STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Crest Health Center	2824 North 66th Avenue Omaha, NE 68104

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.02(H)Based on interview and record review, the facility staff failed to report an allegation of verbal abuse within the required timeframes for 2 (Resident 8 & 59) of 2 sampled residents. The facility staff identified a census of 143.The findings are:Record review of a facility policy entitled Abuse Reporting dated revised 8/8/2024 revealed: -3. All personnel, residents, family members, visitors, etc., are encouraged to report incident of resident abuse or suspected incidents of abuse. Such report may be made without fear of retaliation from the facility or its staff. -4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator/Director of Nursing/Social Services director. -5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator/Director of Nursing/Social Services director. The following information should be reported: -a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred; -b. The date and time that the incident occurred; -c. Where the incident took place; -d. The name(s) of the person(s) allegedly committing the incident, if known; -e. The name(s) of any witnesses to the incident. -f. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); -g. A written statement of the above information; and -h. Any other information that may be requested by management. 6. Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment of offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. It may also result in facility disciplinary action or termination. -7. Staff members and persons affiliated with this facility shall not knowingly: -b. Fail to report an incident of mistreatment or other offense. -8. The Administrator and the Director of Nursing must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing must be called at home and informed of such incident. -9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. -14. In accordance with the Elder Justice Act, the facility administrator or his/her designee will notify immediately, but not later than two hours after the allegation is made if the events that cause the allegation involved result in serious bodily injury or not later than 24 hour if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the following persons or agencies of such incident as applicable: -a. The State licensing/certification agency responsible for surveying/licensing the facility; -b. The local/State Ombudsman; -c. The resident's representative; -d. Adult Protective Services; -e. Law enforcement officials; -f. The resident's Attending Physician; and -g. The facility Medical Director.Record review of Resident 8's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 5/20/2025 identified the facility admitted the resident on 2/14/2025. Further review of the MDS identified Resident 8 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14. According to the MDS manual, a score of 14 indicated the resident was cognitively intact. The MDS identified Resident 8 had diagnoses which included dementia (a usually progressive condition marked by the development of multiple cognitive deficits [such as memory impairment, aphasia, and the inability to plan and initiate complex behavior]), anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it), depression, bipolar disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone), and psychotic disorder (severe mental disorder that causes abnormal thinking and perceptions). Record review of Resident 59's admission MDS dated [DATE] identified the facility admitted the resident on 6/2/2025. Further review of the MDS revealed Resident 59 had a BIMS score of 14 and the resident had delusions (misconceptions, or beliefs that are firmly held, contrary to reality) during the review period. The MDS identified Resident 59 had diagnoses which included dementia, anxiety disorder, and depression. Record review of Resident 59's Progress Notes dated 7/4/2025 showed a note written by Licensed Practical

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observation, record review and interview; the facility staff 1) failed to utilize hand-washing and gloving techniques to prevent potential food contamination during food preparation and meal service and 2) store foods in a manner to prevent potential food borne illness. This practice had the potential to affect all residents in the facility who ate meals from the kitchen. The facility also failed to monitor refrigerator temperatures daily on resident personal refrigerators. This had the potential to affect all residents that used the unit refrigerator on [NAME] and [NAME] Units. The facility census was 143.Findings are: A. Review of the 7/21/2016 version of the Food Code, based on the United States Food and Drug Administration Food Code and used as an authoritative reference for food service sanitation practices, revealed the following: -2-301.14 Food employees shall wash hands and exposed portions of their arms immediately before engaging in food preparation:-after touching bare human body parts other than clean hands and clean, exposed portions of arms,-after handling soiled equipment or utensils,-during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when tasks are changed,-after handling soiled equipment; and-before donning gloves to work with food. -3-304.15 (A) Single use gloves should be used for only one task and should be discarded when soiled or when interruptions occur in the operation -3-305.11(A) Food shall be protected from contamination by storing the food where it is not exposed to splash, dust, or other contamination. Review of the facility policy Handwashing Guidelines for Dietary Employees implemented 8/16/24 revealed the following:-Handwashing was necessary to prevent the spread of bacteria that may cause foodborne illnesses. Dietary employees should clean their hands in a handwashing sink.-Dietary employees should clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and:-Every time an employee enters the kitchen at the beginning of the shift, after returning from break and after using the toilet,-After hands have touched anything unsanitary (garbage, soiled utensils or equipment and dirty dishes).-After hands have touched bare human body parts other than clean hands (such as face, nose and hair) and -Before donning gloves for working with food. Review of the facility policy Food Safety Requirements with an implemented date of 3/25/25 revealed the following:-It was the policy of the facility that foods would be stored, prepared, distributed and served in accordance with professional standards for food service safety.-Food safety practices should be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with the delivery of the food to the residents. B. Observation on 8/28/25 at 10:50 AM to 11:25 AM revealed the following:- Prep Cook, (PC-D) without washing hands donned clean gloves, cut cucumbers into slices and placed them in a large bowl, removed the gloves, opened the refrigerator door and placed the bowl with cucumbers in the refrigerator. No handwashing was identified after removing the gloves.- PC-D then took 5 packages of Hawaiian King buns, donned gloves, removed the buns from the packages, separated the buns and put them in a large white colored rectangle shaped container.- PC-D removed the gloves, picked up the empty bun packages, lifted the lid to the garbage can and threw the bun containers away in the garbage. No handwashing was identified before donning or after removing gloves. -PC-D then opened the refrigerator, brought out a container of sliced cheese and a package of bread. Donned clean gloves, opened the cheese container and package of bread, spread butter on 1 side of 2 pieces of bread, placed a piece of cheese on 1 slice of bread, placed another slice of bread on top of cheese, put the sandwich in a sandwich bag and then put the cheese sandwich in the refrigerator next to the serving line. Gloves were removed, the cheese container was put back into the refrigerator and then closed the package of bread. No hand washing was identified before donning or after removing gloves.- At 11:29 AM Dietary Aide, (DA-E) without washing hands donned clean gloves picked up a plate, used tongs and placed brisket on the plate, picked up another set of tongs and placed a bun on the plate, picked up other tongs and put a baked potato on the plate, plate was put on the serving tray. -DA-E picked up a plate, opened the door to the heating unit and picked up a container of hamburgers, picked up a hamburger bun with the gloved hand, put it on the plate, used tongs to pick up the hamburger and put it on the hamburger bun, used tongs to pick up baked potato and placed the plate on the serving tray with out completing hand hygiene. -DA-E then opened the heating unit door and returned the container of hamburgers to the shelf. -At 12:08 PM DA-E touched a pair of glasses that they