03/31/2026 at 1:41 PM revealed the dishwasher wash tank temperature was 146 F.An interview on 03/31/2026 at 1:41 PM with the DM confirmed the dishwasher wash tank temperature was 146 F.An observation on 04/01/2026 at 11:08 AM revealed a load of dishes being run through the dishwasher with the wash tank temperature 146 F.An interview on 04/01/2026 at 11:08 AM with the DM confirmed the dishwasher temperature had not been repaired yet. An interview on 04/01/2026 at 2:54 PM with the DM confirmed that the wash water tank in the dishwasher did not reach the minimum required temperature for hot water sanitization.C.An observation on 03/31/2026 at 1:34 PM revealed [NAME] C preparing the entree for supper. [NAME] C washed their hands with soap and water for 14 seconds, weighed the ground beef, put the beef into a pot, touching it with their bare hands, then washed their hands with soap and water for 12 sec.An observation on 04/01/2026 at 10:44 AM during (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preparation of altered consistency foods revealed [NAME] D removed their gloves, threw them away by lifting the lid to the large trash can with their bare hands, then put on new gloves without performing hand hygiene. An observation on 04/01/2026 at 10:55 AM revealed [NAME] D wash their hands with soap and water for 30 sec and put on gloves. [NAME] D then put chicken and gravy into the food processor to puree, removed their gloves and put on new gloves without performing hand hygiene.An observation on 04/01/2026 at 12:03 PM during meal service revealed that [NAME] D was wearing a glove on their right hand and no glove on their left hand. [NAME] D stated they wore one glove on their right hand because that is the hand they handled the serving utensils with and that they do not touch anything but the serving utensils with that hand.An observation on 04/01/2026 at 12:08 PM revealed [NAME] D used their gloved right hand to move one of the dietary carts, unwrap a cup of cottage cheese, then throw the wrapper away in the trash can under the sink. The lid of the trash can touched the back of [NAME] D's gloved hand while disposing of the wrapper. When [NAME] D became aware of that, they removed that glove and put on a new glove without performing hand hygiene. An interview on 04/01/2026 at 12:45 PM with [NAME] D confirmed they should have washed their hands between changing gloves.An interview on 04/01/2026 at 2:54 PM with the DM confirmed staff should wash their hands when changing gloves and that handwashing with soap and water should take 20 seconds.

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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. Licensure Reference Number 175 NAC 12-006.10(D) Based on observations, record reviews and interviews, the facility failed to maintain a medication error rate of less than 5%, which affected 2 residents (Resident 11 and Resident 17) of 3 sampled residents. The medication error rate was 7.69%. The facility census was 64. Findings are: A.An observation of a medication administration on 03/31/2026 at 8:00 AM with Medication Aide (MA) MA revealed MA was preparing Resident 11's medications that consisted of Levothyroxine (is a synthetic hormone used to treat hypothyroidism which is an underactive thyroid by replacing or supplementing the body's natural thyroxine. It boosts metabolism and restores energy levels, usually taken daily and on an empty stomach) 88 micrograms take one tablet on an empty stomach.An observation on 03/31/2026 at 8:00 AM of the bubble pack labeled Levothyroxine revealed to take medication on an empty stomach.During an observation MA administered Levothyroxine at the breakfast table where Resident 11 received breakfast at 8:05 AM.An interview on 03/31/2026 at 8:50 AM with MA confirmed that Resident 11 was given Levothyroxine medication five minutes prior to Resident 11's breakfast. MA confirmed that Levothyroxine should be given 30 minutes prior to breakfast.An interview on 3/31/2026 at 9:00AM with the Director of Nursing (DON) confirmed that the Levothyroxine should have been given 30 minutes prior to breakfast.Record review of Resident 11's order summary revealed that Levothyroxine is to be given 30 minutes prior to meals.Record review of the facility's Medication Administration Policy last updated on 12/03/2025 revealed that staff are to follow the six rights of medication administration which are right resident, right medication, right dosage, right route, right time, and right documentation.Record review of the facility's Medication Regimen Review Policy last updated 10/19/2022 revealed that the pharmacy consultant will review the resident medication regimen including the resident chart at least once a month. The consultant pharmacist may need to conduct the medication regimen review more frequently depending on the resident condition, review of short stay residents and risk of adverse consequences to medication therapy. The consultant pharmacist will report in writing any recommendations and irregularities to the Attending Physician, the community Medical Director and DON and if appropriate the Administrator. B.During a medication administration observation on 03/31/2026 at 8:10 AM MA administered Resident 17's Levothyroxine at the breakfast table while Resident 17 was already eating breakfast. An observation on 03/31/2026 at 8:00 AM of the bubble pack labeled Levothyroxine revealed to take medication daily.During an interview on 03/31/2026 at 8:50 AM with the MA confirmed that Resident 17 was given Levothyroxine while Resident 17 was eating breakfast. MA confirmed that Levothyroxine should be given 30 minutes prior to breakfast.An interview on 3/31/2026 at 9:00 AM with the Director of Nursing (DON) confirmed that the medication Levothyroxine should have been given 30 minutes prior to breakfast.Record Review of the facility's Medication Administration Policy last revised on 12/03/2025 revealed that staff are to follow the six rights of medication administration which are right resident, right medication, right dosage, right route, right time, and right documentation.Record review of the facility's Medication Regimen Review Policy last updated 10/19/2022 revealed that the pharmacy consultant will review the resident medication regimen including the resident chart at least once a month. The consultant pharmacist may need to conduct the medication regimen review more frequently depending on the resident condition, review of short stay residents and risk of adverse consequences to medication therapy. The consultant pharmacist will report in writing any recommendations and irregularities to the Attending Physician, the community Medical Director and DON and if appropriate the Administrator.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Licensure Reference Number 175 NAC 12-006.11(D) Based on observations and interviews, the facility failed to ensure that food was provided at a temperature that was appealing to the residents. This had the potential to affect all residents. The facility census was 64. Findings are: A. An interview on 03/30/2026 at 8:16 AM with Resident 2 revealed that Resident 2 complained that the food was cold when the food is suppose to be hot and cold foods warm An observation and interview on 03/31/2026 at 12:00 PM revealed during meal time Resident 2, Resident 14 and Resident 28 after being served their meals, which consisted of Chicken, mashed potatoes and gravy, and cauliflower, confirmed that the food was not hot that the food was lukewarm. An observation on 04/01/2026 at 1:00 PM revealed the last of the room tray was received. The dietary manager checked the temperature of the food on the room tray. The chicken temperature at 128, cauliflower 106, mashed potatoes and gravy 107. An interview with the DM confirmed that the cauliflower and potatoes on the test tray were not served at a temperature warm enough to be palatable. B. A record review of Resident 12's Quarterly Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 02/12/2026 revealed the resident had a 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 14. During an interview on 03/30/2026 at 11:31 AM, Resident 12 stated the hot food was not hot when served. A test tray was obtained on 04/01/2026 at 1:00 PM due to complaints of cold food during the initial pool process. Temperatures were obtained by the Dietary Manager (DM) and were observed to be as follows: Chicken drumstick: 128 degrees Fahrenheit (F),Mashed potatoes with gravy: 107 F,Parslied cauliflower: 106 F. During an interview on 04/01/2026 at 3:38 PM the DM confirmed that the cauliflower and potatoes on the test tray were not served at a temperature warm enough to be palatable.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. Licensure Reference Number 175 12-007.04 D Based on observations and interview, the facility failed to ensure that ventilation system were operational in residents bathroom for rooms 33,34,36,39,40 and 41 to prevent odors. The facility census was 64. Findings are:An observation on 3/30/26 between 9:45 AM and 10:15 AM revealed the ventilation in the bathrooms did not draw a 1 ply square of toilet paper in residents' bathrooms in rooms 33, 34, 36, 39, 40 and 41. The fans were running but not pulling the 1 ply square toilet paper. An observation on 3/31/26 between 9:54 AM 10:15 AM revealed the ventilation in the bathrooms did not draw a 1 ply square of toilet paper in residents' bathrooms in rooms 33, 34, 36, 39, 40 and 41. The fans were running but not pulling the 1 ply square toilet paper. An interview on 3/31/26 at 10:30 AM with the Maintenance Director confirmed that (gender) only checks the ventilations in the bathrooms monthly when cleaning the vents and turns on the fan and if (gender) hears the fan then (gender) said the ventilation was working. The Maintenance Director confirmed that this is the only way (gender) checks the fans. The Maintenance Man confirmed that (gender) wasn't aware of the ventilation system in the bathrooms where not working. The Maintenance Man confirmed that in the fans came on but did not pull the 1 ply piece of toilet paper. The Maintenance Director confirmed that the ventilation system was not working. An interview on 3/31/26 at 10:45 AM with the Administrator confirmed that the ventilation in the bathrooms was not working and they should be working. The Administrator confirmed there was no policy and procedures regarding the ventilation system.