

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Maple Crest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) and 12-006.09(H)(iii)(2). Based on observation, interview and record review the facility failed to implement and monitor interventions to prevent the development of pressure ulcers and to promote wound healing for 3 (Resident 1,2 and 3) of 4 residents sampled. The facility census was 150. The findings are:A.Record review of the facility's policy titled Pressure Injury Prevention Guidelines revealed it is the policy of the facility to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Under the section, Policy Explanation and Compliance Guidelines revealed:-individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment such as moisture management, impaired mobility, and nutritional deficit. -the goal and preferences of the resident and/or authorized representative will be included in the plan of care.-interventions will be implemented in accordance with physician's orders, including the type of prevention devices to be used and, for tasks, the frequency of performing them. -in the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care and will notify the physician to obtain orders. -prevention devices will be utilized in accordance with the manufacturer's recommendations (e.g. heel floatation devices, cushions and mattresses).-interventions will be documented in the care plan and communicated to all relevant staff. -compliance with the interventions will be documented in the medical record. -the effectiveness of the interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: development of a new pressure injury, lack of progression towards healing or changes in the wound characteristics, changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights. B.Record review of the National Library of Medicine article titled Nursing Assessment of Pressure Injury Risk with the Braden Scale dated 11-21-2022 revealed the Braden Scale is an evidence-based nursing tool to assess a patient's risk of developing pressure ulcers based on a score:-a score of 0 to 9 indicates a very high risk of pressure ulcer development.-a score of 10 to 12 indicates a high risk of pressure ulcer development.-a score of 13 to 14 indicates a moderate risk of pressure ulcer development.-a score of 15 to 18 indicates a mild risk of pressure ulcer development.-a score of 19 to 23 indicates no risk of pressure ulcer development. C.Record review of Resident 3's Electronic Medical Record (EMR) under the assessments section revealed Resident 3's Braden Scale Score (BSS) on 05-19-2026 was 17 indicating mild risk of pressure ulcer development. Record review of Resident 3's Skin Check Evaluation (SCE) dated 05-19-2026 revealed Resident 3 had bruising to the left and right forearms and left lateral leg, a surgical wound to the left shin, and general redness to the coccyx (tailbone). Record (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 285149	Facility ID: 285149 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Maple Crest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 05-25-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE]-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required touching assistance with bed mobility.-required partial assistance with bathing-required total assistance with lower body dressing and putting on and taking off footwear. -had a fractured left tibia/fibula (bones in the lower leg).-had surgical repair of fractures with surgical wounds. -was at risk for developing pressure ulcers/injuries.-had no unhealed pressure ulcers/injuries. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 05-21-2026 revealed Resident 3 was at risk of impaired skin integrity due to decreased mobility, bowel and bladder incontinence, and non-weight bearing status. The goal was for Resident 3's skin to remain intact, and interventions listed were:-air loss mattress (a specialized medical surface designed to treat and prevent pressure ulcers) make sure it's plugged in and functioning properly, weight-based alternating on a 15-minute cycle.-Braden skin risk evaluation to be completed on admission, every week for 4 weeks, quarterly and with any significant change. -Nurse aids to observe skin with morning and bedtime cares, report any abnormalities to the nurse.-Consult the dietician for nutritional assessment as needed. -maintain good skin hygiene, moisturize dry skin as needed. -observe for alteration in skin integrity and report to the healthcare practitioner. Skin is inspected by licensed staff weekly. -Provide adequate nutrition and hydration, nutritional supplements and vitamins as ordered.-provide rest periods throughout the day-record percentages of meal consumption. Record review of Resident 3's Progress Note (PN) dated 05-21-2026 revealed Resident 3 had Deep Tissue Injuries (DTI: According to the MDS Manual a DTI is a purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to both heels and skin prep (premoistened towelettes that apply a protective breathable film to intact skin) and prevalon boots (a medical device designed to completely float and offload the heels to prevent and treat pressure injuries in non-ambulatory individuals) were started. Record review of Resident 3's PN dated 05-26-2026 revealed Resident 3 had a DTI to the right heel measuring 2.71 centimeters (cm) in length by 2.63 cm in width and the left heel had a DTI measuring 2.83 cm in length by 2.09 cm in width. Record review of Resident 3's EMR under the section weights and vitals revealed on 07-01-2026 Resident 3 weighed 125 pounds. An observation conducted on 07-07-2026 at 6:12 AM revealed Resident 3 was in bed with a air loss mattress in place on the bed set at 500 pounds with alternating 15-minute and 25-minute cycles. An interview conducted with Registered Nurse (RN) A on 07-07-2026 at 1:35 PM revealed the air loss mattress, Prevalon boots and the treatment of skin prep to the heels was implemented after the DTI were discovered to the bilateral heels. An interview conducted with the Director of Nursing (DON) on 07-07-2026 at 2:30 PM confirmed Resident 3's mattress should be set according to Resident 3's weight. D. Record review of Resident 1's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-had a diagnosis of Diabetes Mellitus, Dementia and Functional Quadriplegia. -cognitive skills for daily decision making were severely impaired.-required total assistance with eating, dressing, hygiene, bathing, toileting, bed mobility and transfers.-was at risk of developing a pressure ulcer.-had pressure ulcer to the sacral area (lower part of the back located at the base of the spine just above the tailbone and between the buttocks). Record review of Resident 1's CCP dated 09-28-2021 and revised 06-18-2026 revealed Resident 1 had an alteration in skin integrity related to having a history of pressure ulcers prior to admission, dementia, bowel and bladder incontinence, immobility, dependence on staff for repositioning, Further review revealed on 04-13-2026 Resident 1 sustained open areas to the coccyx. The goal was stabilization and/or improvement of skin integrity as evidenced by no further (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Maple Crest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	development of pressure injuries, and existing open areas to the coccyx showing signs of healing dated 04-21-2026. Interventions implemented on 04-21-2026 were:-air loss mattress in place, ensure it is plugged in and functioning properly.-leave brief open to air.-turn scheduleInterventions implemented prior to 04-21-2026 were:-cleanse perineal area with each incontinence episode-consult dietician for nutritional assessment as needed, nutrition/hydration interventions as ordered. -tilt wheelchair for pressure reduction and positioning-ensure special mattress is in place for pressure relief- pressure relieving Comfort M2 cushion for wheelchair-Prevalon boots at all times-provide rest periods throughout the day-record amount taken of nutritional supplement-record percentage of meal consumed-staff will turn or reposition the resident every 2 hours-weekly skin assessment, refer skin issues to the wound team and physician for evaluation and treatment orders. Record review of Resident 1's Skin Check Note (SCN) dated 04-11-2026 revealed the skin issue evaluated was on the buttocks and was described as scars and discoloration. Record review of Resident 1's SCN dated 04-13-2026 revealed Resident 1 had 3 new wounds to the left buttock identified as Skin Issue (SI) 2, 3 and 4. The SCN revealed Wound 2 measured 1.0 cm in length by 1.0 cm in width and 0.1 cm in depth, Wound 3 measured 1.5 cm in length by 1.5 cm in width and 0.1 cm in depth and Wound 4 measured 1.0 cm in length by 1.0 cm in width and 0.1 cm in depth. The SCN also revealed a new wound to the right buttock measuring 1.0 cm in length by 1.0 cm in width by 0.1 cm in depth. Record review of Resident 1's Tissue Analytics Evaluation ([NAME]) dated 04-14-2026 revealed Resident 1 had several stage 2 pressure ulcers (according to the MDS Manual a stage 2 pressure ulcer is a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister) to the buttocks, and the right and left buttocks ulcers were measured together as 7.68 cm in length by 4.95 cm in width by 0.1 cm in depth. Record review of Resident 1's April 2026 Documentation Report (DR) for turning and repositioning side to side every 2 hours revealed on 04-11-2026 and 04-12-2026 there was no documentation of turning and repositioning from 6:00 AM to 12:00 PM. Record review of Resident 1's [NAME] dated 04-21-2026 revealed Resident 1's wounds were evaluated and the stage 2 pressure ulcer measured 3.68 in length by 4.45 in width by 0.1 in depth and the wound looked less irritated. Record review of Resident 1's Treatment Administration Record (TAR) revealed no order for an air loss mattress and check for Record review of Resident 1's SCN dated 04-24-2026 revealed Resident 1's wound had deteriorated and a new treatment order was obtained. Record review of Resident 1's PN dated 04-24-2026 revealed Resident 1 can no longer be gotten early in the morning and is to only be out of bed for meals and then placed back in bed and positioned from side to side, 11 days after the stage 2 pressure ulcer was identified and the day the stage 2 pressure ulcer had deteriorated. Record review of Resident 1's Progress Note (PN) dated 04-24-2026 revealed Resident 1 was given a Roho cushion (a specialized, air-filled medical cushion designed for wheelchair users and individuals who sit for extended periods of time) for the wheelchair, 11 days after the stage 2 pressure ulcer was identified. Record review of Resident 1's Skin and Wound Progress Note (SWPN) dated 04-29-2026 revealed Resident 1 was seen by the Wound Nurse Practitioner (WNP) and Resident 1's pressure ulcer to the buttocks was a stage 3 pressure ulcer (According to the MDS Manual a stage 3 pressure ulcer is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Dead tissue may be present but does not obscure the depth of tissue loss) measuring 10.91 cm in length by 5.24 cm in width and the wound bed contained dead skin tissue. Record review of Resident 1's PN dated 05-01-2026 revealed Resident 1 was sent to the hospital due to a high blood sugar level, and the pressure ulcer to the coccyx (tailbone). An interview conducted with the DON on 07-07-2026 at 2:00 PM confirmed the Roho wheelchair cushion was not implemented until 04-24-2026 and the pressure (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Maple Crest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	ulcer had already deteriorated and confirmed the absence of documentation of turning side to side every 2 hours on 04-11-2026 and 04-12-2026. E. Record review of Resident 2's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 5. According to the MDS Manual a score of 0 to 7 indicates severe cognitive impairment. - required set-up assistance with eating.-required total assistance with hygiene, toileting, bathing, dressing, bed mobility and transfers.-was frequently incontinent of bowel and bladder.- was at risk for pressure ulcer development. Record review of Resident 2's CCP dated 03-13-2022 revealed Resident 2 had the potential for altered skin integrity related to cognitive impairment and friction and sheer during bed mobility and transfers. The goal was Resident 2's will maintain intact skin integrity. Interventions listed on the CCP were: -air loss mattress, settings were reviewed and adjusted to the resident's weight-based pressure setting dated 05-18-2026. -complete a Braden assessment quarterly and with any significant change dated 03-13-2022-consult the dietician for a nutritional assessment as needed dated 03-13-2022-nutrition and hydration interventions per physician orders dated 03-13-2022.-provide rest periods throughout the day dated 03-13-2022-record percentage of meal consumption dated 03-13-2022-weekly skin evaluation, refer skin issues to wound team and the physician for evaluation and treatment orders dated 03-13-2022. Record review of Resident 2's Treatment Administration Record (TAR) for July 2026 revealed an order for Prevalon boot to left heel while in bed. An observation conducted on 07-06-2026 at 12:00 PM revealed Resident 2 was lying in bed on an air mattress that was set between 250 and 300 pounds, and the Prevalon boots were in the recliner. An observation conducted on 07-06-2026 at 1:25 PM revealed Resident 2 was sitting in the wheelchair; the air mattress was noted to be set between 250 and 300 pounds. An observation conducted on 07-06-2026 at 2:45 PM revealed Resident 2 was lying in bed with the air mattress set between 250 and 300 pounds and the Prevalon boots were in the recliner. An observation conducted on 07-07-2026 at 6:00 AM revealed Resident 2 was lying in bed with the air mattress set at 150 pounds and the Prevalon boots were in the recliner. An interview conducted with the DON on 07-07-2026 at 2:15 PM confirmed Resident 2's air mattress should have been set at 150 pounds and Resident 2 should have had Prevalon boots on while in bed.		