| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285080 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hillcrest Nursing Home | 309 West 7th Street<br>McCook, NE 69001 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Licensure Reference Number NAC 175 12-006.11(E) Based on observation, record review, and interview, the facility failed to label frozen food packages with contents or dates. This had the potential to affect all 62 residents.A record review of a facility policy, Food Storage Policy, last revised November 2023 revealed the following:Food shall be stored at least 6 inches off the floor. All food and supplies should be stored in compliance with federal and state regulations.All foods shall be clearly labeled with contents, dated with the opening date, and discarded if not dated or expired. Frozen foods shall be dated and properly rotated. An observation on 5/04/2026 at 12:43 PM in the kitchen's walk-in freezer, the first food rack to the left revealed the following:On the 2nd shelf from the top: 2 clear unlabeled plastic bags (each bag greater than gallon-sized) of breaded food items.On the 3rd shelf, 1 clear unlabeled gallon-sized bag of shredded/cut food, 1 clear unlabeled gallon-sized bag of 20 pale brown patties.On the 4th shelf, 2 clear unlabeled bags (each bag greater than gallon-sized) of breaded food items, next to an unlabeled food object wrapped in plastic. On the floor, 1 unlabeled clear plastic bag of 10 breaded patties, the top of the bag tied in a knot. An interview on 5/04/2026 at 12:52 PM with Dietary Cook-A (DC-A) confirmed the bag of meat patties on the floor should have been labeled, dated, and not been on the floor. An interview on 5/04/2026 at 1:01 PM with DC-A confirmed bags of food did not have labels that included contents of the bags or dates to indicate when the items should be used. The interview confirmed the bags did not state whether the item contained cooked or uncooked meat. An interview on 5/06/2026 at 11:54 AM with the Director of Dietary (DD) confirmed the bags in the freezer should have been labeled with contents and the relevant dates. |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Nebraska Reference Number 175 NAC 1-005.06(A) and 12-006.18 Based on observations, interviews and record reviews, the facility failed to have an infection control program that ensured tracking and trending was fully completed and to implement interventions for concerns that were identified to prevent antibiotic overuse, failed to utilize handwashing and gloving techniques to prevent potential cross contamination during personal care for 1(Residents 10) of 4 sampled residents. The facility identified a census of 62. Findings are:A. Record review of Resident 10's Minimum Data Set (MDS) (a federally mandated assessment that aides the facility in identifying a resident's care needs) dated 4/11/2026 revealed the following:<br><br>Section C: the Brief Interview for Mental Status (BIMS) (a screening tool that helps determine a resident's level of cognition, with a score of 0 to 15, 15 being [NAME] cognitively intact) revealed a score of 3.<br><br>Section GG: revealed toilet use coded as dependent.<br><br>Section H: revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel.<br><br>Section I: revealed urinary tract infection within the last 30 days.<br><br>Section M: no skin concerns noted<br><br>An observation on 5/6/2026 from 8:48 AM to 9:45 AM of Resident 10 revealed the resident receiving incontinent care by Nurse Assistant (NA) B and NA-C. NA-B and NA-C entering the room and applying gloves without the benefit of hand hygiene (HH). Both NA's assisted with putting the residents' pants and shoes on for the day. NA- C tucks the soiled brief under the resident then obtained 1 wipe to cleanse the groin area, using the same wipe for 3 swipes. NA-C and NA-B rolled the resident while wearing the soiled gloves and continued cares. NA-C obtained another wipe and swiped 3 times to the center of the buttocks. and with the same soiled gloves obtained a new brief and and tucked it under the resident. NA-C then dipped the soiled gloves into an unlabeled specimen cup to obtain a pink cream to apply to the resident's bottom and then squeezed a large amount of powder over the cream. The NA's rolled the resident over and NA-C used the same soiled glove to dip into the pink cream and apply to Resident 10's groin area. As the NA's completed peri-care the resident voided on the new brief and sheets on the bed. NA-C changed gloves without hand hygiene and NA-B kept the soiled gloves on. Further observations revealed NA-B when cleansing the resident did not wash the residents hip areas. NA-C, with the soiled gloves still on, sat the resident up on the side of the bed to finish dressing Resident 10. NA-B then used a personal wipe to wipe the floor after bagging up the soiled laundry. NA-B left Resident 10's room without completing hand hygiene.<br><br>An interview with NA-B on 05/07/2026 at 7:18 AM regarding the observed incontinent care confirmed missed opportunities for hand hygiene and properly caring for soiled linen.<br><br>An interview with director of nursing (DON) on 05/06/2026 at 12:30 PM confirmed staff is expected to toilet the residents before and after meals and before activities, and to do hand hygiene with glove changing.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of facility policies and procedures for perineal care revised 11/2023 indicates staff will avoid cross contamination by proper glove use and hand hygiene and soiled linens and briefs will be handled per infection control procedures.<br><br>Record review of facility policies and procedures for handwashing/hand hygiene indicates staff are expected to perform hand hygiene with alcohol-based hand sanitizer before applying non-sterile gloves as well as after removing gloves, and staff will wash hands with soap and water when gloves are visibly soiled.<br><br>B.<br><br>Record review of the undated facility policy titled Infection Prevention and Control revealed under Procedure: 1. Investigate, control, and prevent infections in the facility. 5. All staff will be required to wash their hands or use sanitizer after each direct resident contact.<br><br>Record review of the facility infection control binder that contained the facility information regarding infections and tracking and trending each month revealed the following:<br><br>July to December of 2025: A facility map that did not have any documentation on it as well as a seating chart of the facility dining room that did not have any documentation on it.<br><br>January to February of 2026: A facility map that did not have any documentation on it as well as a seating chart of the facility dining room that did not have any documentation on it. A printed report from the facility electronic health record titled The Infection Surveillance Report revealed the number of Healthcare Associated Infections (HAI's) and a summary by infection category. This generated report did not have a complete list of room numbers, signs and symptoms, labs, number of days on antibiotics or other required information for tracking and trending infections.<br><br>An interview with the Infection Preventionist nurse (IP) on 5/7/2026 at 10:15 AM confirmed that the only documentation in the Infection Control binder was the Infection Surveillance Report and the other forms were blank. The IP also confirmed that this report only has the number of infections, type of infection and medication ordered.<br><br>Record review of the facility Quarterly Quality Assurance Meeting (QA)notes dated 1/20/2026 indicated there were 10 Urinary Tract Infections (UTI's) the previous month. Under Focus Audits it is listed for infection prevention to do peri-care audits and catheter cares/hygiene teach to prevent UTI's. The Infection Surveillance Report showed 6 UTI's for December (the previous month), which did not match the QA report.<br><br>Record review of the facility Quarterly Quality Assurance Meeting notes dated 2/17/2026 indicated there were 8 UTI's the previous month. Under Focus Audits it is listed for infection prevention to do peri-care audits and catheter cares/hygiene teach to prevent UTI's, no additional information added, repeated the January QA notes. The Infection Surveillance Report showed 0 UTI's for January (the previous month), which did not match the QA report.<br><br>Record review of the facility Quarterly Quality Assurance Meeting notes dated 3/17/2026 indicated there were 5 UTI's the previous month. Under Focus Audits it is listed for infection prevention to do peri-care audits and catheter cares/hygiene teach to prevent UTI's, no additional information added, repeated the January QA notes. The Infection Surveillance Report showed 0 UTI's for February (the (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | previous month), which did not match the QA report.<br><br>Record review of the facility Quarterly Quality Assurance Meeting notes dated 4/21/2026 indicated there were 6 UTI's the previous month. Under Focus Audits it is listed for infection prevention to do peri-care audits and catheter cares/hygiene teach to prevent UTI's, no additional information added, repeated the January QA notes. The Infection Surveillance Report showed 7 UTI's for March (the previous month), which did not match the QA report.<br><br>An interview with the Director of Nursing (DON) on 5/6/2026 from 11:00 AM to 12:15 PM confirmed that the facility tracks and trends infections by printing the Infection Surveillance Report. The DON also stated that the report was not working accurately during the first part of the year. The DON revealed that the wound nurse was to begin doing peri-care audits and hand hygiene audits based off a Performance Improvement Plan (PIP) for UTI's that was dated 3/17/2026.<br><br>Record review of the undated Quality Performance Improvement Plan that was created post-Covid outbreak 3/17/2026 revealed the facility would begin doing weekly audits of Peri care completion and catheter care. The PIP also indicated toileting and incontinence care every two hours, re-educate on hand hygiene before and after care and glove changes between tasks.<br><br>Record review of the wound nurse audits revealed that the audits were actually education regarding how to perform peri-care and hand hygiene with return demonstration of hand washing and not audits. There was no further documentation found regarding actual peri-care observations/audits.<br><br>An interview with the Registered Nurse (RN) E (the wound nurse) on 5/6/2026 at 12:45 PM confirmed that the forms produced were education not observations of actual peri-care or hand hygiene during cares.<br><br>Record review of the facility Handwashing Competency Audit, which started 4/14/2026 revealed the following each week:<br><br>4/14 to 4/20/2026: 38 out of 122 staff members completed, for a 32.1% compliance rate.<br><br>4/21 to 4/28/2026: 2 out of 124 staff members completed, for a 32.2% compliance rate.<br><br>4/29 to 5/5/2026: 17 out of 126 staff members completed, for a 45.2% compliance rate.<br><br>5/6 to current: 1 out of 126 staff members completed. No compliance rate figured.<br><br>During an interview with the DON on 5/7/2026 at 10:30 AM the DON confirmed the Infection Surveillance Report was used for last year to track and trend does not have all the information needed to completely track and trend infections and does not match the QA numbers. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(3)Based on observation, interview, and record review, the facility failed to provide assistance with oral care in accordance with the resident's assessed needs and plan of care for three (Resident 10. 37. and 40) of four sampled residents. The facility identified a census of 62. A.<br><br>In accordance with the facility's policy titled: Activities of Daily Living (ADL) last revised 11/2020, under policy reads: The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADLs do no deteriorate unless deterioration is unavailable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.<br><br>Record review of facility policy titled Personal Hygiene, last revised 11/2023 under section 3 – oral care – indicate oral care will be provided at least twice daily and as needed.<br><br>Resident 10's Minimum Data Set (MDS) (a federally mandated assessment that aids the facility in identifying a resident's care needs) dated 4/11/2026 revealed the following:<br><br>Section C: the Brief Interview for Mental Status (BIMS) (a screening tool that helps determine a resident's level of cognition, with a score of 0 to 15, 15 being [NAME] cognitively intact) revealed a score of 3.<br><br>Section E: no behaviors noted<br><br>Section GG: revealed bed mobility, transfers and eating required substantial/maximal assistance. Toilet use was coded as dependent.<br><br>Section H: revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel.<br><br>Section I: revealed urinary tract infection within the last 30 days.<br><br>Section K: revealed no difficulty swallowing.<br><br>Section L: revealed no dental concerns.<br><br>Section M: revealed no skin concerns.<br><br>Record review of Resident 10's care plan dated 06/20/2026 revealed the resident required staff to Offer/assist with frequent toileting around meals and activities and at bedtime to promote continence. The care plan further revealed I need moderate assistance to complete grooming and hygiene tasks. I have natural teeth and will need assistance to brush my teeth twice a day and as needed.<br><br>An observation on 05/05/2026 at 8:03 AM revealed a new toothbrush, basin and toothpaste in Resident 10's room dated 05/01/2026 with the package opened but not removed from the package. No other oral care supplies are noted to resident's room.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation on 05/06/2026 at 7:48 AM revealed staff beginning morning cares for Resident 10. Observation revealed staff completing peri-care, dressing and grooming tasks. Observation further revealed no oral care was provided to the resident prior to the resident being transported from the room at 8:16 AM.<br><br>Interview with NA-B on 05/07/2026 at 7:18 AM regarding the observed care confirmed staff missed the opportunity to provide oral care to the resident in accordance with Resident 10's care plan.<br><br>An interview with the Director of Nursing (DON) on 05/06/2026 at 12:39 PM revealed expectations for morning care include peri-care, lotion to extremities, applying compression stockings if ordered, brushing teeth, washing face, combing hair and toileting depending on the resident.<br><br>B.<br><br>In accordance with the facility's policy titled: Activities of Daily Living (ADL) last revised 11/2020, under policy reads: The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADLs do no deteriorate unless deterioration is unavailable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.<br><br>Record review of facility policy titled Personal Hygiene, last revised 11/2023 under section 3 – oral care – indicate oral care will be provided at least twice daily and as needed.<br><br>Record review of Resident 37's Minimum Data Set (MDS) (a federally mandated assessment that aids the facility in identifying a resident's care needs) dated 02/16/2026 revealed the following:<br><br>Section C – the Brief Interview for Mental Status (BIMS) (a screening tool that helps determine a resident's level of cognition, with a score of 0 to 15, 15 being fully cognitively intact) revealed a score of 2.<br><br>Section GG: revealed eating required supervision/touch assistance, toileting was coded as dependent, bed mobility required partial/moderate assistance and transfers were coded as dependent<br><br>Section H: revealed the resident was occasionally incontinent of urine and always continent of bowel.<br><br>Section J: revealed use of pain medications and non-medication pain management.<br><br>Section M: revealed no skin concerns noted.<br><br>Section O: revealed oxygen therapy.<br><br>An observation on 05/05/2026 at 8:02 AM revealed a new toothbrush, basin and toothpaste in Resident 37's room dated 05/01/2026 but still in package, not having been opened yet and no other oral care supplies noted to resident's room.<br><br>An observation on 05/06/2026 at 8:18 AM revealed NA-B assisting Resident 37 with morning cares. During the observation, Resident 37 repeatedly stated I can't hear you, I need my hearing aids! NA-B (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated, They are in the med cart, we will get them later. Observation revealed the resident continued without hearing aids throughout cares despite repeated requests. Observation further revealed no oral care, hand washing or face washing being offered or provided to Resident 37 during the observed morning cares prior to resident leaving room for the day. Despite the resident requiring assistance with ADL care tasks, staff did not observe or assist the resident with brushing teeth or oral hygiene.<br><br>An interview with the Director of Nursing (DON) on 05/06/2026 at 12:39 PM revealed expectations for morning care include peri-care, lotion to extremities, applying compression stockings if ordered, brushing teeth, washing face, combing hair and toileting depending on the resident.<br><br>C.<br><br>Record review of Resident 40's Census Data revealed the resident was admitted to the facility on [DATE].<br><br>A record review of Resident 40's Diagnosis List revealed a diagnosis of unspecified 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]) was added on 8/4/2021. A diagnosis of long term (current) use of anticoagulants (medicines that help prevent blood clots) was added on 8/4/2021.<br><br>Record review of a quarterly MDS dated [DATE], Resident 40 had a BIMS score of 99 which indicated the resident was cognitively impaired. Resident 40 required supervision to complete oral hygiene.<br><br>Record review of Resident 40's Care Plan dated 4/19/2026 revealed an intervention to provide set up help for grooming and hygiene tasks initiated on 9/16/2025.<br><br>An observation on 5/4/2026 at 12:42 PM revealed unopened oral hygiene products dated 5/1 in Resident 40's bathroom in basin on the sink.<br><br>An observation on 5/5/2026 at 10:34 AM revealed, in Resident 40's bathroom, the same toothbrush wrapper was opened to the bristles, but the toothbrush was not removed, and there were no water spots or toothpaste on the wrapper.<br><br>An observation on 5/6/2026 at 1:20 PM revealed, in Resident 40's bathroom, the toothbrush in the wrapper looking the same as it was in the prior observation. Further observation in the cabinet in Resident 40's bathroom revealed no personal toothbrush inside, however, there was another unopened toothbrush inside. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 & 12-006.09(H)(iv)(5) Based on record review and interview the facility staff failed to follow the bowel elimination protocol to prevent constipation for two (Resident 26 and Resident 24) of two sampled residents. The facility census was 62. Findings are:A.<br><br>Review of a policy titled, Bowel and Bladder Management, effective date 11/2023 with revision date 8/2023, indicates the following:<br><br>-Quality Assurance<br><br>The facility will monitor bowel and bladder program effectiveness through audits, care plan reviews, skin reviews, fall tracking, and infection monitoring.<br><br>-Bowel Management<br><br>Nursing will monitor bowel patterns and report: constipation, diarrhea, impaction symptoms, abdominal distention, changes in bowel habits.<br><br>As needed (PRN) and scheduled bowel medication will be administered pre physician orders.<br><br>The physician and responsible party will be notified of significant changes as appropriate.<br><br>B. Record review of Resident 26's Electronic Medical Record (EMR) revealed the following: Resident 26 admitted on [DATE] with diagnoses that include: constipation (when the stool moves too slowly through the large intestine), ulcerative colitis (a chronic inflammatory bowel disease that causes long-lasting inflammation and ulcers in the lining of the large intestine), and non-Alzheimer's dementia (a usually progressive condition marked by the development of multiple cognitive deficits).<br><br>Record review of Resident 26's 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 4/9/2026, revealed the following:<br><br>-Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 6 (which indicated the resident had severe cognitive impairment.)<br><br>-Always incontinent of bowels.<br><br>-Required substantial/maximal assistance for toilet transfers.<br><br>Record review of Resident 26's Care Plan dated 1/30/2026, revealed the resident had incontinence of bladder and bowel. Interventions include offer/assist with frequent toileting around meals and activities and at bedtime to promote continence (initiated 11/11/2025) and resident needs moderate to substantial assistance with grooming and hygiene tasks (initiated 11/25/2025).<br><br>Record review of Resident 26 EMR revealed that Resident 26 did not have a bowel movement on the following dates: 1/6/2026-1/9/26, 1/12/2026-1/15/2026, 1/20/2026-1/21/2026, 1/23/2026-1/24/2026, 1/30/2026-1/31/2026, 3/28/2026-3/29/2026, 4/13/2026-4/16/2026,<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/21/2026-4/22/2026, and 4/27/2026-4/28/2026<br><br>Record review of Resident 26's Order Listing Report dated 5/6/2026 listed the following medications:<br><br>-acidophilus probiotic blend oral capsule (a dietary supplement that contains beneficial bacteria to support digestive health), give 1 capsule by mouth one time a day for gut health.<br><br>-bisacodyl rectal suppository (a medication that contains a stimulant laxative to treat constipation) 10 milligrams (MG), insert 1 suppository rectally as needed for constipation one time a day.<br><br>-milk of magnesia (MOM) concentrate oral suspension (a medication that includes a liquid laxative and an antacid which treats constipation) 2400 MG/10 milliliter (ML), give 30 ml by mouth as needed for constipation once daily.<br><br>During an interview on 5/6/2026 at 9:30 AM, Licensed Practical Nurse (LPN) -G revealed that the night shift provides a list of residents that need bowel intervention based on the Bowel Elimination Protocol and that the medication aide assigned to the specific resident area also receives the list of residents that need intervention and will follow the Bowel Elimination Protocol. LPN-G revealed that the nurses don't necessarily look at what the nurse aides (NA) or medication aides (MA) chart.<br><br>Record review of the Bowel Elimination Protocol, not dated, revealed the following:<br><br>-2nd Day-(48 hours without a bowel movement (BM)) If the resident complains or abdominal/bowel discomfort, please offer a natural laxative foot/fluid (i.e. prune juice, prunes). Only place the name on the list if the resident is complaining or discomfort and requesting intervention.<br><br>-3rd Day-(72 hours without a BM) Give 30mL of MOM PO (or whatever PRN is ordered by their physician) .<br><br>4th Day-(96 hours without a BM) Dulcolax/glycerin suppository to be given on 10p-6a shift.Document on the MAR, progress notes. (Charge nurse to perform focused assessment and document the findings.If bowel sounds are absent, the physician needs to be notified immediately.)<br><br>5th Day-(120 hours without BM) Advance to an enema as ordered, notify provider, and continue with bowel evaluation each shift until resolved. Document in the progress notes, medication administration record (MAR), and below.<br><br>During an interview on 5/7/2026 at 9:06AM, LPN-G confirmed Resident 26 did not have a bowel movement during the date ranges as identified above. LPN-G confirmed that per the facility Bowel Elimination Protocol interventions should have been initiated by the 2nd day and they were not.<br><br>An interview on 5/7/2026 at 11:40 AM with the Director of Nursing (DON) confirmed Resident 26 had not had a bowel movement for the dates identified above and the staff did not follow the facilities Bowel Elimination Protocol for Resident 26.<br><br>C.<br><br>Record review of Resident 24's Census Data revealed the resident was admitted to the facility on<br>(continued on next page) |

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| | 285080 | A. Building<br>B. Wing | 05/07/2026 |

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| Hillcrest Nursing Home | 309 West 7th Street<br>McCook, NE 69001 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [DATE].<br><br>A record review of Resident 24's Diagnosis List revealed a diagnosis of cerebral infarction (a localized area of brain cell death resulting from prolonged lack of blood flow) was added on 4/13/2026. A diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a result from damage to the brain's left hemisphere that causes complete and partial loss of movement affecting the right dominant side, potential aphasia [speech difficulty], and requires extensive rehabilitation) was added on 4/13/2026. A diagnosis of adult failure to thrive (a syndrome in older adults characterized by a complex, often unintentional, decline in physical and mental health, marked by weight loss, malnutrition, dehydration, and functional impairment) was added on 5/5/2026. A diagnosis of muscle weakness (a reduced ability to exert force with muscles, often feeling like extra effort is needed to move arms, legs, or other body parts) was added on 4/13/2026. A diagnosis of polymyalgia rheumatica (a disorder that causes muscle pain and stiffness in your neck, shoulders, and hips) was added on 4/13/2026. A diagnosis of pain, unspecified (a disorder characterized by the sensation of marked discomfort, distress or agony) was added on 4/13/2026. A diagnosis of unspecified dementia with agitation (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] with a common, distressing symptom characterized by restlessness, verbal/physical aggression, and pacing) was added on 4/13/2026. A diagnosis of disorientation (a state of confusion regarding time, place, or identity, often caused by underlying issues like infections, dehydration, medication side effects, or head injuries) was added on 4/13/2026.<br><br>Record review of an admission MDS dated [DATE] revealed Resident 24 had a BIMS score of 99 which indicated Resident 24 was cognitively impaired. Resident 24 was dependent on toileting hygiene.<br><br>A record review of Resident 24's current Care Plan revealed a focus of I have impaired mobility and weakness r/t stroke with right-sided hemiplegia. I am incontinent of bladder and bowel initiated and revised on 5/4/2026. Interventions listed included I need total assistance with toileting hygiene and moderate to substantial assistance to transfer on and off the toilet. Offer/assist with frequent toileting around meals and activities and at bedtime to promote continence initiated on 5/4/2026. Another intervention included was restorative program as ordered to build strength and endurance, promote independence with ADLs, promote bowel/bladder continence, and ensure nutritional needs are met initiated on 5/4/2026. Further record review of Resident 24's current Care Plan revealed a focus of I have acute right arm pain post CVA with right-sided hemiplegia. I am usually able to let staff know when I am having pain. I am taking opioid medication for pain management initiate and revised on 5/4/2026. An intervention included monitor/document for side effects of pain medication. Observe for constipation initiated on 5/4/2026. There were no interventions included in the care plan for constipation.<br><br>A record review of Resident 24's Orders revealed an order for fentanyl transdermal patch 72-hour 25mcg/hour (Fentanyl), apply 1 patch trans-dermally every 72 hours related to polymyalgia rheumatica; pain, unspecified and remove per schedule started 4/28/2026. Further review of Resident 24's orders revealed the practitioner ordered Docusate Sodium Capsule 100 mg, give 1 capsule by (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mouth every 24 hours as needed for constipation started 4/14/2026 with no routine bowel medications were ordered.<br><br>A record review of Resident 24's Bowel Elimination Documentation revealed that Resident 24 did not have a bowel movement on 4/27/2026, 4/28/2026, 4/29/2026, 4/30/2026, 5/2/2026, 5/3/2026, 5/4/2026, 5/5/2026, and 5/6/2026.<br><br>A record review of the Medication Administration Record (MAR) revealed no documentation for the docusate sodium capsule for constipation being administered from 4/27/2026 through 4/30/2026 and 5/2/2026 through 5/6/2026. T<br><br>An interview with Medication Aide (MA)-N on 5/7/2026 at 9:45 AM confirmed that if residents don't have a bowel movement, they would get prune juice on day 2, Milk of Magnesium (over-the-counter treatment for constipation) on day 3, and a suppository (inserted rectally and will help promote a bowel movement to relieve constipation) on day 4. MA-N confirmed that the nurses print out a list showing residents that have not had bowel movements and how long it has been since their last bowel movement. MA-N was shown the bowel elimination documentation for Resident 24 from 5/2/2026 through 5/6/2026 and reviewed Resident 24's MAR for May and confirmed that the resident should have been administered medication to help with the constipation. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>175 NAC Licensure reference number 12-006.09(H)(iii)(1), 12-006.09(H)(iii)(2)Based on record review, interview, and observations, the facility staff failed to evaluate and implement interventions to prevent additional pressure ulcer development for 1(Residents 37) of 3 sampled residents. The facility identified a census of 62. Record review of Resident 37's Minimum Data Set (MDS) (a federally mandated assessment that aids the facility in identifying a resident's care needs) dated 02/16/2026 revealed the following: Section GG: revealed toileting was coded as dependent, bed mobility required partial/moderate assistance and transfers were coded as dependentSection J: revealed use of pain medications and non-medication pain management.Section M: revealed no skin concerns noted. Record review of Resident 37's care plan dated 03/02/2026 revealed the resident had been identified as being at risk for skin breakdown. There was no evidence of the resident's pressure ulcer to their left heel being addressed or of any interventions being put into place to treat the current pressure ulcer or to prevent additional pressure ulcers to the right heel from developing. Record review of Resident 37's Braden Scale (a standardized tool used by healthcare professionals to assess a resident's risk of developing pressure injuries and guide preventative care with a score of 19-23 indicating a low or no risk, 15-18 indicates mild risk, 13-14 indicates a moderate risk and 12 points or below indicates high to very high risk of developing a pressure injury). The following dates of assessment were completed: 02/10/2026 Braden Score on admission: 13 (moderate risk)02/17/2026 Braden Score: 16 (mild risk)03/03/2026 Braden Score: 17 (mild risk)03/10/2026 Braden Score: 14 (moderate risk) Further record review revealed no further Braden assessments were completed for this resident since the last one completed 03/10/2026. Record review of skin evaluation from Resident 37's chart dated 04/29/2026 states no current skin issues. Record review of skin evaluation from Resident 37's chart dated 05/03/2026 indicates new wound, unstageable, in-house acquired to left heel measuring 1.4 centimeters (cm) in length, 1.2 cm in width, no undermining or tunneling noted, 100% eschar (a piece of dead tissue that is cast off from the surface of the skin, particularly after a burn injury, but it can also be seen in conditions such as pressure ulcers). An observation on 05/06/2026 at 6:56 AM revealed Resident 37 laying in bed on the resident's back with entire bottom portion of bilateral feet pressed against the footboard of the bed. Observation revealed no heel offloading to right foot; a soft blue boot was in place to the left foot. An observation on 05/07/2026 at 7:10 AM revealed the resident scooted down in bed with entire bottom of bilateral feet pressed against the footboard with soft blue boot applied to left foot, no interventions to right foot.An observation on 05/06/2026 at 7:30 AM revealed LPN-D and Assistant Director of Nursing (ADON) performing would care to Resident 37's left heel. During the observation, LPN-D stated, regarding left heel wound, Yeah, it's scabbed and we just found it on Sunday (May 3, 2026). Observation further revealed the resident crying in bed after wound care complete stating My leg hurts really bad!.An observation on 05/06/2026 at 6:57 AM revealed Resident 37 crying and grimacing during transfers and shoe application related to left foot pain. When tennis shoes are applied Resident 37 states, Oh that hurts my foot! I should be wearing my booty! NA-B responded, Oh, you can put that on later if you want, but right now I need you to have your shoes on to go to the bathroom. Resident 37 was observed to be a one person assist transfer taking three small steps with the use of 4-wheeled walker to wheelchair. An observation of 05/06/02026 at 9:26 AM revealed Resident 37 sitting in a recliner with tennis shoes in place, resting heels on cross bar of footrest of recliner, applying pressure to bilateral heels. An additional observation at 10:28 AM revealed Resident 37 sitting in a recliner with a blue padded boot applied to the left foot with no interventions to prevent additional pressure injuries from occurring were in place to right foot. An interview with Registered Nurse (RN)-E on 05/06/2026 at 12:48 PM confirmed there were no interventions in place to prevent additional pressure ulcers. RN-E confirmed Resident 37 was at risk of developing a pressure ulcer as the resident sat in the recliner throughout the day resting heels on the crossbar section of the footrest on recliner. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number: 12-09(H)(iv)(6)Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTIs) and maintain bladder continent for one (Resident 10) of one resident reviewed for urinary continence and infection prevention. The facility failed to implement the resident's toileting interventions despite recurrent urinary tract infections, ongoing urinary symptoms, decline in condition, and a history of urosepsis. These failures place the resident at risk for worsening infections, skin complications, discomfort, decline in continence status, and hospitalization. The facility identified a census of 62.Record review of the facility policy titled Perineal Care last revised on 11/2023 revealed under section Policy states Perineal care will be provided routinely and as needed to maintain cleanliness, prevent infection, reduce odor, protect skin integrity, and promote resident dignity and comfort after incontinent episodes. Staff will provide care in a respectful, sanitary, and individualized manner according to resident needs and physician orders. Record review of Resident 10's Minimum Data Set (MDS) (a federally mandated assessment that aides the facility in identifying a resident's care needs) dated 4/11/2026 revealed the following: Section C: : the Brief Interview for Mental Status (BIMS) (a screening tool that helps determine a resident's level of cognition, with a score of 0 to 15, 15 being [NAME] cognitively intact) revealed a score of 3 which indicated the resident had severe cognitive impairment.Section GG: revealed toilet use coded as dependent.Section H: revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel.Section I: revealed urinary tract infection within the last 30 days. Record review of Resident 10's undated Care Plan revealed staff were to Offer/assist with frequent toileting around meals and activities and at bedtime to promote continence. Record review of Resident 10's Progress Notes revealed Resident 10 experienced recurrent infections and multiple antibiotic courses during 2026. Record review of the progress notes from January 2026 to April 2026 revealed the following:On 01/23/2026 the staff documented the resident's Bactrim (an antibiotic medication) would be discontinued on 01/24/2026.On 02/10/2026 the Nurse practitioner (NP) was in the facility and assessed the resident. The NP wrote a new order for Augmentin (antibiotic medication) to be given twice a day for the diagnosis of sinusitis. On 02/17/2026 prior to breakfast the resident was incontinent of a bowel movement (BM) and required assistance with personal care. That day was the last day of their antibiotic for sinusitis.On 02/20/2026 at 11:56 AM the resident complained of generalized back pain rated at a 4 out of 10 and was given an as needed pain medication. At 12:05 PM the resident had complaints of headache and chest pain in addition to back pain. The resident was shaking and has shallow breathing and their oxygen saturation 85%. At 12:12 PM emergency medical services arrived and transported the resident to the hospital. Later on 02/20/2026 staff documented the resident had received intravenous (IV) Rocephin (an antibiotic medication) for UTI. The resident also had new orders for Cephalexin (an antibiotic medication) 250 milligrams (MG) twice daily for 5 days for UTI and Paxlovid (antiviral medication) for 5 days for diagnosis of COVID-19. There was also an order for Vancomycin (antibiotic to treat Clostridioides difficile (C-Diff), a toxin producing bacterium that infects the colon, causing diarrhea and colitis, most often after antibiotic use) started QID (four times per day) for 10 days.On 02/24/2026 the provider follow-up note revealed the resident's gastrointestinal (GI) panel was positive for C-Diff, and leukocytosis/UTI.On 03/02/2026 the resident receive their last dose of Vancomycin and was still experiencing loose stoolsOn 03/08/2026 the stop and watch tool was utilized and noted that resident was requiring more help with ADLs, eating and drinking less, and was tired and weakOn 03/10/2026 the resident's urine culture was received from the emergency department and revealed greater than 100,000 enteric gram-negative rods.On 03/13/2026 the resident was observed to be moaning and stating I don't feel good to staffOn 03/16/2026 the resident was not<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | acting themself. The resident was sitting in a chair in the dining room with their eyes closed, and their hands and feet were noted to be shakingOn 03/17/2026 the provider was updated on the resident's decline and a urinalysis (UA) with micro was ordered by the NP.On 03/19/2026 the facility received the resident's UA results which were abnormal.On 03/19/2026 the resident received a new order for Cipro (an antibiotic medication) 500mg BID for 14 days for UTIOn 03/26/2026 staff documented the resident's Cipro was discontinued on 03/20/2026 because the urine culture was negative.On 04/02/2026 Resident 10 was transferred to the hospital related to tremors and tachycardia (increased heartrate). The resident was admitted to the hospital with a diagnosis of urosepsis (a life-threatening, emergency condition where a urinary tract infection (UTI) spreads to the bloodstream, causing a severe, overactive inflammatory response).On 04/05/2026 hospital discharge documentation revealed Sepsis from urinary source and positive C-Difficile infection. The resident returned to the facility with an order for vancomycin. An observation on 05/04/2026 from 1:19 PM to 4:45 PM Resident 10 was noted to be sitting in the common area by the nurse's station until becoming incontinent of bowel, at which time the resident was taken to resident room where staff laid the resident down in bed and provided peri-cares and then returned the resident to the common area where the resident remained until 4:45 PM. During this continuous observation, Resident 10 was never observed to be placed on the toilet for eliminating bowels or bladder and was never offered any type of hydration. An observation on 05/05/2026 from 7:04 AM to 8:47 AM revealed Resident 10 had been in therapy, in the dining room and the common area before being transported back to the room and placed in a recliner. No toileting assistance was offered. Observations of Resident 10 on 05/05/2026 at 9:07 AM, 10:00 AM, 1:55 PM, 2:57 PM and 4:02 PM revealed Resident 10 sitting or sleeping in the recliner. No toileting assistance was observed during the survey observation period. Interview with NA-B 05/06/2026 at 6:32 AM confirmed that resident had not been toileted during the observation period the previous day. An observation of Resident 10 getting morning care on 5/6/2026 at 6:36 AM revealed the resident was incontinent of bowel movement and the staff provided cares in bed and then got resident up for the day and took them to dining area. An observation on 5/6/2026 from 8:48 AM to 9:45 AM revealed Resident 10 laid down in their bed and two nurse aides provided peri-cares and changed the resident's brief. After the new brief had been placed under the resident, the resident urinated on it, requiring the staff to then change the new brief as well as the resident's soiled bedding. An interview with director of nursing (DON) on 05/06/2026 at 12:30 PM confirmed staff was expected to toilet the residents before and after meals and before activities. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to monitor 2 (Residents 6 and 20) of 2 sampled residents for adverse effects following dialysis treatments. The faciity identified a census of 62 residents. Record review of a facility policy titled, Hemodialysis Access, dated November 2024, revealed the following:The stated purpose of the policy was to ensure safe monitoring, protection, and documentation, of dialysis access sites and prevent complications for residents receiving dialysis.The dialysis site (for example, a fistula, a surgically created connection between an artery and vein to provide long term access for dialysis) would be assessed on admission/readmission, upon return from dialysis, and with any change in condition.After residents return from dialysis, care of the fistula includes 1. Assess dressing; 2. Check for bleeding; 3. Verify thrill and bruit (the audible and palpable signs of turbulent blood flow that mean a fistula is functioning); 4. Monitor for hypotension (low blood pressure); 5. Document findings. Record review of the face sheet for Resident 6 revealed they were admitted on [DATE] with end stage renal disease (final stage of kidney failure where kidneys can no longer function on their own), dependence on renal dialysis, pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and right side of the heart), cardiomegaly (enlarged heart), systolic and diastolic heart failure (when the heart does not pump effectively or relax normally between heartbeats), coronary artery disease (a narrowing or blockage of the arteries that supply oxygenated blood to the heart muscle) , type 2 diabetes mellitus (a metabolic disorder where the body cannot effectively regulate blood sugar), and bipolar disorder (a long term mental health condition that causes extreme mood swing and energy levels).A record review of Resident 6's comprehensive minimum data set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) dated 5/1/26 revealed Resident 6 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score 15 of a possible 15 points, indicating they were cognitively intact.A record review of Resident 6's undated Care Plan revealed the following:Resident 6 had dialysis scheduled three times a week at an outside facility.Obtain, record, and report vital signs as ordered per protocol, initiated 2/17/2025 and last revised 5/20/2025.Assess fistula for inflammation, pain, bleeding after dialysis and as needed, initiated 12/2/16.Use a stethoscope to listen for blood flow (bruit) in a fistula, initiated 12/2/16.Palpate the fistula for a thrill (the purring/vibrating sensation that indicates blood is flowing through, initiated 12/2/16.A record review of Resident 6's Dialysis Communication records from 2/27/26 to 5/4/26 revealed the following:Of the 28 separate dates reviewed, all 28 records were missing vital signs after Resident 6 returned to the facility post-dialysis.7 of the 28 records did not have vital signs recorded by the facility before or after dialysis.On 3/23/26, in dialysis notes, Resident 6 had a very large fluid gain over the weekend, and dialysis staff were unable to remove all extra fluid, and requested the facility stress the importance of the fluid restrictions with Resident 6.B.Record review of the face sheet for Resident 20 revealed they were admitted [DATE] with diagnoses of end stage renal disease, chronic obstructive pulmonary disease (a progressive lung and airway disease that restricts breathing) type 2 diabetes, hypertension (high blood pressure), and coronary artery disease.Record review of Resident 20's quarterly MDS assessment dated [DATE] revealed Resident 20's BIMS score was 15 out of 15 indicating they were cognitively intact.A record review of Resident 20's care plan revealed the resident had dialysis scheduled three times a week, and stated the facility would obtain, record, and report vital signs as ordered per protocol, date initiated 2/17/2025, last revised 5/20/2025.A record review of Resident 20's Dialysis Communication records from 3/2/26 to 5/6/26 revealed the following:Of the 26 separate dates reviewed, all 26 were missing vital signs after Resident 20 returned to the facility post-dialysis.On 4/10/26, in the dialysis facility notes, no dressing was on the CVC (central venous catheter) site, and a request was written to avoid removing the CVC dressing,<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and monitor for infections symptoms due to exposure.A record review of a facility document dated 5/5/26 revealed Resident 20 had gone to the hospital for a procedure, and the resident should elevate their upper extremity as much as possible to control swelling, avoid showering for 24 hours, lift less than 20 pounds for 2 weeks, follow a renal diet, and follow up with the vascular surgery/cardiology specialist.An interview on 5/05/2026 at 3:15 PM with Licensed Practical Nurse-G (LPN-G) revealed Resident 20 was at a hospital having a new fistula created on 5/5/26.A record review of Resident 20's nursing progress notes revealed a note dated 5/06/2026 at 3:20 AM that stated Resident 20 returned from the hospital at 8:30 PM on 5/5/26 by facility van. The right fistula was palpated, and the incision was intact. Vitals signs were included in the note. The progress notes also revealed a new order for hydrocodone/acetaminophen tablets (a narcotic pain reliever with an anti-inflammatory) was received at 5:49 PM on 5/5/26. No other information about Resident 20's condition after the fistula placement was revealed.A record review of the Resident 20's vital sign in the electronic medical record revealed blood pressures charted at the following times:5/4/2026 4:54 PM 90 / 60 millimeters of mercury (mmHg)5/6/2026 6:24 AM 124 / 72 mmHg5/6/2026 4:34 PM 89 / 52 mmHg5/6/2026 8:39 PM 95 / 65 mmHgAn interview on 5/06/2026 at 1:59 PM with Medication-Aide O (MA-O) revealed care on the day of dialysis included different medications being held or administered per physician order, a numbing medication used on the access site for some residents, and taking the blood pressure and in the morning prior to the resident leaving the facility. The interview also revealed no additional care was required afterward.An interview on 5/7/26 at 8:45 AM with the Director of Nursing revealed the nursing staff took vital signs prior to any dialysis residents leaving the facility to go to dialysis, and that no vital signs were taken when they returned, their access sites were assessed each shift routinely, but no extra cares were given after returning from receiving dialysis services to check for bleeding or changes. The interview also revealed there was no policy about how to provide care on the day of dialysis. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 285080 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Nursing Home | 309 West 7th Street<br>McCook, NE 69001 |

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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 (Resident 7) of 5 residents' medication regimens were free from unnecessary bowel management medications. The facility identified a census of 62 residents.Record review of Resident 7's care plan revealed Resident 7 was admitted on [DATE] with diagnoses of coronary artery disease, atrial fibrillation (a type of irregular heart rhythm), Diabetes Mellitus Type 2 (a metabolic disorder where the body can't use insulin effectively), dementia (a progressive condition marked by the development of multiple cognitive and behavioral problems), macular degeneration (an eye disease that commonly leads to vision loss), and a history of falling. A record review of Resident 7's most recent quarterly minimum data set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) dated 2/26/26 revealed Resident 7 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) scored 15 of a possible 15 points, indicating they were cognitively intact. A record review of Resident 7's physician orders revealed an active order for polyethylene glycol (an osmotic laxative with the brand name MiraLAX), 17 grams (g) twice a day to treat constipation, beginning 4/24/25. A record review of Resident 7's physician orders revealed an active order for docusate sodium (Colace, a stool softener) 100 milligram (mg) twice a day to treat constipation, beginning 4/24/2025.A review of Resident 7's bowel record in Point Click Care (PCC) revealed the following:During April 2026, Resident 7 had a BM documented on at least 2 shifts/day for 13 of 30 days and no BMs on 1 of 30 days.During March 2026, Resident 7 had a BM documented on at least 2 shifts/day for 19 of 31 days and did not have any days where zero BMs were charted.During February 2026, Resident 7 had a BM documented on at least 2 shifts/day for 16 of 28 days and 1 day where there was no BM charted.A record review of the website miralax.com revealed the recommended directions for adults to take MiraLAX included using 17 grams of MiraLAX once a day for a maximum of 7 days. An interview on 5/06/2026 at 10:39 AM Resident 7 revealed their usual routine included having 2-3 bowel movements (BMs) per day, which they felt was too often. The interview also revealed they were taking medications to prevent constipation.An interview on 5/06/2026 at 3:20 PM with the Director of Nursing (DON) revealed Resident 7 complained about their bowels to the facility. The interview also confirmed Resident 7 was taking MiraLAX to aid in having routine bowel movements, and that 2-3 bowel movements were too many in one day on a routine basis, and they were unsure why the MiraLAX was ordered by the physician twice daily. |