STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285163	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Estates	2520 Avenue M Gothenburg, NE 69138

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Licensure Reference Number 175 NAC 12-006.11Based on record review, observation, and interview the facility failed to follow the menus and recipes to ensure that residents were receiving the required nutritional intake during meals. This affected all residents eating meals from the kitchen. The facility census was 39. Record review of the facility policy The Dining Experience; Staff Responsibilities copyright dated 2013 revealed the goals of the dining experience are to enhance the individual's quality of life through person centered dining: providing nourishing, palatable, and attractive meals that meet the individual's daily nutritional needs. The food service manager will perform meal rounds routinely to determine if the meals are timely, attractive, nutritious, and meet the needs of the individual. The food service manager will observe meals for preferences portion sizes, temperature, flavor, variety, and accuracy. The food service manager will report any concerns to the administrator, nursing director, registered dietician or designee, or other staff as appropriate. Food will be the proper texture/consistency to meet each individuals' needs and desires. Under the subheading portion control the serving utensils were described; a #8 scoop is 1/2 cup or 8 ounces.Record review of the Certified Dietary Manager certificate for the Dietary Manager (DM) revealed that the DM was certified on 7/2/24 and continued to be certified as a Certified Dietary Manager for the facility. Record review of the menu posted for 6.16.2026 revealed the dietary staff was to serve beef and broccoli stir fry with fettuccine noodles, buttered bread roll, soft brownies, and a beverage for the noon meal. A. Record review of recipes received from the Dietary Manager (DM) on 6.16.26 revealed the recipes for beef and broccoli stir fry, soft fried noodles, mini egg rolls, and brownies.In an interview with the DM on 6.16.2026 at 10:12 AM, it was revealed the DM had substituted buttered bread rolls for the egg rolls because nobody liked the egg rolls that I ordered. The DM did not indicate this was an approved substitution from the Registered Dietician.In a confirmation interview on 6.16.26 at 11:20 AM, the DM confirmed that the egg rolls which were to be served were not served and that dinner rolls which had been cooked the day before would be served to the residents.In an interview on 6.16.26 at 1:15 PM, the Administrator (Admin) confirmed that menu substitutions needed consent from the Registered Dietitian, especially the buttered dinner rolls for the egg rolls which were completely different in the nutritional makeup of the foods.B. Record review of the recipe for the brownies received from the DM revealed the only ingredients in the brownie recipe were brownie mix and water. There was no butter called for in the recipe.Observation on 6.16.26 at 10:15 AM revealed brownies that resembled a dump cake with dry ingredients on top.In an interview with the facility cook (Cook-D) on 6.16.26 at 10:15 AM, it was revealed Cook-D had worked at the facility for 18 months and worked only in the kitchen. Cook-D revealed that the dessert for the day was already completed and that Cook-D had used too much butter when the brownies were prepared and so had merely sprinkled more cake mix on the top of the dessert.C. Record review of the recipe of the stir-fried noodles revealed the following recipe requirements for 30 servings:1 pound 13 ounces of dry fettucine pasta1 gallon 3 quarts of water2/3 cup of oil4 3/4 ounce fresh green onion minced1 1/4 teaspoon (tsp) black pepper4 tablespoon (Tbl) soy sauceThe noodles were to be cooked in lightly salted water and cooked until tender. The oil was to be heated in a wok or heated frying pan, and the green onions were to be added and sauteed for 5 (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	minutes. The noodles were to be added slowly while gently stirring the noodles until they were lightly browned and crisp on the outside and seasoned with pepper and soy sauce.Each serving consisted of using a #8 or 1/2 cup serving size per person.Observation on 06/16/2026 10:20 AM of the meal preparation by the facility cook (Cook-D) revealed Cook-D opened 4-16 ounce boxes of Fettuccine noodles, emptied the contents into a large rectangular cooking container, took the container to the sink and ran an unmeasured amount of hot water into the pan with the noodles and placed the pan in the steam oven to cook the noodles at 10:25 AM. The noodles were removed from the steam oven at 10:59 AM, drained, and returned to the rectangular cooking pan. Cook-D poured an unmeasured amount of vegetable oil onto the noodles, stirred the noodles, placed a plastic wrap over the noodles, and placed the covered noodles in a hotbox until time to serve the meal. In a confirmation interview on 6.16.26 at 11:05 AM, Cook-D confirmed that there was nothing added to the water and the pasta during or after it was cooked. D. Record review of the beef and broccoli stir-fry recipe revealed that the recipe called for the following ingredients - among others- to make 48 servings:12 pounds of beef stew meat10 pounds of broccoli florets frozen7 onions1 quart and 2 cups of waterAfter the meat and vegetables were cooked, a mixture of soy sauce, brown sugar, cornstarch, ginger and water was to be added to the meat and broccoli prior to serving and brought up to a final temperature of at least 165 degrees Fahrenheit (F).The resulting serving size was 2-#8 scoops for a total of 1 cup of the meat dish.Observation on 06/16/2026 10:25 AM of the meal preparation by the facility cook (Cook-D) revealed Cook-D removed the beef from the oven and transferred the beef to another large rectangular baking pan and covered with plastic and placed in a hot box until ready for further preparation. Cook-D then poured oil into a large wok/frying pan on the stove and added 6 pounds of broccoli to the pan and 2 small, sliced onions and began to fry the vegetables. Once the vegetables were heated and fried to the point of tender, Cook-D added the beef to the vegetables and cooked everything together, stirring occasionally. Cook-D added a soy sauce, brown sugar, ginger and cornstarch mixture that followed the recipe for the 48 servings to the mixture, brought this all to a temperature over 165 degrees F, covered the food and put this in a hot box to maintain temperature prior to serving. In a confirmation interview on 6.16.26 at 11:05 AM, Cook-D confirmed the beef and broccoli recipe used was for 48 people Cook-D further confirmed only 10 pounds of beef was cooked and the recipe required 12 pounds of beef, only 6 pounds of broccoli were prepared in the dish that required 10 pounds of broccoli, only 2 onions were used in the stir fry which required 7 onions, and that the required 1 quart and 2 cups of water had not been added to the stir fry which resulted in a very sticky meal consistency. E. Observation of Cook-D on 6.16.26 during the time period of 12:05 PM to 12:57 PM during the service of the meal, Cook-D prepared each plate for residents who received the beef and broccoli stir fry using tongs to measure a small amount of noodles and then another small amount of the meat and vegetables onto the noodles. The measurements were inconsistent in size and portion of both the noodles and the meat and vegetable mixture. A total of 32 plates of beef and broccoli stir fry were served to residents. All residents were served the brownie dessert.In an interview on 6.16.26 at 1:15 PM, the Administrator (Admin) confirmed that by not following the recipes that the residents had definitely not received the required amount of protein for each resident. The Admin further confirmed that meat and vegetable portions were not appropriate and that residents needed the appropriate nutritional intake of proteins, vegetables, etc. The Admin reported there was no excuse for facility staff to not follow the recipes.

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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. Licensure Reference Number 175 NAC 12-006.11(E) Based on record review, observation, and interview, the facility failed to perform handwashing when working with foods, failed to perform temperature checks of the facility's kitchen refrigerator and freezer units, and failed to maintain potentially hazardous foods at the appropriate temperature. This affected all residents in the facility. The facility census was 39. A. Record review of the facility policy Hand Hygiene dated June 2022 revealed that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel residents and visitors. This applies to all staff working in all locations with in the facility. Hand Hygiene is defined as a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol based hand rub. 1.) Staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. 6.) Additional considerations include; a.) the use of gloves does not replace hand hygiene. If you task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Observation of the facility cook (Cook-D) on 6/16/26 during the period of 10:15 AM to 10:42 AM revealed Cook-D used gloves during the preparation of the meat and broccoli. Cook-D put on gloves and removed a pan of meat from the oven. When Cook-D finished removing the meat from the pan and transferring to another one, Cook-D removed gloves from both hands and continued to work without performing hand hygiene.Observation of Cook-D on 6/16/26 12:05 PM to 12:55 PM in the kitchen while the noon meal was served revealed: -Cook-D washed both hands with soap and water prior to starting the meal service and filled several dishes of food. Cook-D used separate tongs for the meat/vegetable dish, the noodles, and the bread. -At 12:14 PM Cook-D went to the refrigerator to obtain prepared sandwiches. Cook-D put a glove on the left hand only, obtained and prepared a plate with a ham and cheese sandwich and chips, and handed this to the dietary aide through the dining room service window. Cook-D removed the glove from the left hand, put the used glove on the counter approximately two feet away, and prepared more plates for meal service without hand hygiene. -At 12:18 PM, Cook-D donned a glove on the left hand, fixed a hamburger, removed the glove and put it next to the other glove on the counter approximately two feet to the left with the glove discarded earlier. Without the benefit of hand hygiene, Cook-D added a small amount of the main meal to the resident's plate. Cook-D continued to prepare more plates for the residents in the dining room. -At 12:27 PM, Cook-D donned a glove on the right hand only, prepared a plate of hamburger and chips and gave the plate to DA-C. Cook-D did not perform hand hygiene and continued to prepare more plates for service. -At 12:39 PM, Cook-D was told one resident wanted a peanut butter and jelly sandwich. Cook-D removed the plastic from the container with the already prepared sandwiches, removed a sandwich with their bare hands, and prepared the plate and handed it to DA-C. -At 12:43 PM, Cook-D was told one resident wanted a ham and cheese sandwich, removed a ham and cheese sandwich from the container of sandwiches with bare hands, prepared the plate with chips. -At 12:46 PM, Cook-D was informed another resident wanted 2 ham sandwiches, Cook-D removed 2 ham sandwiches from the container of sandwiches with bare hands, and prepared the resident's plate.Interview with Cook-D on 6/16/26 at 11:05 AM confirmed they had not washed hands after donning and doffing gloves when working with the meat and should have.In a confirmation interview with the DM on 6/16/26 at 1:05 PM, confirmed that hand hygiene must be followed during meal service and while preparing foods in the kitchen.B. Record review of the policy titled HACCP and Food Safety with a copyright date of 2013 it was revealed that facility staff will be well trained on food safety policies and procedures. Supervisors will monitor staff and correct any problems or concerns at the time they occur. The food service manager will implement a food safety system to prevent food borne illness. (A food borne illness is an illness that is transmitted to humans through food.) The US Department of Health and Human Services Food Code uses 41 degrees Fahrenheit (F) for cold foods and 135 degrees F for hot (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	foods. Record review of the dietary staff meeting notes dated 6/8/26 received from the Dietary Manager (DM) revealed;Cooks were told they had to start temping out food, charting it, temp it again before serving, especially the room trays.Survey (mandated yearly state survey of the facility by the department of health and human services) can be any day now so keep yourself prepared by doing things the right way at all times, then there will be no bad habits to break when they get here.Attached to the written notes was information that had been used for training that revealed the temperatures which foods need to be maintained (41 degrees F or below for cold foods and 135 degrees F for hot foods. There was also information pertaining to Food Code implementation and foodborne illness risk factor reduction.Record review of the walk-in freezer temperature logs for the month of June 2026 (which was labeled March 2025 at the top of the page) revealed that freezer temperatures were not logged on 6/6/26, 6/7/26 or the morning of 6/9/26.Record review of the walk-in refrigerator temperature logs for the month of June 2026 (which was labeled March 2025 at the top of the page) revealed that refrigerator temperatures were not logged on 6/6/26, 6/7/26 or the morning of 6/9/26.In an interview with the Dietary Manager on 6/10/26 at 9:10 AM it was revealed that the facility uses and follows the US Department of Agriculture Food Code while working with foods and in the kitchen. The DM also confirmed there were missing temperature recordings for the daily refrigerator and walk-in freezer temperature checks from the past weekend 6/6-7/26 and on 6/9/26.C. Observation of Cook-D on 6/16/26 12:05 PM to 12:55 PM in the kitchen while the noon meal was served revealed: -At 12:31 PM, Cook-D checked the temperature of the beef and broccoli and it measured 105 degrees Fahrenheit (F). Cook-D did not check the temperature of the noodles. The foods were handed to DA-C who delivered the food to the table. -At 12:50 PM [NAME] -D finished serving the meal and did a temperature check of the foods that remained. Foods remained above 135 degrees on the steam table. In an interview with COOK-D at 12:31 it was confirmed that the temperature of the meat/broccoli dish was 105 degrees F and that the noodles were not checked for temperature. Cook-D further confirmed the meal was served to the resident at that time without rewarming.In a confirmation interview with the DM on 6/16/26 at 1:05 PM it was confirmed that the facility does follow the USDA Food Code. The DM further confirmed hot foods are to always be above 135 degrees F during the service of the meals.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Licensure Reference Number 175 NAC 12-006.05 (D)(E)Based on record review and interview the facility failed to ensure that all residents and/representatives were given the risks and benefits of psychotropic medications prior to the first dose of a medication or when the psychotropic medication dosage was increased. This affected 3 of 5 sampled residents (Resident 2, 21, and 26). The facility census was 39. Record review of the facility policy dated 6/2026 revealed that it is the intent of the policy to ensure residents only receive psychotropic medications when other non-pharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. A chemical restraint was defined as any drug that is used for discipline or makes it more convenient for staff to care for a resident and not required to treat medical symptoms. Adequate indications for use were defined as the identified and documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. The policy stated that a psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.In a confirmation interview with the Director of Nursing (DON) on 6.15.26 at 10:20 AM, it was revealed that there were no Consents for the Use of Psychotropic Medications found in the files of Residents 21, Resident 26 or Resident 2 while performing resident chart audits prior to the survey. The DON confirmed that (gender) had been the facility DON for one year. Although nursing staff do call the families to let them know of medication changes these forms were not completed prior to 6.3.2026. When it was discovered that the residents did not have these documents in their medical records, the facility staff contacted all the Power's of Attorney (POA) for these residents and received telephone consents. Then a copy of the Consent for the Use of Psychotropic Medications form was mailed to those POA's.A.Record review of the quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 6.5.26 revealed Resident 21 was admitted on 3.1.24, had a Brief Interview for Mental Status (BIMS - a brief screener that aids in detecting cognitive impairment) score of 15 (13-15 indicates a person is cognitively intact), had no rejection of cares, no wandering or behaviors in the 7 day look back time period, had a complex medical history that included non-Alzheimer's dementia, depression, major depressive disorder, and others, and took an antipsychotic medication and an antidepressant medication. The last Gradual Dose Reduction (GDR - stepwise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued) was completed on 5.27.25 and the physician had included a rationale stating that it was contraindicated to reduce the medication dosage of the psychotropic medications.Record review of the medication orders for Resident 21 revealed this resident had orders for the following medications: Abilify also known as aripiprazole (an antipsychotic medication used to treat various medical conditions including major depressive disorder) 5 milligram (mg) 1/2 tablet at bedtime used to treat depression started on 10.28.24; and Bupropion hydrochloride (an atypical antidepressant medication used to treat major depressive disorder) 150 mg at bedtime started on 9.19.25.Record review of the Consent for the Use of Psychotropic Medications form revealed a completion date of 6.3.26 in which telephone consent for the use of the medications for Resident 21 was received from this resident's POA. Potential side effects, available alternatives, benefits of the medications, the right to refuse treatment, the need for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	continued use of the above listed medication would be reviewed quarterly and as needed, consent could be withdrawn at any time, and questions had been asked and answered were all marked as discussed with the resident representative at the time of consent for the medications. The Consent for the Use of Psychotropic Medications form requested consents for the following medications:9.19.25 Bupropion hydrochloride extended release 150 mg every night for major depressive disorder recurrent moderate - an antidepressant depressant medication; and10.28.24 Abilify 5 mg 1/2 tablet every night for depression - an antipsychotic medication.B.Record review of the quarterly MDS dated 3.30.26 for Resident 26 revealed that this resident was admitted to the facility on 4.22.25, had severe cognitive impairment, was rarely understood, had rejection of cares and treatments 1 to 3 times a week in a 7 day look back period, antidepressant and antianxiety medications, had progressive neurological disorder, non-Alzheimer's dementia, severe malnutrition, restlessness, and agitation. Record review of the Progress Notes for Resident 26 revealed that the last GDR was completed on 5.27.26.Record review of the medications orders for Resident 26 revealed there were orders for the following medications:Risperidone (an atypical antipsychotic that can be used at times by healthcare providers to treat behavioral disturbances such as severe agitation and/or aggression associated with dementia) 0.5 mg twice a day for dementia with agitation started on 4.2.26;Lorazepam (a medication used for short-term relief of severe anxiety, anxiety associated with depression, or general anxiety disorders) 0.5 mg twice a day for restlessness and agitation and used as an antianxiety medication started on 5.21.26;Lorazepam 0.5 mg daily as needed for restlessness and agitation used as an antianxiety medication started on 5.21.26; andLorazepam 0.5 mg three times a day as needed for restlessness and agitation that was started 4.27.26 and ended on 5.21.26.Record review of the Consent for the Use of Psychotropic Medications form revealed a completion date of 6.3.26 in which telephone consent for the use of the medications for Resident 26 was received from this resident's POA. Potential side effects, available alternatives, benefits of the medications, the right to refuse treatment, the need for continued use of the above listed medication would be reviewed quarterly and as needed, consent could be withdrawn at any time, and questions had been asked and answered were all marked as discussed with the resident representative at the time of consent for the medications. The Consent for the Use of Psychotropic Medications form requested consents for the following medications:Risperidone 0.5 mg twice a day for dementia with agitation started on 4.2.26;Lorazepam 0.5 mg twice a day for restlessness and agitation and used as an antianxiety medication started on 5.21.26;Lorazepam 0.5 mg daily as needed for restlessness and agitation used as an antianxiety medications started on 5.21.26; andLorazepam 0.5 mg three times a day as needed for restlessness and agitation that was started 4.27.26 and ended on 5.21.26 was not included on the consent form as it had been discontinued prior to date of consent for treatment.C.Record review of the quarterly MDS dated 5.1.26 revealed that Resident 2 had a BIMS score of 15, no signs of hallucinations or delusions, no behaviors, no psychosis, no refusal of cares and no wandering in the 7 day look back period and received antidepressant and antipsychotic medications with indications for the medications, and took an antipsychotic medication regularly, had non-Alzheimer's dementia, depression, post-traumatic stress disorder (a psychiatric condition that can develop after experiencing or witnessing a life-threatening or terrifying event. People with PTSD experience persistent, frightening thoughts, severe anxiety, and flashbacks long after the traumatic event has ended, severely disrupting their daily lives), major depressive disorder, and other diagnoses. The last date for the GDR was completed on 4.6.26 with an indication for use.Record review of the physician orders for Resident 2 revealed that this resident received the following medications:Citalopram (an antidepressant medication) 40 mg daily for major depressive disorder started on 4.4.24; andAbilify 10 mg at bedtime for post-traumatic stress disorder and started 9.12.25.Record review of the Consent for the Use of Psychotropic Medications form revealed a completion date of 6.3.26 in which telephone consent for the use of the medications for Resident 2 was received from this resident's POA. Potential side effects, available alternatives, benefits of the (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(c)(ii)Based on record review and interview the facility failed to complete a Significant Change 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) Assessment with in 14 days of a identified significant status change for 2 (Resident 6 and Resident 43) of 12 sampled residents. The facility census was 39.Findings are: Record review of a facility policy titled MDS 3.0 Completion and dated 05/2026 revealed it was the policy of the facility that residents are assessed using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary care plan. A Significant Change Assessment (SCSA) should be completed within 14 days of the identification of a status change. A significant change is defined according to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) as a decline or improvement in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting.-Impacts more than one area of the resident's health status-Requires interdisciplinary review and or revision of the care plan.Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated 10/2025 revealed a (SCSA) is appropriate when:-A condition is not self-limiting (will resolve without clinical intervention within 2 weeks)-If there are either two or more areas of decline or two or more areas of improvement such as a change in Activities of Daily Living (ADL), residents decision-making ability, presence of a resident mood item not previously reported, resident incontinence pattern changes, unplanned weight loss, emergence of a new pressure related skin alteration (Stage 2 or higher), resident begins to use a restraint, emergence of a condition or disease in which a resident is judged to be unstable.A.Record review of a Face Sheet revealed that the facility re-admitted Resident 6 on 05/07/2026 with a diagnosis of osteomyelitis (an infection in the bone) of the right thigh, abscess (an enclosed pocket of infection that forms in the tissue) of the right lower limb and pressure-induced deep tissue damage of the sacral region.Record review of the Quarterly MDS assessment with the Assessment Reference Date (ARD) of 02/24/2026 for Resident 6 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 10 and no alterations in mood. The resident used a walker and wheelchair for mobility throughout the facility. Staff provided set up or clean up assistance with eating, and partial moderate assistance with bed mobility, toilet use, and transfers. The resident was coded to be continent of both bowel and bladder and no unhealed pressure related skin alterations.Record review of the Annual MDS assessment with the ARD of 05/11/2026 for Resident 6 revealed the resident had a BIMS score of 6 (a decline from the previous assessment) and alterations in mood of little pleasure and interest in doing things several days (the prior assessment revealed no alterations in mood). The resident used a wheelchair for mobility throughout the facility (used a wheelchair and walker in the prior assessment). Staff provided partial to moderate assistance with eating, substantial or maximal assistance with bed mobility, and the resident was dependent on staff assistance for toilet use and transfers (the resident required more assistance from staff than the prior assessment). The resident was coded to be frequently incontinent of bladder and bowel (a decline from the prior assessment) and had an unhealed pressure-related skin alteration coded as a stage 2 (no pressure related skin alterations in the prior assessment). The resident was also coded to have a surgical wound and was receiving routine intravenous antibiotic medication.In an interview completed on 06/17/2026 at 2:30 PM with the Minimum Data Set Coordinator (MDSC), the MDSC confirmed that Resident 6 was readmitted to the facility on [DATE]. The MDSC confirmed that the resident had a change or decline in condition. The (continued on next page)

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	285163	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Estates	2520 Avenue M Gothenburg, NE 69138

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDSC confirmed that Resident 6 changes met the definition of a significant change in status per the RAI Manual and a SCSA assessment should have been completed instead of the Annual assessment that was completed on 05/11/2026. B.Record review of Resident 43's Census record on 06/11/2026 revealed that the facility re-admitted resident 43 to the facility from a hospital leave.Record review of Resident 43's Progress Notes revealed documentation that the resident re-admitted to the facility following a surgical repair of a hip fracture.Record review of the admission MDS assessment with the ARD of 10/29/2025 revealed the resident had no coding indicating the resident had any behavior, and staff provided moderate assistance with bed mobility, toilet use and transfers. The resident was coded to be continent of bowel and bladder and no limitations to functional range of motion to either upper or lower extremities.Record review of the Quarterly MDS assessment with the ARD of 02/04/2026 revealed the resident was coded to have exhibited the behavior of rejection (a change from previous assessment), and staff providing substantial or maximal assistance with bed mobility (a decline from the previous assessment). The resident was coded to be dependent on staff assistance with toilet use and transfers (a decline from the previous assessment) and to have limitation in functional range of motion to one side on the lower extremity (a change from the previous assessment). The resident was also coded to be occasionally incontinent of bowel and bladder (a decline from the previous assessment).In an interview completed on 06/17/2026 at 2:30 PM with the Minimum Data Set Coordinator (MDSC), the MDSC confirmed that Resident 43 was readmitted to the facility on [DATE]. The MDSC confirmed that the resident had a change or decline in condition. The MDSC confirmed that Resident 43's changes met the definition of a significant change in status per the RAI Manual and a SCSA assessment should have been completed instead of the Quarterly assessment that was completed on 02/04/2026.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-00.09 (D)Based on record review and interviews, the facility failed to accurately code the 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) for 2 residents (Resident 6 and Resident 43) of 12 sampled residents. The facility census was 39.Findings are:Record review of a facility policy titled MDS 3.0 Completion dated 05/2026 revealed the facility according to federal regulations conducts accurate standardized assessment of each residents functional capacity using the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities). It the policy of the facility to follow the guidelines of the RAI Manual for the coding of each assessment.A.Record review of Resident 6's Medication Administration Record for the month of February 2026 revealed that Resident 6 received Aspirin (a medication classified as an antiplatelet) 81 milligram tablet once daily every day. It was documented that the resident was administered the medication every day 02/17/2026 through 02/24/2026.Record review of the Quarterly MDS assessment with the Assessment Reference Date (ARD) of 02/24/2026 for Resident 6 revealed in section N0415 item I was not coded that the resident received an antiplatelet medication during the 7 day look back period (02/17/2026 through 02/24/2026) Record review of Resident 6's Medication Administration Record for the month of May 2026 revealed that Resident 6 received Aspirin (a medication classified as an antiplatelet) 81 milligram tablet once daily every day. It was documented that the resident was administered the medication every day 05/04/2026 through 05/11/2026.Record review of the Annual MDS with the ARD of 05/11/2026 for Resident 6 revealed in section N0415 item I was not coded that the resident received an antiplatelet medication during the 7 day look back period (05/04/2026 through 05/11/2026) In an interview completed on 06/17/2026 at 2:30 PM with the Minimum Data Set Coordinator (MDSC) the MDSC confirmed that Resident 6 received Aspirin an antiplatelet medication 05/04/2026 through 05/11/2026. The MDSC confirmed that the Quarterly MDS with the ARD of 02/24/2026 and the Annual MDS with the ARD of 05/11/2026 were not coded correctly in section N0415. The MDSC confirmed that the resident receiving an antiplatelet medication should have been coded on both MDS's.B.Record review of Resident 43's Treatment Administration Record (TAR) for the time period of 03/31/2026 through 04/06/2026 revealed documentation that the resident utilized a BiPAP (a noninvasive ventilator used to assist breathing) at night. Documentation was present that staff verified the use every bedtime.Record review of the comprehensive MDS dated [DATE] revealed in section O0110 item G2 BiPAP was not coded that the resident utilized this during the look back period (03/31/2026 through 04/06/2026)In an interview completed on 06/17/2026 at 2:30 PM with the MDSC, the MDSC confirmed that the comprehensive MDS with the ARD of 04/06/2026 was not coded correctly. The MDSC confirmed that residents' use of the BiPAP should have been coded on the MDS and was not.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC 12-006.09Based on record review, observation, and interview the facility failed to complete glucometer control testing per manufacturer recommendations for 2 residents (Resident 4 and Resident 6), Failed to provide cares of a PICC (peripherally inserted central catheter) line (a long, thin, flexible tube inserted into a vein in the upper arm and threaded to a large vein near the heart) per professional standards of practice for 1 resident (Resident 6), failed to follow provider orders for performing flushing of a PICC line for 1 resident (Resident 6), failed to ensure orders for the administration of an intravenous medication contained components directing reconstitution and duration of administration of administering an intravenous medication for 1 resident (Resident 6). The facility census was 39.Findings are: A.Record review of a document titled Assure Platinum Blood Glucose Monitoring System and dated 10/2024 revealed a control solution test should be performed when opening a new bottle of test strip to confirm the meter and test strips are working properly.In an observation completed on 06/15/2026 at 10:40 AM it was observed that stored in the medication cart were the supplies for obtaining blood glucose levels for residents including glucometers and bottles of test strips for residents in small plastic bins. The bin containing Resident 6's glucometer and test strips revealed that the bottle of test strips was labeled with the date of 06/10/2026.Record review of an undated facility document titled Glucometer Calibration and Quality Control Log on 06/15/2026 revealed Resident 6's name and dates listed of 11/02/2025, 03/09/2026, and 03/17/2026. Each date was followed by the resident's name, test strip lot number, expiration date, low control results, high control results, test solution information and the nurses initials. There was no date of 06/10/2026 with the subsequent information listed on the document.In an interview completed on 06/15/2026 at 10:40 AM with Registered Nurse A (RN-A), RN-A stated that a control solution test was completed using the resident's dedicated glucometer with the opening of each new test strip bottle. The RN stated the test strip bottle is labeled with the date that the bottle is opened and the information obtained when completing the control solution test is recorded on the Glucometer Calibration and Quality Control Log that is stored on the medication cart. The RN confirmed that Resident 6's test strip bottle was labeled with the open date of 06/10/2026 indicating that was the day the bottle was opened and the control solution test should have been performed and recorded on the log and was not.In an observation completed on 06/15/2026 at 11:20 AM it was observed that stored in a second medication cart were the supplies for obtaining blood glucose levels for residents including glucometers and bottles of test strips for residents in small plastic bins. The bin containing Resident 4's glucometer and test strips revealed that the bottle of test strips was labeled with the date of 06/13/2026.Record review of an undated facility document titled Glucometer Calibration and Quality Control Log on 06/15/2026 revealed Resident 4's name and date listed of 02/21/2026. The test strip lot number, expiration date, low control results, high control results, test solution information and the nurses' initials were also present. There was no date of 06/13/2026 with the subsequent information listed on the document for Resident 4.In an interview completed on 06/15/2026 at 11:20 AM with Medication Aide F (MA-F), MA-F stated that the control solution test is to be completed and recorded on the Glucometer Calibration and Quality Control Log when each bottle of test strips is opened. The MA confirmed that the bottle of test strips is labeled with the opened date. The MA confirmed that Resident 4's test strips were labeled with the date of 06/13/2026 indicating the bottle was opened on that date and there was no information recorded on the Log indicating that the control solution test was completed for Resident 4's test strips that were opened on 06/13/2026.In an interview completed on 06/15/2026 at 2:28 PM with the facility Director of Nursing (DON), the DON confirmed that the Glucometer Calibration and Quality Control Log is to be completed when a new test strip bottle is opened and was not for Resident 6 and Resident 4.B.Record review of a facility policy titled PICC line Dressing Change and dated 05/2026 revealed:-Set up a clean field on the overbed table with the needed supplies.-Open the sterile dressing change kit and lay (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out the sterile drape. Place supplies on the sterile field, being careful not to contaminate them.-Wash hands and put on clean gloves.-Remove the old dressing beginning at the device hub and gently pull the dressing perpendicular to the skin toward the insertion site.-Remove and discard gloves.-Perform hand hygiene and put on sterile gloves.-Use sterile measuring tape to measure the external length of the catheter the measure the circumference of the arm around the insertion site.-Clean the insertion site with the antiseptic using a side-to-side motion for at least 30 seconds.In an observation completed on 06/16/2026 at 10:45 am through 11:20 AM of RN-A completing a PICC line dressing change to Resident 6 the following was observed:-The RN placed the needed supplies on the resident's cleaned overbed table.-The RN opened the sterile dressing change kit and removed the sterile drape from the kit. The nurse used a fanning motion to open the sterile drape and placed it on the overbed table. (The RN did not place the drape down in a manner to prevent the risk of contamination)-The RN placed the resident's arm on the sterile drape with the other sterile items sitting on it potentially contaminating the items.-The RN removed the old dressing by beginning at the device hub, gently pulling the dressing from the outer positions to the innermost. (The RN did not remove their gloves, perform hand hygiene and place new gloves after opening the package, placing the drape and items, and positioning the resident's arm on the drape)-The RN then removed their gloves and discarded them, completed hand hygiene using an alcohol-based gel and applied sterile gloves.-The RN used a tipped application to cleanse the insertion site of the PICC line in the resident left upper arm. The RN used a wiping motion moving from the outer aspect of the resident's arm moving to the inner aspect of the arm. (The RN did not use a side-to-side motion working from the insertion site to the outer portion of the insertion site preventing the risk of cross contamination when cleansing the site. The RN did not measure the site with the sterile measuring tape prior to cleansing the site)-The RN picked up the sterile measuring tape from the draped table and unraveled the tape. The RN used the sterile measuring tape to measure around the resident's arm above the insertion site the sterile measuring tape meeting the residents' skin and then used the tape to measure the catheter length the measuring tape meeting the catheter. (The RN did not measure the site prior to cleansing the site. The RN allowed the sterile measuring tape to meet the residents' uncleansed skin contaminating the measuring tape and then placed the measuring tape directly on the cleansed catheter possibly contaminating the catheter)In an interview completed on 06/16/2026 at 11:20 AM with RN-A, RN-A confirmed that they used a fanning motion to open the sterile drape and should have handled it by only touching the outermost portion and laying it out on the overbed table. The RN confirmed that they did not complete hand hygiene and changed their gloves after opening the dressing change kit and placing the resident's arm on the table and should have. The RN confirmed that they should not have placed the resident's arm on the sterile drape on the table near the sterile items possibly contaminating them. The RN confirmed that they should have measured the residents' arm and catheter prior to cleansing the site and did not. The RN confirmed that they measured the uncleansed area of the resident's arm with the tape measure and then used the tape measure to measure the catheter possibly contaminating the catheter and should not have. The RN confirmed that they did not cleanse the site using the proper technique working from the cleanest portion of the site working to the dirtiest, decreasing the chance of contamination of the site. The RN confirmed that they did not complete the PICC line dressing change following the facility policy and in a manner that prevented cross contamination and should have.C.Record review of a facility policy titled Peripherally Inserted Catheter Flushing and dated 05/2026 revealed the facility will use a solution and flush Peripheral Inserted Catheters per facility protocol and providers orders. The policy stated peripherally inserted catheters will be flushed and aspirated for blood return prior to each infusion and after each infusion.In an observation completed on 06/11/2026 at 1:05 PM RN-A cleansed the blue capped end of Residents 6's PICC line with an alcohol swab. The RN screwed on a 10-milliliter syringe labeled 0.9% sodium chloride to the end of the catheter and pulled back on the syringe observing for Flash (blood presence in the catheter) and then injected/flushed the catheter with the sodium chloride. The RN (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then attached the intravenous medication line to the blue end of the catheter initiating the infusion of the intravenous medication into the blue line of the catheter.Record review of Resident 6's Orders for the month of June 2026 revealed the resident had an order listed as sodium chloride 0.9% 10 milliliter syringe with directions to flush both of Resident'6's lumens four times a day dated 05/27/2026.In an observation completed on 06/11/2026 at 3:03 PM RN-A entered Resident 6's room and observed that the intravenous medication bag was empty indicating all the medication had been infused. The RN unscrewed the intravenous medication tubing from the blue line of the catheter and screwed on a 10-milliliter syringe labeled 0.9% sodium chloride to the end of the catheter and injected the solution into the catheter. The nurse thanked the resident and exited the room.In an interview completed on 06/11/2026 at 3:05 PM with RN-A, RN-A confirmed that Resident 6 had orders for both lumens of their catheter to be flushed four times a day. The RN confirmed that Resident 6's catheter is flushed every 6 hours with the infusion of their intravenous medication. The RN confirmed that both lumens should be flushed and the RN did not flush both lumens as ordered by the provider.D.Record review of a document titled Nursing Rights of Medication Administration dated 09/04/2023 from www.ncbi.nlm.nih.gov revealed intravenous medication orders are highly specific instructions detailing how a drug is introduced directly into a patient's bloodstream. They are comprised of critical clinical components such as the exact drug, dosage, route, and rate and require strict adherence to safety.Record review of a facility policy titled Peripherally Inserted Catheter Flushing and dated 05/2026 revealed the nurse will obtain an order for the type of intravenous solution or medication including the dose, rate and length of treatment. Record review of a facility policy titled Medication Orders and dated 05/2026 revealed elements of the medication orders should include the type or formulation of the medication.Record review of Resident 6's Medication Administration Record (MAR) Orders for the month of June 2026 revealed the resident had orders for Unasyn (an antibiotic medication) 3-gram reconstitution solution to be infused every 6 hours until 06/21/2026. The order did not contain the amount of solution to be infused, the length of time the medication was to be infused over, and the rate at which the medication was to be infused.In an observation completed on 06/11/2026 at 1:05 PM RN-A cleansed the end of Residents 6's PICC line with an alcohol swab. The RN then flushed the line with 0.9% sodium chloride 10 milliliter syringe and then attached the intravenous medication line to the end of the catheter initiating the infusion of the intravenous medication into the line of the catheter.In an observation completed on 06/11/2026 at 1:05 PM of Resident 6's intravenous medication bag it was observed to be labeled with the pharmacy label stating Ampicillin/Sulbactam (Unasyn) 3 grams in normal saline 100 milliliters and to infuse the contents of the bag over 30 minutes at 200 milliliters per hour every 6 hours using gravity tubing.In an interview completed on 06/11/2026 at 3:05 PM with RN-A, RN-A confirmed that the MAR Orders for Resident 6's intravenous medication Unasyn did not contain the amount of solution to be infused, the length of time the medication was to be infused over, and the rate at which the medication was to be infused. The RN confirmed that the orders on the residents MAR and the order on pharmacy label on the resident's intravenous medication did not match. The RN confirmed that the order in the MAR should contain the amount of solution to be infused, the length of time the medication should be infused over and the rate at which the medication should be infused and did not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Licensure Reference Number 175 NAC 12-006.12(D)(vii)Based on observation, record review, and interview the facility failed to dispose and or destroy a medication in a manner in compliance with applicable state and federal requirements for 1 resident (Resident 21) of 3 residents. The facility census was 39.Findings are: In an observation completed on 06/11/2026 at 7:50 AM of medication administration by Licensed Practical Nurse E (LPN-E) to Resident 21, LPN-E emptied a packet labeled Questran Powder 4gm into a clear plastic cup containing approximately 4 ounces of water. The LPN stirred the powder into the water. The LPN took the cup with the powder dissolved into the water and a clear plastic cup containing the resident's pills into the resident's room. Resident 21 told the LPN that they did not wish to take the powder dissolved into the water medication until after breakfast or about 9:00 AM. The resident stated that they did not like to take that medication until after their meal and other medications. The LPN told the resident that was ok and took the cup with the dissolved powder medication and water into the residents bathroom and poured the substance into the resident's toilet and flushed the resident's toilet.Record review of a facility policy titled Destruction of Unused Drugs and dated 04/2026 revealed it was the facility's policy that drugs would be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. The policy stated that prescription drugs may not be flushed down the toilet in accordance with Environmental Protection Agency (EPA) regulations. Drug destruction was to be witnessed by 2 approved staff members, recorded on the medication destruction record, and placed into a drug disposal bottle.Record review of a document titled Information for Hospitals, Pharmacies and other Businesses that have Medicines to Dispose dated 01/22/2026 from https://www.epa.gov/ revealed the EPA prohibits sewering (flushing down the sink or toilet) of pharmaceuticals. In an interview completed on 06/11/2026 at 8:05 AM with LPN-E, LPN-E stated that the facility utilizes medication destruction bottles for disposal of medications. To dispose of medications the medication is to be recorded on the log and 2 staff sign off on the log as witnessing the medication being placed into the medication destruction bottle. The LPN confirmed that they did not dispose of the Questran Powder correctly and should have.In an interview completed on 06/11/2026 at 1:40 PM with the facility Director of Nursing (DON), the DON confirmed that LPN-E did not correctly destroy the prepared medication for Resident 21. The DON confirmed that the medication should not have been flushed down the toilet.

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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. Licensure Reference Number 175 NAC 12-006.18Based on observation, record review, and interviews, the facility failed to dispose of items of regulated waste (items potentially or contaminated with blood or other potentially infectious material) in a manner consistent with manufacturer and facility policy for 2 residents (Resident 21 and Resident 6) of 2 sampled residents. The facility census was 39.Findings are:A.In an observation completed on 06/11/2026 at 7:50 AM of obtaining a blood glucose level by finger stick by Licensed Practical Nurse E (LPN-E) to Resident 21, LPN-E used a retractable lancet to poke Resident 21's finger. The LPN squeezed the resident's finger until a visible drop of blood was present. The LPN used a cotton ball to wipe away the visible drop of blood and squeezed the resident's finger until another visible drop of blood was present. The LPN touched the end of an Assure Platinum blood glucose test strip to the visible drop of blood. After a reading of the resident's blood sugar was obtained the LPN removed the test strip with the blood on it from the testing monitor. The LPN threw the test strip with blood on it and the cotton ball with the blood on it into the resident's trash can located beside the resident's bed.Record review of a facility policy titled Regulated (Biohazard) Medical Waste dated 02/26/2026 revealed the definition of regulated waste includes pathological and microbiological wastes containing blood or other potentially infectious materials. The facility will utilize single, leak resistant biohazard bags to contain regulated medical waste.Record review of a document titled Assure Platinum Blood Glucose Monitoring System and dated 10/2024 revealed all components that come into contact with blood samples should be considered to be biohazards capable of transmitting viral diseases between patients and healthcare professionals.In an interview completed on 06/11/2026 at 8:05 PM with LPN-E, LPN-E confirmed that the cotton ball and the test strips were potentially contaminated items due to having blood on them and should be disposed of following the facility policy.B.In an observation completed on 06/15/2026 at 1:05 PM Registered Nurse A (RN-A) prepared to administer an intravenous medication to Resident 6. The RN used an alcohol wipe to wipe off the catheter end of the residents double lumen PICC (a long, thin, flexible tube inserted into a vein in the upper arm extending to just above the heart) line. The RN connected a syringe containing 10 milliliters of sodium chloride to the cleansed catheter tip and attached the syringe by using a twisting motion. The RN depressed the plunger at the end of the syringe injecting the sodium chloride into Resident 6's PICC line. Once all of the solution was instilled the RN left the empty syringe attached to the PICC line and walked over to the IV pole. The RN prepared the IV solution to be administered to the resident. The RN returned to the resident with the syringe still attached to the PICC line and unscrewed the syringe from the end of the PICC line. There was visible red liquid substance in the syringe approximately 1/4 of the syringe. The RN threw the syringe containing the red liquid substance into the resident's trash can sitting on the floor beside the resident. The RN proceeded to complete the procedure for administration of the intravenous medication and left the resident's room.In an interview completed on 06/15/2026 at 1:20 PM with RN-A, RN-A confirmed that there was blood (red fluid) in the syringe and they should not have thrown it away in the resident's trash can. In an interview completed on 06/15/2026 at 3:30 PM with the facility Director of Nursing (DON), the DON confirmed that contaminated waste should not be disposed of in residents trash cans.