STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285164	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holmes Lake Rehabilitation & Care Center	6101 Normal Blvd Lincoln, NE 68506

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility failed to ensure food was served in a safe and timely manner to prevent potential food born illnesses. This had the potential to affect all residents who ate from the kitchen. The facility census was 52.Licensure Reference Number 175 NAC 12-006.11 (E) A record review of the kitchen menu revealed the mealtimes were: 8:00 AM for breakfast, noon for lunch and 6:00 PM for supper.An interview on 4/8/26 with the Dietary Manager confirmed that the mealtimes were: 8:00 AM for breakfast, noon for lunch and 6:00 PM for supper.An observation on 4/9/26 at 7:00 AM with the Dietary Manager and the Cook-A who was preparing the lunch meal revealed, Cook-A opened two bags of chicken breast and placed them in two greased pans. Cook-A did not count how many chicken breast had been placed in the two greased pans. The Dietary Manager stated to the Cook-A that (gender) did not believe there was enough chicken breast for the residents. Cook-A stated (gender) believed there was enough chicken. An observation on 4/9/26 at noon with Cook-A serving lunch revealed: -Cook-A took the temperatures before the start of serving: chicken 172.9 degrees (Fahrenheit), rice 167.2 degree and veggies 180.1 degrees-Cook-A then with gloved hands started serving up the plates, where Cook-A would move the food around on the plate with (genders) gloved hands. Cook-A did this without changing (gender) gloves through the whole serving process. Cook-A would move around the kitchen grabbing hot plates, and dish covers with the same gloves on that Cook-A was serving and moving the food around on the plate.-During the serving, it was observed that the main meal of chicken breast was 11 pieces short for the meal.-The Dietary Manager at 12:45 PM started grilling the 11 chicken breasts.-The chicken breast was grilled in the 15 minutes and then coated the chicken breast in the Swiss sauce and put on the plates to serve the remaining residents. An interview on 4/9/26 at 1:30 PM with the Administrator confirmed that Cook-A should not have been touching or moving the food around on the plate with contaminated gloves and that the Dietary Manager should have counted the chicken breast when (gender) did not believe there was enough chicken breast for the meal.

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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(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. The facility failed to ensure Enhanced Barrier Precautions (EBP, refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were used during G-tube (surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach) feeding and medication administration for 1 sampled resident (Resident 5). The facility census was 52. Licensure Reference Number 175 NAC 12.006.18(B) Findings are: A record review of admission record with the printed date of 4/8/26 revealed Resident 5 was admitted with nutritional problems related to dysphagia (difficulty swallowing) following cerebral infarction (stroke). A. During an observation on 04/08/2026 at 1:00 PM Licensed Practical Nurse (LPN-B) administered gastric tube medications to Resident 5 without wearing appropriate EBP. A record review of the facility's MDRO (multi-drug resistant organisms) PPE-Enhanced Barrier Precaution Policy last revised on 03/20/2024 revealed EBP is to be worn for residents with any of the following indwelling medical devices such as central lines, urinary catheters, feeding tubes, and tracheostomies. During an interview on 4/08/2026 at 2:45 PM Licensed Practical Nurse (LPN-B) confirmed that LPN-B should have worn a gown when administering g-tube medications to Resident 5. During an interview on 04/08/2026 at 2:50 PM with the Director of Nursing (DON) also confirmed that when administering medications via G-tube staff should wear a gown and gloves. B. An observation on 4/8/26 at 9:00 AM on Resident 5 room door was a sign for EBP precautions. An observation on 4/8/26 at 1:00 PM revealed LPN-B laid a barrier down on the tray table (Resident 5) where LPN-B placed the glasses of water, syringe, and medications cups. LPN-B did use hand sanitizer and explained to Resident 5 what (gender) was going to do. LPN-B did not have a gown on. LPN-B did listen for placement of G-tube (surgically placed device used to give direct access the stomach for supplemental feeding, hydration or medicine), with a small amount of air in the syringe. LPN-B then added some water and a cup of medication to the syringe and the water and medication went down the G-Tube. LPN-B then added a small amount of water to the syringe and it (the water) did not go down the G-tube. LPN-B tried some air in the syringe and could not get the water to move down the G-Tube. An observation on 04/08/2026 at 2:43 PM revealed LPN-B and LPN-C attempting to unclog Resident 5's G-Tube and LPN-C ended up cutting the G-Tube were it was clogged. LPN-B and LPN-C did not have gowns on during the procedure. LPN-B continued to administer the tube feeding. LPN-B did apply (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves but did not put on a gown. Record review of the facility's PPE (Personal Protective Equipment)- Enhanced Barrier Precautions policy last revised 3/20/24 stated that EBP are an infection control intervention designed to reduce transmission of resident organisms that employs targeted gown and glove used during high contact resident care activities. EBP may be indicated when contact precautions do not otherwise apply for resident with any of the following wounds or indwelling medical devices, regardless of MDRO colonization status. Indwelling medical devices include central lines, urinary catheters, feeding tubes, tracheostomies, or peripheral intravenous line. An interview on 4/08/2026 at 2:45 PM with LPN-B confirms that (gender) should have worn a gown when administering G-tube medications to Resident 5. An interview on 04/08/2026 at 2:50 PM with the Director of Nursing confirmed that when administering medications via G-tube staff should be wearing gown and gloves.