

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	

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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>52170</p> <p>Based on interview and record review; the facility failed to transmit a Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) record to the Centers for Medicare and Medicaid Services (CMS) within the prescribed time frames for 1 (Resident 6) of 1 sampled resident. The facility census was 31.</p> <p>Findings are:</p> <p>Record review of the Resident Assessment Instrument (RAI) manual revealed the facility is required to transmit the MDS within 14 days of completion.</p> <p>Record review of Resident 6's death tracking record with an assessment reference date (ARD) of 11/19/24, revealed the assessment was completed on 12/2/2024 but was not transmitted to CMS.</p> <p>An interview with the MDS Specialist (MDSS) on 03/10/2025 at 12:01 PM revealed that the MDS was marked as not to be transmitted to CMS. The MDSS confirmed the record should have been submitted to CMS.</p> <p>An interview with the Corporate Nurse Specialist (CNS) on 03/10/2025 at 3:46 PM confirmed the facility follows guidelines in the RAI manual for MDS transmission.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52170</p> <p>Licensure Reference Number 175 NAC ,d+[DATE].09(F)(iii)</p> <p>Based on record review and interview; the facility failed to update the Comprehensive Care Plan (CCP, a written interdisciplinary plan detailing how to provide quality care for a resident) to accurately reflect code status for 2 (Residents 5 and 12) of 2 sampled residents. The facility census was 31.</p> <p>Findings are:</p> <p>Record review of a facility policy entitled Care Plans-Comprehensive dated [DATE] revealed that the facility develops a comprehensive care plan for each resident which would include measurable objectives and timetables designed to meet the resident's medical, nursing, mental, and psychosocial needs through compassionate, trauma informed care, as identified in the comprehensive assessment. The policy identified that the care plan is periodically reviewed and revised by the interdisciplinary team after assessment.</p> <p>A.</p> <p>Record review of Resident 5's Census List dated [DATE] revealed the facility admitted the resident on [DATE].</p> <p>Record review of Resident 5's Diagnosis List dated [DATE] revealed the resident had diagnoses of non-ST elevation myocardial infarction (heart attack), metabolic encephalopathy (a brain dysfunction caused by a problem with the body's chemical processes), and unspecified dementia with behavioral disturbance.</p> <p>Record review of Resident 5's Minimum Data Set (MDS, a federally mandated assessment used for care planning) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 02 which indicated a severe cognitive impairment.</p> <p>Record review of Resident 5's Resuscitation Authorization dated [DATE] revealed the resident wished to have cardiopulmonary resuscitation (CPR) attempted if needed.</p> <p>Record review of Resident 5's updated Resuscitation Authorization dated [DATE] revealed that the resident's code status was changed to Do Not Resuscitate (DNR).</p> <p>Record review of Resident 5's Order Summary Report dated [DATE], revealed an order dated [DATE] for DNR.</p> <p>Record review of Resident 5's CCP revealed an entry dated [DATE] that the resident admitted long-term care and the resident has personal choices. An intervention dated [DATE] identified the resident's code status as CPR/Full Code.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on [DATE] at 2:17 PM with the Social Services Designee (SSD) confirmed that Resident 5's updated code status was DNR and that the care plan was not updated and should have been.</p> <p>B.</p> <p>Record review of Resident 12's Census List dated [DATE] revealed that the facility admitted the resident on [DATE].</p> <p>Record review of Resident 12's Diagnosis Report dated [DATE] revealed the resident had diagnoses that included chronic respiratory failure with hypoxia, dysphagia (difficulty swallowing), cerebral infarction (stroke), myocardial infarction (heart attack), pulmonary hypertension, malignant melanoma of scalp and neck (skin cancer), and congestive heart failure.</p> <p>Record review of Resident 12's MDS dated [DATE] revealed a BIMS score of 9 which indicated a moderate cognitive impairment.</p> <p>Record review of Resident 12's Resuscitation Authorization dated [DATE] revealed the resident wished to have cardiopulmonary resuscitation (CPR) attempted if needed.</p> <p>Record review of Resident 12's updated Resuscitation Authorization dated [DATE], revealed that the resident's code status was changed to Do Not Resuscitate (DNR).</p> <p>Record review of Resident 12's Order Summary Report dated [DATE], revealed an order dated [DATE] for DNR.</p> <p>Record review of Resident 12's CCP revealed an entry revised on [DATE] that the resident has personal choices. An intervention dated revised [DATE] identified the resident's code status as CPR.</p> <p>An interview on [DATE] at 2:17 PM with the SSD confirmed that Resident 12's updated code status was DNR and that the care plan was not updated and should have been.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52170</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on observation, interview, and record review; the facility failed to implement interventions to prevent the potential for hot liquid burns for 1 (Resident 5) of 2 sampled residents. The facility census was 31.</p> <p>Findings are:</p> <p>A record review of the facility's policy entitled Hot Liquids Safety dated 2/16/22 revealed that the facility would have a process in place to assess risk of injury from hot liquids so appropriate interventions could be implemented to reduce the risk of burns.</p> <p>A record review of Resident 5's Census List dated 03/11/2025 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 5's Diagnosis List dated 03/10/2025 revealed the resident had diagnoses of non-ST elevation myocardial infarction (heart attack), metabolic encephalopathy (a brain dysfunction caused by a problem with the body's chemical processes), need for assistance with personal care, visual hallucinations, psychotic disorder with delusions, unspecified dementia with behavioral disturbance, and chronic peripheral venous insufficiency.</p> <p>A record review of Resident 5's Minimum Data Set (MDS, a federally mandated assessment used for care planning) dated 01/07/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 02 which indicated the resident had severe cognitive impairment. The resident required setup or cleanup assistance with eating and was dependent upon staff for wheelchair mobility.</p> <p>A record review of Resident 5's Hot Liquid Safety assessment dated [DATE] identified that Resident 5 would use a cup with lid and drink hot liquids while sitting at a table only.</p> <p>A record review of Resident 5's Comprehensive Care Plan (CCP, a written interdisciplinary plan detailing how to provide quality care for a resident) revised 05/03/2024 revealed that Resident 5 was at risk for injury related to hot liquid burns. The CCP interventions included that Resident 5 would only consume hot liquids while sitting at a table and hot liquids would have a lid.</p> <p>Continuous dining observation on 03/10/2025 at 8:11 AM to 8:59 AM revealed Resident 5 was served coffee in a paper cup with no lid. Resident 5 picked up the cup of coffee and turned the cup in a pouring motion, then sat the cup down on the table. There was no spillage from the cup.</p> <p>An observation on 03/10/2025 at 12:42 PM revealed Resident 5 received a paper cup of coffee with no lid.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 03/10/2025 at 8:43 AM with Lead Server (LS)-F revealed kitchen staff does not serve hot liquids in resident rooms unless it is approved by nursing, residents sit at the table with hot liquids, and all residents who receive hot liquids receive a lid unless the resident requested the lid to be off. If a resident request the lid to be off the cup, the nursing department would be notified.</p> <p>An interview on 03/10/2025 at 1:58 PM with Registered Nurse (RN)-A revealed [gender] was not notified that Resident 5 was served coffee without a lid.</p> <p>An interview on 03/10/2025 at 2:00 PM with Nursing Assistant (NA)-G revealed [gender] was not notified that Resident 5 was served coffee without a lid.</p> <p>An interview on 03/10/2025 at 2:01 PM with Care Partner (CP)-I revealed [gender] was not notified that Resident 5 was served coffee without a lid.</p> <p>An interview on 03/10/2025 at 2:03 PM with CP-H revealed [gender] was not notified that Resident 5 was served coffee without a lid.</p> <p>An interview on 03/11/2025 at 1:32 PM with the Director of Nursing confirmed that Resident 5 was at-risk for hot liquid burns and that the care plan identified interventions of cups containing hot liquids to have lids, and hot liquids to be consumed at a table only. The DON confirmed the expectation is that if the resident is care planned to have lids on hot liquid cups, that the lids would be utilized.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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** 52351</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observation, interview, and record review; the facility failed to ensure a medication error rate of 5% or less as evidenced by three errors out of 25 opportunities and resulted in a medication error rate of 12%. This affected two (Resident 1 and Resident 36) out of three residents sampled. The facility census was 31.</p> <p>The Findings are:</p> <p>A.</p> <p>A record review of an Admission Record indicated the facility admitted Resident 36 to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic right hip joint and age-related osteoporosis without current pathological fracture.</p> <p>An observation on 03/10/25 at 7:12 AM of medications for Resident 36 revealed Register Nurse (RN)-A administered the following:</p> <p>Acetaminophen 500 milligram (mg) take 2 tablets by mouth three times a day. Do not exceed 4 grams in one day. For pain control.</p> <p>Alendronate 70 mg take 1 tablet by mouth weekly with full glass of water on an empty stomach, sit up for 30 minutes, no food, medications, or beverages for 30 minutes. For age related osteoporosis without current pathological fracture.</p> <p>Aspirin low chew 81 mg take 1 tablet by mouth twice a day for 42 days for periprosthetic fracture around internal prosthetic right hip joint.</p> <p>Lidocaine Patch 4% - apply 1 patch at 8:00 AM daily for right hip pain.</p> <p>Oyster Shell/Vitamin D 500/200 tablet take 1 tablet by mouth daily as a calcium supplement.</p> <p>Tramadol HCL tablet 50 mg take 1 tablet by mouth three times a day for pain.</p> <p>Vitamin D3 2000Units (50 micrograms (MCG)) take 1 tablet by mouth daily for supplement.</p> <p>Record review of Resident 36's physician orders revealed the following:</p> <p>-Alendronate tab 70 milligram (mg), take one tablet by mouth weekly with a full glass of water on an empty stomach, sit up for 30 minutes, no food, medications or beverages for 30 minutes. Do not crush.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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>Record Review of manufacturer's recommendation for Resident 36's Alendronate revealed: According to the manufacturer's package labeling for many bisphosphonates, absorption is decreased when Oyster Shell Calcium with vitamin D Oral Tablet 500-5 MG-MCG is co-administered. Clinical impact is not known.</p> <p>An interview with the Director of Nursing (DON) on 3/11/25 at 1:45 PM confirmed the Alendronate should have been given 30 minutes prior to any other medication or food.</p> <p>B.</p> <p>A record review of an Admission Record indicated the facility admitted Resident 1 to the facility on [DATE] with a diagnosis of aspiration pneumonitis and a diagnosis of Gastroesophageal reflux disease (GERD).</p> <p>An observation on 3/11/25 at 8:46 AM revealed Resident 1 finished eating prior to medication administration. RN-A began medication administration at 9:04 AM and administered:</p> <p>Omeprazole 40 mg take 1 capsule by mouth every morning, take 60 minutes before meals, do not crush/chew. For GERD.</p> <p>Record review of Resident 1's physician orders revealed the following: Omeprazole capsule 40 mg - take one capsule by mouth every morning, take 60 minutes before meals, do not crush/chew.</p> <p>An interview was conducted on 3/11/25 at 9:32 AM with RN-A who confirmed Resident 1 had already eaten breakfast. RN-A stated that some residents have requested to receive their medications all together for medications like omeprazole and thyroid replacements because they don't want to be woken up. That's why [gender] omeprazole is scheduled in the AM.</p> <p>An interview on 3/11/25 at 9:35 AM with the Asisstant Director of Nursing confirmed that at the time of medication administration, it would be the expectation to administer the omeprazole 60 minutes before meals.</p> <p>Record review of Resident 1's Omeprazole revealed: According to the manufacturer's guidance, swallow intact with a glass of water at least 1 hour prior to a meal. Do not use with any other liquid. Do not open capsules or mix the contents with food.</p> <p>Record Review on 3/11/25 of the Facility Medication Administration Policy effective 3/8/22 revealed the following:</p> <p>-Medications for individual residents will have pharmacy label with the resident name, drug, dose, directions and prescribing physician.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	
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>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** 52351</p> <p>Licensure Reference Number 175NAC ,d+[DATE].11(E)</p> <p>Based on observation, interview, and record review; the facility failed to ensure expired food was discarded on or before the expiration date and failed to ensure opened food items were sealed and dated. The facility also failed to perform hand hygiene prior to and after touching soiled items while preparing food which had the potential for food borne illness. The facility also failed to measure items according to the recipe while preparing food. This had the potential to affect 30 out of 31 residents who consumed from the main kitchen in the facility. The facility census was 31.</p> <p>Findings are:</p> <p>A.</p> <p>An observation during the initial kitchen tour of the main kitchen on [DATE] at 12:22 PM revealed the dry storage area had two bags of corn flakes opened with no date, and a third bag opened with a date of , d+[DATE]. One bag of premier white chips opened with no date, one small bin of white chips with no lid, one can of coconut pecan frosting with expiration date of [DATE]. One 25 pound bag of lentil beans opened with a date of [DATE] in a tub with no lid. One bag of cinnamon granola opened with no date, seven boxes of cheese sticks that expired on [DATE], one opened bag of jet puffed marshmallows with no date, a small spaghetti bag opened and wrapped with plastic wrap but not dated, a bag of rotini noodles opened with no date, a bag of small pasta shells opened with no date, a bag of elbow macaroni opened with no date, a large bag of spaghetti opened, wrapped with plastic wrap and no opened date, Crunchy dip bag opened with no date. Several gallon jugs of salad dressing with no expiration date to be found on containers. One package of an unidentified white substance with a date of ,d+[DATE] written on it, six boxes cream of wheat that expired [DATE].</p> <p>An interview on [DATE] at 12:30 PM with the Sous Chef (SC-C) confirmed no manufacturer date could be found on the salad dressings and the above listed items were opened, expired foods and available for use in the dry storage area. SC further confirmed that the items listed above should be removed so that they are no longer available for use.</p> <p>An observation on [DATE] at 1:05 PM during the initial tour of the main kitchen of the small freezers that were available on the food preparation line revealed the following; one bag of breaded meat opened with no date, a bag of french fries opened with no date, a bag of tater tots opened with no date, a bag of hash brown patties opened with no date, a large bag of fish opened with no date, a bag of fajita blend veggies opened with no date, a small bag of curly fries opened with no date, a small bag of sweet potato fries opened with no date, a bag of onion rings opened with no date, a box of Quick steak opened with no date, a small steam pan with chicken fried steaks with no cover, one bag of corn opened and dated ,d+[DATE] and two additional bags of corn opened with no date, two bags of peas opened with no date, a bag of sunshine carrots opened with no date, one bag of chuckwagon corn opened with no date, one bag of chicken nuggets opened with no date, and a bag of opened cookie dough with no date.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	

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 interview on [DATE] at 12:22 PM with the Executive Chef (EC-D) confirmed the above listed foods were undated and opened in the freezers, and should be closed and dated.</p> <p>Record review of the facility policy titled Food Storage General Guidelines with a review date of [DATE] revealed under Procedure, General Guidelines:</p> <ul style="list-style-type: none"> -All foods are labeled and dated. -Expiration dates of food products are checked when the stock is rotated. -Food is stored in clean, approved containers that are covered, labeled and dated. This includes foods stored in refrigerators, freezers, and pantries. Opened, dated perishable food is used or discarded following the guidelines provided in item 3) above. <p>B.</p> <p>An observation on [DATE] at 9:00 AM of Lead [NAME] (LC-E) preparing scrambled eggs with ham and cheese for the noon meal using an 80 servings recipe. The LC-E completed hand hygiene and applied clean gloves. The LC-E obtained four 12x24x2 pans, sprayed pans with gloves on, and then poured an undetermined amount of ham cubes into each pan, with no amount measured. The recipe called for 2 pounds plus 3 ,d+[DATE] ounces of ham. LC-E removed gloves, completed hand hygiene and began cracking eggs into a bowl. Egg shells fell in the bowl, LC-E dumped bowl of eggs into trash, removed gloves, rinsed hands under water with no soap and applied new gloves. LC-E then retrieved new bowl and began to crack more eggs. After all the eggs were in the bowl the measurement was at approximately 5 liters, the recipe called for 1 ,d+[DATE] gallons plus 1 ,d+[DATE] cup of eggs. LC-E obtained milk and poured an undetermined amount into the bowl of eggs and mixed with electric blender stick. The recipe called for 1 quart plus 1 ,d+[DATE] cup of milk. LC-E then poured the mixture into four separate pans and determined more egg mixture was needed. Approximately 60 more eggs were cracked and blended without milk and poured into the first pan that needed more egg mixture. The pans were covered with tin foil and then placed in the oven.</p> <p>An observation on [DATE] at 10:06 AM revealed LC-E completed hand hygiene and applied clean gloves then obtained a bag of shredded cheese and dumped a portion into a visibly soiled bowl with food particles. LC-E removed the pans one at a time from the oven with the same gloves on, completed temperature checks and stirred each pan, then with the same soiled gloves on LC-E sprinkled an undetermined amount of cheese on top of all four pans, and returned pans to oven uncovered. The recipe called for 2 pounds plus 3 ,d+[DATE] ounces of cheese.</p> <p>An interview on [DATE] with EC-D at 10:35 AM confirmed that LC-E did not measure the ingredients per the recipe and stated, they have been using the recipe for quite some time and the cooks know the amounts for 80 servings for all recipes. The EC-D also confirmed the hand hygiene and gloving concerns when preparing food.</p> <p>Record review of the Facility Policy Sanitary Conditions effective date [DATE] revealed Policy Statement A: food is stored, prepared, distributed, and served in accordance with professional standards for food service safety.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 17600 Arbor Street Omaha, NE 68130	

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>Record review of the Facility Policy Hand Washing Food Service effective date of [DATE] revealed Procedure:</p> <ul style="list-style-type: none"> -After handling soiled equipment and utensils, -when changing tasks, -scrub for a minimum of 20 seconds. <p>Record review of the Facility Policy Glove Use Food Service effective date of [DATE] revealed Procedure</p> <ul style="list-style-type: none"> -after handling soiled equipment or utensils, -after any activity that contaminates the gloves.