

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 17th Street Fairbury, NE 68352	
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observations, interviews, and record reviews; the facility failed to ensure medications were administered at the right time for 2 (Residents 29 and 49) of 7 sampled residents for medication administration. The facility also failed to ensure the medication error rate was less than 5%. Observations of 25 opportunities of medication administration revealed 2 medication errors, resulting in an 8% medication error rate. The facility census was 50 at the time of survey.</p> <p>Findings are:</p> <p>Record review of the facility provided policy titled Safe Medication Administration Practices with a revised date of May 19, 2025 revealed:</p> <ul style="list-style-type: none"> -nurses must adhere to the five rights of medication administration to include right resident, right medication, right dose, right time, and right route prior to administering the medication -medication error that does not cause harm is referred to as a potential adverse drug event -need to ensure timely administration of scheduled medications -be sure to administer medications identified as time critical within 30 minutes of the intended administration time. <p>Record review of the facility's provided insulin administration policy date revised May 19, 2025 revealed that rapid acting insulin should be administered up to 15 minutes before a meal.</p> <p>Review of insulin definition from Medline Plus.gov - Insulin Aspart is a rapid-acting man-made insulin used to manage blood sugar levels in people with diabetes (disease characterized by high blood sugar levels, resulting from the bodies inability to produce or effectively use insulin). It works by helping the body utilize glucose (sugar) for energy and preventing the liver from producing excess sugar. It's commonly used to treat both type 1 and type 2 diabetes. Insulin Aspart generally has a fast onset of action, meaning it starts working soon after the injection. Insulin Aspart (Novolog) is typically taken 5-10 minutes before a meal.</p> <p>(continued on next page)</p>		

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of package insert from Insulin Aspart revealed instructions to administer Insulin Aspart by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal.</p> <p>A.</p> <p>Record review of Resident 29's admission record printed 6/16/25 revealed the resident was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes.</p> <p>Record review of Resident 29's physician orders revealed the resident had an order with a start date of 03/10/2025 for Novolog (Insulin Aspart) insulin a (rapid acting insulin) routine dose of 6 units with meals and additional units of insulin to be administered according to blood sugars.</p> <p>Record review of Resident 29's Medication Administration Record (MAR) revealed a blood sugar on 6/12/25 scheduled to be done at 0800 was 184 and 2 units of Novolog was given per the residents sliding scale orders.</p> <p>During an observation on 6/12/25 at 8:10 AM Resident 29 ate breakfast in the main dining room.</p> <p>During an observation on 06/12/25 at 9:24 AM RN - A administered Resident 29's insulin in the chapel.</p> <p>During an interview on 06/12/25 at 9:32 AM RN - A confirmed that (gender) usually gives insulin shots after the residents eat their meals and that (gender) normally does the accucheck before the meal and then gives the insulin after the meal. It was also confirmed that (gender) did Resident 29's accucheck before breakfast and gave Resident 29's insulin after breakfast.</p> <p>B.</p> <p>Record review of Resident 49's admission record printed 6/16/25 revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Type 2 Diabetes Mellitus.</p> <p>Record review of Resident 49's physician orders revealed the resident had an order with a start date of 05/16/2025 for Novolog routine dose of 8 units to be given with meals.</p> <p>Record review of Resident 49's MAR revealed that on 6/12/25 insulin is scheduled to be given at 11:30 AM and it was administered subcutaneously at 1:21 PM.</p> <p>During an observation on 06/12/25 at 1:21 PM Licensed Practical Nurse (LPN) - B gave insulin to Resident 49 in the resident's room after lunch.</p> <p>During an interview on 06/12/25 at 1:23 PM LPN - B confirmed that (gender) usually does the resident's accucheck before the meal and then gives the insulin after they eat. It was further confirmed that (gender) did Resident 49's accucheck before lunch and gave Resident 49's insulin after lunch.</p> <p>During an interview on 06/16/25 at 10:37 AM the Director of Nursing (DON) confirmed that insulin administration errors would be considered a significant medication error, and that insulin should be given when it is ordered and before meals.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observations, record review, and interviews; the facility failed to ensure 2 (Residents 29 and 49) of 2 sampled residents for insulin administration were free from significant medication errors. The facility census was 50 at the time of survey.</p> <p>Findings are:</p> <p>Record review of the facility provided policy titled Safe Medication Administration Practices with a revised date of May 19, 2025 revealed:</p> <ul style="list-style-type: none"> -nurses must adhere to the five rights of medication administration to include right resident, right medication, right dose, right time, and right route prior to administering the medication -medication error that does not cause harm is referred to as a potential adverse drug event -need to ensure timely administration of scheduled medications -be sure to administer medications identified as time critical within 30 minutes of the intended administration time. <p>Record review of the facility's provided insulin administration policy date revised May 19, 2025 revealed that rapid acting insulin should be administered up to 15 minutes before a meal.</p> <p>Review of insulin definition from Medline Plus.gov - Insulin Aspart is a rapid-acting man-made insulin used to manage blood sugar levels in people with diabetes (disease characterized by high blood sugar levels, resulting from the bodies inability to produce or effectively use insulin). It works by helping the body utilize glucose (sugar) for energy and preventing the liver from producing excess sugar. It's commonly used to treat both type 1 and type 2 diabetes. Insulin Aspart generally has a fast onset of action, meaning it starts working soon after the injection. Insulin Aspart (Novolog) is typically taken 5-10 minutes before a meal.</p> <p>Review of package insert from Insulin Aspart revealed instructions to administer Insulin Aspart by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal.</p> <p>A.</p> <p>Record review of Resident 29's admission record printed 6/16/25 revealed the resident was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes.</p> <p>Record review of Resident 29's physician orders revealed the resident had an order with a start date of 03/10/2025 for Novolog (Insulin Aspart) insulin a (rapid acting insulin) routine dose of 6 units with meals and additional units of insulin to be administered according to blood sugars.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.006.11(C)</p> <p>Licensure Reference Number 175 NAC 12.006.11(E)</p> <p>Based on observation, interview, and record review, the facility failed to ensure recipes were followed during food preparation (prep) and food reached the required minimum final cooking temperature (temp), ensure all stored food was labeled, dated, and sealed, ensure kitchen surfaces were clean to prevent potential foodborne illness. This had the potential to affect all residents that consumed food from the kitchen. The total facility census was 50.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility's Roasted Fresh Summer Squash recipe dated Spring/Summer 2025 revealed:</p> <p>Ingredients for 50 servings:</p> <ul style="list-style-type: none"> &bull; 12 and $\frac{1}{2}$ pounds (lbs) yellow fresh squash cut into $\frac{1}{2}$ inch thick half [NAME] &bull; 1 cup and 1 tablespoon (tbsp) vegetable oil &bull; 2 tsp iodized salt &bull; 1 tsp garlic powder &bull; 1 tsp black ground pepper &bull; May substitute zucchini for squash &bull; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>May substitute olive oil for vegetable oil</p> <p>&bull;</p> <p>May use other spices in place of salt, pepper, and garlic powder</p> <p>Directions:</p> <p>Combine oil, garlic, salt, and pepper and set aside. Place cut squash in a large bowl and drizzle oil mixture over the squash and toss until all pieces are covered. Place squash in a single layer on a sheet pan sprayed with non-stick spray. Bake uncovered for 10-12 minutes until fork tender and desired internal temperature is reached. The suggested equipment was a 18 by (x) 26 x 1 inch sheet pan. Oven temp was 400 degrees Fahrenheit (F) or 375 degrees F for convection oven. Final internal cooking and holding temp should have been 135 degrees F.</p> <p>A record review of the facility's Mashed Sweet Potatoes recipe dated Spring/Summer 2025 revealed:</p> <p>Ingredients for 50 servings:</p> <p>&bull;</p> <p>12 and $\frac{1}{2}$ lbs(pounds) fresh, peeled sweet potatoes</p> <p>&bull;</p> <p>2 gallons water</p> <p>&bull;</p> <p>$\frac{1}{2}$ lb margarine</p> <p>&bull;</p> <p>3 cups milk</p> <p>&bull;</p> <p>1 tsp iodized salt</p> <p>&bull;</p> <p>1 tsp nutmeg</p> <p>&bull;</p> <p>2 cups brown sugar</p> <p>Directions:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A record review of the facility's Complaint/Grievance Report forms dated 02/25/2025, 02/26/2025, 03/28/2025, and 04/16/2025 revealed 12 residents had submitted complaints regarding the food being overcooked, undercooked, not warm enough, and not fresh. The facility's investigations verified the complaints, and the kitchen staff had been educated or disciplined.</p> <p>A record review of the facility's Temperature Log sheets dated 05/01/2025 - 06/16/2025 did not reveal food temps were recorded for all 3 meals on 25 of 29 days, not all food items had temps recorded on the meals that were recorded, cold items were only recorded for 2 meals, and on 05/16/2025 the oven fried fish was only cooked to 150 degrees F and 06/06/2025 the baked fish was only cooked to 150 degrees F instead of 165 degrees F.</p> <p>An observation of the food prep process on 06/16/2025 at 9:42 AM revealed the Dietary Manager (DM) prepared the menu items for lunch, which was honey glazed turkey, mashed sweet potatoes, roasted fresh summer squash, frosted banana cake, dinner roll/margarine, and beverage. The turkey roast had already been placed in the oven. The observation revealed:</p> <p>&bull;</p> <p>The DM cut the squash into pieces and placed the squash into 2 shallow steam pans, got a large metal bowl and dumped 1 of the steam pans of squash into the bowl, measured vegetable oil and dumped $\frac{1}{2}$ of the measuring cup of vegetable oil over the squash, sprinkled a measured amount of salt, pepper and garlic salt instead of garlic powder over the squash and tossed until the pieces were coated. The DM then dumped the large metal bowl of squash in a shallow steam pan that had not been sprayed with non-stick spray and did not put the squash in a single layer. The DM then repeated the above process with another large metal bowl of squash and another shallow steam pan without spraying the steam pan with non-stick spray or putting the squash in a single layer. The observation did not reveal that the squash had been weighed prior to prep or placed the squash in a single layer while baking.</p> <p>&bull;</p> <p>The DM then cleaned and peeled the sweet potatoes without weighing. The DM then cubed the sweet potatoes (instead of leaving them whole) and dumped them into a large metal pot of boiling water on the stove. After boiling the potatoes for an un-timed amount of time, the DM drained the potatoes and put them into a large mixing bowl. The DM sprinkled 1 tsp nutmeg, 1 tbsp of brown sugar instead of 2 cups, and an un-measured amount of salt over the potatoes. The DM then placed the large mixing bowl on the floor stand mixer and beat the sweet potatoes for an un-timed period. During the process the DM added an un-measured amount of Creamy Classic Mixed Potato dry mix to the sweet potatoes and added water, not milk.</p> <p>&bull;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The DM removed the turkey roast from the oven and cut it in half to remove the deep square steam pan it was in and placed it on a cutting board. The center of the roast was still dark red in color and appeared soft and moist as it was cut into slices. The DM layered the slices of turkey into a large steam pan and poured half of a partially mixed mixing cup of glaze over the turkey slices. The DM then placed the uncovered steam pan of turkey slices into the oven. The observation did not reveal the turkey was ever basted, the glaze was added to the roast during the cooking process, prior to slicing, that the entire amount of glaze was used, and that the turkey was allowed to rest before slicing.</p> <p>&bull;</p> <p>The DM scooped the mashed sweet potatoes from the large mixing bowl into a deep, large steam pan and placed on the steam table. The DM then removed the squash from the oven and checked the temp of the squash which was 88 degrees F, so the DM placed the squash back in the oven. The DM got the turkey slices from the oven and temped the turkey at 114 degrees F so the DM placed the turkey back in the oven. The DM took the pan of sweet potatoes and placed them on the steam table and temped at 120 degrees F, so the DM put the sweet potatoes back in the oven. The DM then removed the turkey from the oven and temped it at 120 degrees F. The DM went to get the sweet potatoes from the oven to re-temp and dropped the entire pan of sweet potatoes on the floor. While the squash and turkey were cooking, the DM prepared the mechanical soft textured turkey and pureed textured (blended to and easy to chew or swallow thickness) without temping the turkey prior to the process, covered with foil, and placed in the oven. The DM then got the turkey from the oven and re-temped several pieces and the warmest was 132 degrees F and placed the sliced turkey back in the oven. The DM removed the squash from the oven and checked several pieces until the DM got a temp of 135 degrees F and placed it on the steam table. The DM then temped the pureed turkey at 130 degrees F and placed it back in the oven. The DM then left to speak with the Administrator and returned and temped the pureed turkey again and it was 165 degrees F and was placed on the steam table. The ovens never brought the mechanical soft textured or sliced turkey to a temperature of 165 degrees F, so the decision was made not to serve the mechanical soft or sliced turkey and get orders from the residents off of the always available menu to feed the residents.</p> <p>In a telephone interview on 06/16/2025 at 4:07 PM, Cook-C confirmed the facility's coolers were always a mess, most of the staff did not temp the food, the staff did not complete temp logs, and the ovens never worked correctly, and the pilot light would go out every time someone closed the door, so maintenance just gave up fixing them. There was a lot of food going out (being served) that didn't meet the minimum final cooking temperature.</p> <p>In an interview on 06/17/2025 at 1:23 PM, the DM confirmed it was the DM's expectation that all meals would be temped and staff would record and that it was not being completed.</p> <p>In an interview on 06/16/2025 at 2:27 PM, the DM confirmed the DM did not follow recipes and should have temped the turkey prior to blending the mechanical soft and puree textured meals.</p> <p>B.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A record review of the facility's undated Labeling and Dating policy revealed food should have been dated with the day or date the food should be consumed (eaten), at the time the food was opened or prepared, and may not exceed the manufacturer's use-by date or three days, whichever is earlier. The cook shall check daily for items that are expiring and discard it accordingly.</p> <p>A record review of the facility's Complaint/Grievance Report forms dated 02/25/2025, 02/26/2025, 03/28/2025, and 04/16/2025 revealed 12 residents had submitted complaints regarding the food being overcooked, undercooked, not warm enough, and not fresh. The facility's investigations verified the complaints, and the kitchen staff had been educated or disciplined.</p> <p>An observation on 06/11/2025 at 8:40 AM revealed the True 3-door refrigerator (fridge) on the South wall contained 1 gallon container of Essentials Classic [NAME] Dressing and 1 gallon container of Hidden Valley Ranch Salad Dressing that had been opened but not dated. The walk-in fridge contained 1 container of [NAME] Cottage Cheese that had been opened but not dated and had an expiration date of 06/10/2025, and 1 5-gallon container of hamburger pickle slices that was opened and not sealed or dated. The dry storage room contained 1 open bag of dry, small, pieces that were not labeled, dated, or sealed and 1 box labeled croutons with a blue bag inside that was opened but not sealed or dated.</p> <p>An observation on 06/11/2025 at 9:27 AM with the DM revealed the True 3-door refrigerator (fridge) on the South wall contained 1 gallon container of Essentials Classic [NAME] Dressing and 1 gallon container of Hidden Valley Ranch Salad Dressing that had been opened but not dated. The walk-in fridge contained 1 container of [NAME] Cottage Cheese that had been opened but not dated and had an expiration date of 06/10/2025, and 1 5-gallon container of hamburger pickle slices that was opened and not sealed or dated. The dry storage room contained 1 open bag of dry, small, pieces that were not labeled, dated, or sealed and 1 box labeled croutons with a blue bag inside that was opened but not sealed or dated.</p> <p>In an interview on 06/11/2025 at 9:27 AM the DM confirmed the True 3-door refrigerator (fridge) on the South wall contained 1 gallon container of Essentials Classic [NAME] Dressing and 1 gallon container of Hidden Valley Ranch Salad Dressing that had been opened but not dated. The walk-in fridge contained 1 container of [NAME] Cottage Cheese that had been opened but not dated and had an expiration date of 06/10/2025, and 1 5-gallon container of hamburger pickle slices that was opened and not sealed or dated. The dry storage room contained 1 open bag of dry, small, pieces that were not labeled, dated, or sealed and 1 box labeled croutons with a blue bag inside that was opened but not sealed or dated. The DM confirmed all items should have been labeled, dated, and sealed.</p> <p>C.</p> <p>A record review of the undated Daily Task Checklist cleaning log for 06/08/2025 - 06/14/2025 sweep/mop at end of shift had been completed on the night shift Tuesday 06/10/2025. It did not reveal a cleaning task for the microwave, oven surfaces, behind the cooking equipment, or the ceilings.</p> <p>A record review of the facility's undated Cleaning Checklist revealed the walk-in refresh was to be completed every Monday and the microwave was to be done on Thursdays. It did not reveal a cleaning task for the oven surfaces, behind the cooking equipment, or the ceilings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 17th Street Fairbury, NE 68352	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 06/11/2025 at 8:40 AM revealed the kitchen microwave contained an uncovered sandwich and had food splatters and debris on all surfaces. There was food debris behind the range. There was a gray fuzzy substance on the electrical and gas lines behind the Southbend range. The Southbend range had food splatters on both of the front doors and the handles were sticky. The Wolf double ovens had food splatters on the front and food debris on the interior bottoms. The walk-in fridge had food drainage on the floor on both sides. The left side interior floor of the walk-in fridge as you enter had food debris and 2 dried hamburger pickle slices. The dry storage room floors had scattered powder spills and food debris on the floors. The ceilings above the shelving on the North wall contained scattered food stains.</p> <p>An observation on 06/11/2025 at 9:27 AM with the DM revealed the kitchen microwave had food splatters and debris on all surfaces. There was food debris behind the range. There was a gray fuzzy substance on the electrical and gas lines behind the Southbend range. The Southbend range had food splatters on both of the front doors and the handles were sticky. The Wolf double ovens had food splatters on the front and food debris on the interior bottoms. The walk-in fridge had food drainage on the floor on both sides. The left side interior floor of the walk-in fridge as you enter had food debris and 2 dried hamburger pickle slices. The dry storage room floors had scattered powder spills and food debris on the floors. The ceilings above the shelving on the North wall contained scattered food stains.</p> <p>In a telephone interview on 06/16/2025 at 4:07 PM, Cook-C confirmed the facility's coolers were always a mess, most of the staff did not temp the food, the staff did not complete temp logs, and the ovens never worked correctly, and the pilot light would go out every time someone closed the door, so maintenance just gave up fixing them. There was a lot of food going out that didn't meet the minimum final cooking temperature.</p> <p>In an interview on 06/11/2025 at 9:27 AM, the DM confirmed the kitchen microwave had food splatters and debris on all surfaces. There was food debris behind the range. There was a gray fuzzy substance on the electrical and gas lines behind the Southbend range that had been there for awhile. The Southbend range had food splatters on both of the front doors and the handles were sticky. The Wolf double ovens had food splatters on the front and food debris on the interior bottoms. The walk-in fridge had food drainage on the floor on both sides. The left side interior floor of the walk-in fridge as you enter had food debris and 2 dried hamburger pickle slices. The dry storage room floors had scattered powder spills and food debris on the floors. The ceilings above the shelving on the North wall contained scattered food stains. The DM confirmed all of the above should have been clean.</p>		

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NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 17th Street Fairbury, NE 68352	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>Licensure Reference Number 175 NAC 12.006.19(A)(i)</p> <p>Based on observation, interview, and record review, the facility failed to ensure the ovens in the facility's kitchen were maintained in a safe and operating condition. This had the potential to affect all residents that consumed food from the kitchen. The total facility census was 50.</p> <p>Findings are:</p> <p>A record review of the facility's Roasted Fresh Summer Squash recipe dated Spring/Summer 2025 revealed the oven temp required was 400 degrees Fahrenheit (F) or 375 degrees F for convection oven. Final internal cooking and holding temp should have been 135 degrees F.</p> <p>A record review of the facility's Mashed Sweet Potatoes recipe dated Spring/Summer 2025 revealed the oven temp was not listed. Final internal cooking and holding temp should have been 135 degrees F.</p> <p>A record review of the facility's Honey Glazed Turkey recipe dated Spring/Summer 2025 revealed final internal cooking temperature should have been 165 degrees Fahrenheit (F) for greater than (>) 1 second.</p> <p>A record review of the facility's Temperature Log sheets dated 05/01/2025 - 06/16/2025 did not reveal food temps were recorded for all 3 meals on 25 of 29 days, not all food items had temps recorded on the meals that were recorded, cold items were only recorded for 2 meals, and on 05/16/2025 the oven fried fish was only cooked to 150 degrees F and 06/06/2025 the baked fish was only cooked to 150 degrees F instead of 165 degrees F.</p> <p>A record review of the facility's Complaint/Grievance Report forms dated 02/25/2025, 02/26/2025, 03/28/2025, and 04/16/2025 revealed 12 residents had submitted complaints regarding the food being overcooked, undercooked, not warm enough, and not fresh. The facility's investigations verified the complaints, and the kitchen staff had been educated or disciplined.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation of the food prep process on 06/16/2025 at 9:42 AM revealed the Dietary Manager (DM) prepared the menu items for lunch, which was honey glazed turkey, mashed sweet potatoes, roasted fresh summer squash, frosted banana cake, dinner roll/margarine, and beverage. The turkey roast had already been placed in the oven. The observation revealed the DM scooped the mashed sweet potatoes from the large mixing bowl into a deep, large steam pan and placed on the steam table. The DM then removed the squash from the oven and checked the food temp which was 88 degrees F, so the DM placed the squash back in the oven. The DM got the turkey slices from the oven and temped (took the temperature) the turkey at 114 degrees F so the DM placed the turkey back in the oven. The DM took the pan of sweet potatoes and placed them on the steam table and temped at 120 degrees F, so the DM put the sweet potatoes back in the oven. The DM then removed the turkey from the oven and temped it at 120 degrees F. The DM went to get the sweet potatoes from the oven to re-temp and dropped the entire pan of sweet potatoes on the floor. While the squash and turkey were cooking, the DM done the mechanical soft textured turkey and pureed textured (blended to and easy to chew or swallow thickness) without temping the turkey prior to the process, covered with foil, and placed in the oven. The DM then got the turkey from the oven and re-temped several pieces and the warmest was 132 degrees F and placed the sliced turkey back in the oven. The DM removed the squash from the oven and checked several pieces until the DM got a temp of 135 degrees F and placed it on the steam table. The DM then temped the pureed turkey at 130 degrees F and placed it back in the oven. The DM then left to speak with the Administrator and returned and temped the pureed turkey again and it was 165 degrees F and was placed on the steam table. The ovens never brought the mechanical soft textured or sliced turkey to a temperature of 165 degrees F, so the decision was made not to serve the mechanical soft or sliced turkey and get orders from the residents off of the always available menu to feed the residents.</p> <p>In a telephone interview on 06/16/2025 at 4:07 PM, Cook-C confirmed the facility's coolers were always a mess, most of the staff did not temp the food, the staff did not complete temp logs, and the ovens never worked correctly, and the pilot light would go out every time someone closed the door, so maintenance just gave up fixing them. There was a lot of food going out that didn't meet the minimum final cooking temperature.</p> <p>In an interview on 06/17/2025 at 1:23 PM, the DM confirmed it was the DM's expectation that all meals would be temped and staff record and that it was not being completed.</p> <p>In an interview on 06/16/2025 at 2:27 PM the DM confirmed the oven had issues and the DM was altering the menus until the oven was repaired.</p> <p>In an interview on 06/16/2025 at 4:48 PM the Administrator confirmed the ovens were not working correctly and the 2 ovens below the stove do not work. The Administrator confirmed they had a new oven in storage but they were still waiting for a part to get it installed.</p> <p>In an interview on 06/17/2025 at 7:18 AM, Maintenance Supervisor (MS)-D confirmed the temp on the stackable ovens in the kitchen were off about 75 degrees. MS-D was able to adjust the setting on the knob and they were still off about 10 degrees. MS-D confirmed a kitchen repair company had been contacted and it would be about 1 week before they could get there. MS-D confirmed the ovens that were in storage were used from a different facility and did not want to install them if the kitchen repair company would be out in a week because MS-D was not sure if they even worked. The 2 Southbend ovens below the stove do not work and they are waiting on a gas regulator that had backordered for a while to get them repaired.</p>		