

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/03/2025
NAME OF PROVIDER OR SUPPLIER  Hillcrest Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1702 Hillcrest Drive Bellevue, NE 68005	

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 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to evaluate change of condition for 1 [Resident 3] of 3 sampled residents. The facility had a total census of 119. Findings are:A. A review of Resident 3's admission Record revealed Resident 3 was admitted to the facility on [DATE] with a diagnosis of infection and inflammatory reaction due to internal right hip prosthesis, chronic systolic heart failure [a condition in which the heart muscle is weakened and cannot pump blood effectively], and presence of prosthetic heart valve. A review of Resident 3's Progress Note dated 8/22/25 revealed Brief Interview for Mental Status [an evaluation of cognitive status] score of 11. A review of MDS [Minimin Data Set; a comprehensive assessment used for care planning] Manual revealed a score of 8-12 indicates moderately impaired cognitive impairment. A review of Resident 3's oxygen saturation levels [a percentage of oxygen carried by red blood cells in the blood stream] documented in the vitals section of the electronic medical record revealed Resident 3's oxygen saturation level was between 92-98% on room air between 8/21/25-8/29/25. A review of undated facility document titled Vital Sign Alert Parameters identified a low threshold of less than 90% for oxygen saturation. A review of Resident 3's oxygen saturation level documented in the vitals section of the electronic medical record revealed an oxygen saturation level of 86% on room air at 9:59 PM on 8/29/25. A review of Resident 3's Progress Note dated 8/30/25 at 4:03 AM revealed Resident 3's oxygen saturation was low in one hand and above 90% in the other hand on 1.5 liters of oxygen. A review of Resident 3's order recap report for orders between 8/21/25-9/30/25 did not reveal an order for oxygen. A review of Resident 3's oxygen saturation level documented in the vitals section of the electronic medical record revealed the following oxygen saturation levels:-8/30/25 at 7:17 AM 90% on room air-8/30/25 at 6:25 PM 86% on room air A review of Resident 3's Progress Note on 8/30/25 at 8:30 PM revealed Resident 3's oxygen saturation level was rechecked and found to be 91% on room air. Resident 3 was noted to refuse oxygen. A review of Resident 3's oxygen saturation level documented in the vitals section of the electronic medical record revealed an oxygen saturation level of 54% on 8/31/25 at 6:58 AM. In an interview on 9/3/25 at 12:55 PM, Nurse Aide A reported that Nurse Aide A checked Resident 3's oxygen saturation level on 8/31/25. Nurse Aide A first checked oxygen saturation on Resident 3's pinkie finger and it was 42-47%. Nurse Aide A then checked oxygen saturation level on Resident 3's ring finger and it started going up to 57-59%. Nurse Aide A reported Resident 3's other vital signs were normal and Nurse Aide A got busy and forgot to notify the nurse of the oxygen saturation level. In an interview on 9/3/25 at 1:17 PM, Medication Aide B reported Resident 3's oxygen saturation level was low and Medication Aide B replaced Resident 3's oxygen when checked on 8/31/25. Medication Aide B reported that Resident 3 was not having trouble breathing. In an interview on 9/3/25 at 11:59 AM, Registered Nurse C reported that Registered Nurse C was not alerted by staff that Resident 3's oxygen level was low. Registered Nurse C reported being alerted by dietary staff around 9:30 AM on 8/31/25 that Registered Nurse C needed to check on Resident 3. Registered Nurse C entered the room and discovered that Resident 3 was gone. A review of Resident 3's Progress Note dated 8/31/25 at 3:49 PM revealed that Registered Nurse C was notified at 9:30 AM that Resident 3 was not responding. Resident 3 was checked on and no signs of life were noted including no heartbeat or respirations. In interviews on 9/3/25 at 4:07 PM, 4:48 PM, and 5:23 PM, the Director of Nursing reported the expectations:-Resident 3's doctor/provider would have been notified when oxygen was applied to Resident 3-When Resident 3's oxygen saturation was low the physician orders would have been checked for any orders for oxygen or as needed medication orders-Resident 3 would have been checked to ensure Resident 3 was breathing through the nose as oxygen was coming through nasal cannula-Resident 3's oxygen saturation level would be rechecked and if oxygen saturation level did not improve doctor would have been called A review of undated facility policy titled Change In Condition or Status of Guest revealed the following:- 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (Interact Version 4.0) Communication Form. B. In interviews on 9/3/25 at 7:47 AM, 10:12 AM, and 10:30 AM, the Administrator reported that an investigation was started on 8/31/25 after Administrator was notified of Resident 3's death with involved staff members being suspended. The Administrator reported that education was of all nursing staff members with all nursing staff members required to complete the education before the next scheduled shift An audit of all residents with oxygen was completed to ensure</p>		