

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER The Willows at Gretna		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Highway 6 Gretna, NE 68028	
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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(iii)(1 & 2)Based on observations, interviews, and record review, the facility failed to evaluate causal factors and failed to implement interventions to prevent pressure wounds for 1 (Resident 3) of 4 sampled residents. The facility staff identified a census of 44. The findings are:Record review of Resident 3's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 7/1/2025 revealed the facility staff identified the following about the resident: -Resident 3 was rarely or never understood and had short and long-term memory problems. -Resident 3 did not exhibit behaviors. -Resident 3 was dependent upon staff for all cares including bed mobility, transfers, hygiene, and toileting. -Resident 3 had a gastrostomy tube (g-tube, a flexible tube passed into the stomach for introducing fluids and liquid food into the stomach) and that Resident 3 received 51% or more of calories through and 501 milliliters (mL) per day or more of fluids through the g-tube. -Resident 3 was identified as at-risk for pressure ulcer development. -Resident 3 had one stage 4 pressure ulcer present on admission.Record review of Resident 3's Braden Risk Evaluation-V2 dated 6/30/2025 identified the resident was at high risk for pressure ulcer development.Record review of Resident 3's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) identified Resident 3 had an actual impairment of skin integrity dated 3/28/2025, and had the potential for the development of a pressure ulcer dated 5/5/2025. The CCP identified interventions that included: -4/17/2025: Bed mobility dependent, transfers dependent. -5/5/2025 Air mattress to bed -5/5/2025 Off load heels as ordered and as needed -5/5/2025: Reposition frequently or more often as needed or requested. -5/5/2025: Pressure relieving/reducing devices on bed/chair. -7/8/2025 Blisters/wounds to bilateral feet -7/16/2026 Foot board removed from bedRecord review of Resident 3's Skilled Nursing Visit Note dated 7/4/2025 identified Resident 3 had impaired skin integrity with a goal to be free from additional wounds.Record review of Resident 3's Order Summary Report printed 8/19/2025 revealed the following provider orders: -Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after feeding is stopped dated 3/24/2025. -Keep Negative Pressure Wound Therapy (wound vac) @ 120 millimeters of mercury (mmHg), assess pump per shift, ensure pump is charged/plugged in (check middle of cord), change canister when full, document output dated 5/8/2025. -If wound vac comes off, okay to pack wound with gauze lightly soaked with saline until next wound vac change day, cover with Mepilex (an absorbent, soft foam dressing) dated 6/30/2025. -Wound vac to coccyx at 120mmHg with continuous suction. Assess pump Q shift for function and change canister prn if full and document output dated 7/10/2025. -Cleanse with Vashe wound cleanser (a hypochlorous acid-based wound cleanser designed to cleanse, irrigate, moisten, and debride acute and chronic wounds, including ulcers and burns, as well as minor cuts and abrasions), cut and apply double layer of collagen alginate (a composite wound dressing made from a combination of natural collagen fibers and acts as a scaffold for new tissue growth, providing a moist wound environment that supports wound healing) to wound bed, specifically over exposed bone, apply DuoDerm (a hydrocolloid dressing that creates an airtight seal and is used to help manage wound under a vacuum assisted closure device) to peri-wound, apply protective layer of film, apply black sponge from wound bed to hip then apply top layer of film, apply suction appliance. Do not allow resident to lay on her back. Change dressing every Tuesday, Thursday, and Saturday dated 7/13/2025. -Pedal Wounds - cleanse area with soap and water, pat dry, apply betadine paint to wound, allow to completely dry daily by facility or hospice nurse dated 8/18/2025. A. Record review of Resident 3's Progress Notes (PN) dated 7/6/2025 identified a fluid filled blister on the bottom Resident 3's right foot measuring 5.5 centimeters (cm) by (x) 4.5 cm and an open area remained to the right heel.Record review of Resident 3's PN dated 7/8/2025 revealed facility staff contacted Resident 3's hospice provider regarding blisters/pressure wounds on bilateral feet. The hospice provider reported they would be at the facility on 7/9/2025. New orders were received for all pedal wounds: Betadine wet to dry dressing: A betadine-soaked gauze followed by dry gauze and abdominal pad (ABD, a large, multi-layered, and highly absorbent dressing) over them as well for padding and so betadine doesn't leak through to socks/bedding. Secure with kerlix (a sterile gauze bandage made of pre-washed, fluff-dried, 100% woven cotton gauze that provides bulk and cushioning) and a light layer of Coban (self-adherent elastic wrap that functions like a tane but sticks only to itself) (no compression) change three times a week and as needed		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I)Licensure Reference Number 175 NAC 1-009.04(D)(i)(1)Based on observation, interview, and record review, the facility failed to ensure bathing and showering water temperatures (temps) did not exceed 110 degrees Fahrenheit (F)(a temperature unite of measure) to prevent potential accidents. The facility census was 44.Findings are:A record review of the facility's Resident Showers policy with a date reviewed/revised of 7/2025 revealed the staff should help the resident sit on the shower chair, turn the shower on, the water temperature should be 98.6 degrees F to 120 degrees F. They could use a thermometer if one was available or test the water on the inside of the staff's wrist. A record review of the facility's Safe Water Temperatures policy with a date reviewed/revised of 7/2025 revealed water temperature should be set at no 98.6 degrees F to 120 degrees F or the state's allowable maximum water temperature. The Maintenance staff would check water heater temperature controls and the temps of tap water in all hot water circuits weekly and as needed.A record review of the facility's Testing and Logging Water Temperatures steps dated 08/23/2025 revealed For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this can still cause burns if exposure reaches five minutes. Although 100 degrees Fahrenheit is considered a safe water temperature for bathing. On 08/19/2025 the bathhouse 100-hall shower was 116.2 degrees F, the 200-hall shower was 115.7 degrees F, and the 100-hall tub was 115.9 degrees F.A record review of the facility's Task Name: Test and log the hot water temperatures log dated 08/13/2025 revealed bathhouse 200's temp was 115.7 degrees F and the bathhouse 100 was 115.6 degrees F.A record review of the facility's Task Name: Test and log the hot water temperatures log dated 07/21/2025 - 07/30/2025 revealed on 7/22/2025 bath house 200's temp was 109.6 degrees F and the bath house 100 was 115.3 degrees F. On 07/23/2025 bath house 200's temp was 113.4 degrees F, bath house 100's tub was 111.4 degrees F, and the bath house 100 was 116.4 degrees F. On 07/24/2025 bath house 200's temp was 111.6 degrees F, Bath house 100 tub was 113.4 degrees F, and the bath house 100 was 111.9 degrees F. On 07/30/2025 bath house 200's temp was 112.6 degrees F, Bath house 100's tub was 112.8 degrees F, and the bath house 100 was 115.2 degrees F. A record review of the facility's Resident Listing Report dated 08/20/2025 revealed out of the 45 residents listed, 1 was in the hospital and 22 were marked as being cognitively impaired (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The report revealed 3 residents often refuse and self bathe.An observation on 08/19/2025 at 12:42 PM with the facility's Regional Lead Maintenance (RLM) revealed the RLM tested the 200-hall bath house sink, and the temperature was 115.5 degrees F. The RLN tested the 200-hall shower, and the temp was 113.7 degrees F. An observation on 08/19/2025 at 12:52 PM with the facility's RLM revealed the RLM tested the 100-hall bath house tub, and the temperature was 115.7 degrees F. The RLN tested the 100-hall bath house shower, and the temp was 116.4 degrees F. In an interview on 08/19/2025 at 3:34 PM, the RLM confirmed that the maximum bathing temperature should be 110 degrees F and the bath house's tubs and showers were not below that.In an interview on 08/20/2025 at 3:35 PM, the facility's Regional Director of Operations (RDO) confirmed the safe bathing temperatures was less 110 degrees F and the facility did not have a policy specific to bathing in a tub. In an interview on 08/21/2025 at 7:15 AM, facility's Administrator confirmed the Resident Listing Report dated 08/20/2025 that the Administrator provided revealed out of the 45 residents listed, 1 was in the hospital and 22 were marked as being cognitively impaired and confirmed those 22 residents bathed in the bath houses, however 3 residents often refuse and self bathe.		

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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	Licensure Reference Number 175 NAC 12.006.11(E) Based on observation, interview, and record review, the facility failed to ensure the chemical low-temperature (temp) dish machine reached a minimum temp of 120 degrees Fahrenheit (F)(a temperature scale) during all wash and rinse cycles. This had the potential to affect 43 residents that consumed food from the kitchen. The total facility census was 44. Findings are:A record review of the facility's Dishwasher Temperature policy dated 8/2023 revealed all items cleaned in the dishwasher would be washed in water that is sufficient to sanitize any and all items. Manufacturer's instructions shall be followed for washing and sanitizing. The wash temp shall be 120 degrees F. Water temperatures shall be measured and recorded prior to each meal.A record review of the facility's undated Dishwashing: Machine Operation Guideline and (&) Procedure Manual revealed all dishwashing machines should be operated according to the manufacturer's recommendation. The staff should check the dishwashing machine first and if the unit has not been used for several hours, allow the dishwashing machine to cycle for one or two cycles to allow the dishwashing machine to come up to proper function. If the machine is found out of the acceptable range for either final rinse temp or chemical sanitizing concentration, do not proceed to wash dishes. A record review of the National Sanitation Foundation (NSF) Machine Operational Requirements sticker on the facility's dish machine revealed wash temperature was a minimum of 120 degrees F, and the minimum rinse temperature was 120 degrees F.A record review of the facility's Dish Machine Temperature Log - Low Temperature dated July 2025 revealed the minimum temperature is 120 degrees F or to manufacturer rating. On 07/26/2025 breakfast log revealed a wash temp of 115 degrees F. 07/24/2025 and 07/26/2025 did not reveal any readings were recorded.A record review of the facility's Dish Machine Temperature Log - Low Temperature dated August 2025 revealed the minimum temperature is 120 degrees F or to manufacturer rating. Only 3 of 19 days were breakfast readings recorded. 08/02/2025, 08/05/2025, 08/12/2025, and 08/19/2025 did not reveal any readings were recorded.A record review of the undated American Dish Service AF-3D Dishwasher - Specification Sheet revealed Supply Water Temp: 120 degrees F minimum (low-temp chemical sanitize).A record review of American Dish Service Installation Instructions dated 08/20/2025 revealed water heaters or boilers must provide the minimum temperature of 120 degrees F required by the machine listed above. An observation on 08/19/2025 at 2:19 PM revealed Dietary Aide (DA)-B rinsed off dishes and put them on a rack. DA-B then opened the dishwasher and removed a large cookie sheet and put it away, DA-B pushed the rack of sprayed off dishes in the dishwasher, started the dishwasher, and returned to spraying off other dishes. The thermometer on the dish was read 116 degrees F during the wash cycle and 124 degrees F during the rinse cycle. At 2:24 PM, DA-B removed the dishes from the dish machine and started another load. DA-B put the cleaned dishes from the dishwasher away in their designated areas in the kitchen. The 2nd observed load in the dishwasher reached 119 degrees F on the wash cycle and 128 degrees F on the rinse cycle. When that cycle was completed, DA-B put the dishes away in their designated area in the kitchen.An observation on 08/20/2025 at 7:37 AM revealed that DA-A loaded the dishwasher with a rack of 4 plates and 4 plastic trays and started the machine. DA-A continued to spray off dishes in the sink as the dish machine ran. The wash temp reached 80 degrees F and the rinse temperature reached 100 degrees F on the thermometer. At 7:39 AM DA-A unloaded the dishwasher, pushed another load of 2 plates, a large plastic pitcher and lid, and 1 bowl in, and started the dishwasher. DA-A put one of the plates back on the dirty side and put the rest away in the kitchen. The load that was started at 7:39 AM wash temp reached 90 degrees F and the rinse temp reached 94 degrees F. At 7:47 AM DA-A unloaded the dishwash and put the dishes away. In an observation on 08/20/2025 at 7:41 AM with the facility's Cook-A, that had been identified as the assistant dietary manager revealed DA-A ran a load of 2 large bowls and 1 plate through the dishwasher. The was temp reached 98 degrees F and a rinse temp of 101 degrees F. At 7:45 AM DA-A ran a load of 11 plates and 2 bowls through the dishwasher and the wash temp reached 102 degrees F and a rinse temp of 119 degrees F. At 7:55 AM, DA-B put the dishes away in the kitchen.In an interview on 08/20/2025 at 7:47 AM, DA-A confirmed the thermometer on the dishwasher was not working right and the machine used twice as much detergent as it should. DA-A confirmed DA-A forgets to look at temp gauge on the dishwasher. In an interview on 08/20/2025 at 10:05 AM, DA-A confirmed the dishes that were put away that morning were used for the lunch food preparation and service. In an interview on 08/20/2025 at 11:16 AM, the facility's Registered Dietician (RD) confirmed the facility's dishwasher should have reached a minimum temperature of 120		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LICENSURE REFERENCE NUMBER175 NAC 1-005.06 (D & E)LICENSURE REFERENCE NUMBER175 NAC 12-006.18 (B & D)Based on observation, interview, and record review, the facility failed to utilize a gown during personal cares for a resident who was identified as being in Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition [e.g., residents with wounds or indwelling medical devices]) for 1 (Resident 4) of 3 sampled residents; and the facility failed to ensure staff performed hand hygiene between glove changes to prevent cross contamination for 1 (Resident 4) of 5 sampled residents. The facility staff identified a census of 44.The findings are: A. Record review of a facility policy entitled Enhanced Barrier Precautions dated revised 5/31/2025 revealed: -EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves use during high contact resident care activities. -2b. An order for enhanced barrier precautions will be obtained for residents with any of the following: -i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. -3b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. -4. High-contact resident care activities include: -a. dressing -b. bathing -c. transferring -d. providing hygiene -e. changing linens -f. changing briefs or assisting with toileting -g. device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters -h. Wound care: any skin opening requiring a dressing. Record review of Resident 4's admission Record printed 8/20/20025 revealed the facility admitted the resident on 11/20/2024 and identified diagnoses which included multiple sclerosis (MS, a demyelinating disease marked by patches of hardened tissue in the brain or the spinal cord and associated especially with partial or complete paralysis and jerking muscle tremor), paraplegia, non-pressure chronic ulcer of the left foot, and unspecified open wound of left buttock.Record review of Resident 4's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 5/10/2025 revealed 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. Further review of the MDS identified the resident was dependent upon staff for bed mobility and transfers, had an indwelling urinary catheter, and was always incontinent of bowel. The MDS identified Resident 4 had two Stage 2 pressure ulcers that were present on admission.Record review of Resident 4's Order Summary Report printed 8/20/2025 lacked an order for EBP.Record review of Resident 4's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed the facility required EBP due to pressure injury and urinary catheter. The CCP further directed staff to wear gowns and gloves during high-contact resident care activities.Observation on 8/20/2025 at 9:55 AM revealed an EBP sign that has the letter B written at the bottom.Observation on 8/20/2025 from 9:55 AM through 10:20 AM revealed Nurse Aide (NA)-D and NA-E assisted Resident 4 with morning care. NA-D and NA-E each performed hand hygiene and donned (applied) gloves. Without donning a gown, NA-D assisted Resident 4 with perineal care in bed after a bowel movement and applied a new brief. Without donning a gown, NA-D changed Resident 4's urinary catheter drainage bag to a leg bag and assisted Resident 4 to roll side-to-side in bed to pull up a pair of slacks. Without donning a gown, NA-D and NA-E placed the lift sling under Resident 4, crossed the straps and secured the lift sling to the Hoyer lift, and transferred the resident to the wheelchair.An interview on 8/20/2025 at 10:23 AM with NA-E revealed NA-E was not aware of the need to utilize EBP when providing high contact cares with Resident 4.An interview on 8/20/2025 at 10:25 AM with the Director of Nursing (DON) confirmed Resident 4 was in EBP for wound and urinary catheter. The DON was unsure of the reason for the letter B being marked at the bottom of the sign.An interview on 8/20/2025 at 12:29 PM with NA-D revealed NA-D was not aware of the need to utilize EBP when providing high contact		