STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	702 Cedar Avenue Laurel, NE 68745

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.18B1 Based on observations and interviews; the facility failed to ensure a call light was within reach for 1 (Resident 10) of 1 sampled resident who required assistance with activities of daily living. The facility census was 17. Findings are: Review of Resident 10's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 2/13/24 indicated the resident was admitted [DATE] with diagnoses of heart failure, arthritis, Chronic Obstructive Pulmonary Disease, malnutrition, and dysphagia (difficulty swallowing). The assessment identified the resident required substantial to maximal assistance with personal and toileting hygiene, and partial to moderate assist required with dressing, bed mobility and transfers. In addition, the resident was frequently incontinent of bowel and bladder. During observations on 4/29/24, the following was observed: -8:59 AM the resident was seated in a recliner in the resident's room. The resident's call light was attached to the positioning bar on the resident's bed. The resident's call light was not within reach of the resident. -9:19 AM Licensed Practical Nurse (LPN)-C entered the resident's room. The resident remained seated in the recliner, but the resident was leaning forward and was attempting to stand from the chair. LPN-C questioned the resident to determine pain level or need for toileting assistance. The Resident refused offers for assistance and LPN-C exited the resident's room without assuring the call light was within reach. -11:03 AM the resident remained in the recliner with the call light out of reach and attached to the resident's bed. -2:02 PM the resident remained seated in the recliner in the resident's room with feet/lower legs elevated on a foot stool with a pillow. The resident's call light remained out of reach for the resident. Interview with LPN-C on 4/29/24 at 3:29 PM revealed the following regarding Resident 10: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-required assistance with transfers, mobility and toileting and was involuntary of bowel and bladder, -did use the call light to seek staff assistance with toileting and transfers, and -the resident was to always have a call light within reach. During an interview with the Director of Nursing (DON) on 4/30/24 at 11:57 AM, the DON confirmed Resident 10 required staff assistance with activities of daily living. The DON further confirmed the residents should have their call lights placed within reach to call for assistance when needed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 29638 Licensure Reference Number 175 NAC 12-006.05(1) Based on record review and interview, the facility failed to provide Resident 10 or the resident's representative, bed hold information when the resident was transferred to the hospital. The sample size was 1 and the facility census was 17. Findings are: A. Review of the facility Bed Hold Prior to Transfer Policy (undated) revealed the facility was to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident went on a therapeutic leave. The written information to be given to the resident and/or representative included the following: -the duration of the state bed-hold, if any, during which the resident was permitted to return and resume residence in the facility, -the reserve bed payment policy in the state plan if any, -the facility policy regarding bed-hold periods to include permitting residents to return to the next available bed, and -conditions upon which the resident would return to the facility. The facility was to provide this written information to all residents regardless of their payor source. B. Review of Resident 10's Nursing Progress Notes revealed the resident had been admitted to the hospital 3/15/24 to 3/27/24 for heart failure and aspiration pneumonia. Review of Resident 10's medical record from 3/15/24 to 3/27/24 revealed no evidence the resident or the resident's representative were notified of the facility bed hold policy. During an interview on 4/30/24 at 9:13 AM, the Administrator confirmed the facility had no documented evidence that Resident 10 or their representative were provided with the required bed hold information when discharged to the hospital from 3/15/24 to 3/27/24.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D6(1) Based on observation, record review and interview, the facility failed to check placement of a feeding tube (medical device used to provide liquid nourishment, fluids and medications bypassing oral intake) for 1 (Resident 10) of 1 sampled resident to prevent the potential for complications. The facility census was 17. Findings are: A. Review of the undated Care and Treatment of Feeding Tubes Policy revealed feeding tubes were to be utilized according to physician orders, which typically included: the kind of feeding and its caloric intake value, volume, duration. Mechanism of administration and frequency of flush. In accordance with facility protocol, licensed nurses were to monitor and check the feeding tube was in the right location (stomach or small intestine depending on the tube): -tube placement was to be verified before beginning a feeding and before administering medications, and -the enteral retention device was to be checked daily to assure it was properly approximated to the abdominal wall and the surrounding skin was intact. Tube placement may be checked by aspirating gastric contents. B. Review of an Order Summary Report printed 5/2/24 revealed a physician order dated 3/27/24 for the staff to check the resident's gastric residual before administering medications, flushing the feeding tube, and starting a feeding. If greater than 100 cubic centimeters (cc) of residuals, then staff were to hold the tube feeding. The resident was to receive 240 milliliters (ml) of Jevity 1.5 cal. 4 times a day. Observation on 4/30/24 at 7:02 AM revealed the resident was seated in a recliner in the resident's room. Licensed Practical Nurse (LPN)-A administered Resident 10's routine medications per the feeding tube without an assessment to ensure proper placement of the tube. After completion of the medication administration, LPN-A still without checking placement of the feeding tube, initiated the resident's bolus (large doses of formula administered several times a day) feeding. The tube feeding was administered despite the resident's order to hold the feeding if the resident had gastric residual of greater than 100 cc's. During an interview on 4/30/24 at 7:30 AM, LPN-A confirmed the LPN's failure to check placement of the feeding tube before administering medications and starting the resident's tube feeding. In addition, LPN-A confirmed the staff were to hold the resident's tube feeding if the resident had a gastric residual of greater than 100 cc's.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.09D Based on record review and interview; the facility failed to attempt a Gradual Dose Reduction (GDR) and/or have a documented contraindication for 3 of 5 sampled residents (Residents 2, 4, and 6) psychotropic (a drug or substance that affects how the brain works) medication. The facility census was 17. Findings are: A. Review of the undated facility policy Use of Psychotropic Medication revealed the following: -Residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. -psychotropic medication included antipsychotics, antidepressants, anti-anxiety, and hypnotics, -attending physicians assumed leadership in medication management by developing, monitoring, and modifying regimens in collaboration with residents, families/responsible parties, other professionals, and the interdisciplinary team, -the indication for use of psychotropic medications were documented in the medical record, -residents and their families were educated on the benefits and risks of psychotropic medications as well as alternate treatments available, -residents who used psychotropic medications received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue those medications, and -the Physician in collaboration with the Consultant Pharmacist re-evaluated the use of medication and considered whether or not the medication could be reduced or discontinued. B. Review of Resident 2's Minimum Data Set (MDS- federally mandated comprehensive assessment used to develop resident Care Plans) dated 4/23/24 revealed the resident had dementia, and depression and took antipsychotic (drug used to treat symptoms of psychosis) and antidepressant (drug used to treat the symptoms of depression) medication. Review of Resident 2's Physician's Orders revealed an order for the antidepressant medication Escitalopram Oxalate 1 tablet orally one time a day for depression with a start date of 6/1/21. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident 2's Monthly Pharmacy Regimen Review dated 8/31/21 revealed the physician refused a GDR of Escitalopram (antidepressant medication). There was no evidence the medication was considered for reduction or discontinuation after that date. Review of Resident 2's Care Plan with a revision date of 4/12/24 revealed the resident had depression, used psychotropic medication, and required monitoring for potential adverse effects. In addition, the pharmacy reviewed medications monthly. During an interview on 4/30/24 at 9:00 AM the facility Administrator confirmed the facility had no evidence the facility had requested or attempted a GDR of Resident 2's Escitalopram since 8/31/21 and had no evidence of a documented contraindication by the provider. 29638 C. Review of Resident 4's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of diabetes, heart failure, chronic pain syndrome, and major depressive disorder and had orders for use of an antidepressant medication. Review of Resident 4's Order Summary Sheet which was printed 5/1/24 revealed the resident had an order dated 5/27/21 for Cymbalta (medication used to treat depression) 60 milligrams (mg) 1 capsule daily. Review of Resident 4's Monthly Pharmacy Regimen Review from 4/23/23 to 4/25/24 revealed no evidence the Consultant Pharmacist reviewed the resident's medication regimen to determine the need for a potential GDR of the resident's Cymbalta. Review of the resident's medical record revealed no evidence the resident's use of Cymbalta was reviewed from 4/23/23 to 4/25/24 by the resident's physician to determine the need for a potential GDR. During an interview with the Director of Nursing (DON) on 5/2/24 at 12:38 PM, the DON confirmed the facility had not completed/requested a GDR on Resident 4's Cymbalta in over a year. D. Review of Resident 6's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of insomnia, chronic pain, anxiety disorder, dementia, and depression and had orders for use of an antianxiety and an antidepressant medication. Review of Resident 6's Order Summary Sheet which was printed 4/29/24 revealed the resident had an order for Lorazepam (medication used to treat anxiety) 1 mg daily at bedtime. Review of the resident's Monthly Pharmacy Regimen Review from 4/23/23 to 4/24/24 24 revealed no evidence the Consultant Pharmacist reviewed the resident's medication regimen to determine the need for a potential GDR of the resident's Lorazepam. Review of the resident's medical record revealed no evidence the resident's use of Lorazepam was reviewed by the resident's physician to determine the need for a potential GDR from 4/23/23 to 4/24/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 5/1/24 at 2:04 PM, confirmed Resident 6's use of Lorazepam had not been reviewed to address the need for a potential GDR in the past year.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42360 Licensure Reference Number 175 NAC 12-006.10D The facility failed to ensure medications were given as ordered; including not crushing Resident 3's medication that were not recommended to crush, and to ensure a medication error rate of 5 percent or less. The facility had an observed medication error rate of 7.14 percent. The sample size was 5 and the facility census was 17. Findings are: Review of the undated facility policy Medication Administration revealed the following: -Medications were administered by licensed nurses who were legally authorized to do so, and ordered by a physician in accordance with professional standards of practice, and the facility -administered medications as ordered in accordance with manufacturer specifications, -compared medication directions with the Medication Administration Record (MAR), to verify the residents name, medication name, form, dose, route, and time in accordance with facility policy, and -crushed medications as ordered and did not crush medications with do not crush instructions. Review of the undated facility policy Medication Errors revealed the following: -The facility provided protection for the health, welfare, and rights of each resident by ensuring residents received care and services safely in an environment free of significant medication errors. -a medication error was an observed or identified preparation or administration of medication or biologicals which was not in accordance with the prescriber's order, manufacturer's specifications regarding the preparation and administration of medication or biologicals, or within accepted standards of practice, -the facility ensured medications were administered according to physician's orders, per manufacturer's specifications, and with accepted standards of practice, -the facility ensured a medication error rate of 5% or less, -medication errors once identified were evaluated to determine if they were significant, and -to prevent medication errors the facility nurses verified the right medication, the right dose, the right time of administration, the right resident, and the right documentation. During an observation on 4/30/24 at 8:19 AM Licensed Practical Nurse (LPN)-A crushed and administered in applesauce the following medications for Resident 3: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Acetaminophen 325mg (milligrams) 2 tablets -Buspar 7.5mg 1 tablet -Calcium 600mg with Vit D3 300 mg 1 tablet -Carvedilol 12.5mg 1 tablet -Certa-vite Senior 1 tablet -FeSo (Ferrous Sulfate) 325mg 1 tablet -Furosemide 40mg 1 tablet -Lamotrigine 150mg 1 tablet -Levetiracetam 750mg 2 tablets -Losartan 100mg 1 tablet -Metformin 500mg 2 tablets -Paxil 20mg 1 tablet -Ropinirole 1mg 1 tab -Ziprasidone 40mg 1 capsule Review of the on-line Physician's Desk Reference (PDR-most commonly used resource used with detailed administration indications and instruction for medications) revealed the following: -Ziprasidone capsules should not be crushed, opened, or chewed and should be administered whole, and -FeSo (Ferrous Sulfate) tablets should not be crushed or chewed and should be administered whole. Review of Resident 3's Medication Administration Record (MAR) for April 2024 indicated Resident 3 took medications in applesauce, however there was no evidence the resident had an order to crush medications. During an interview on 4/30/24 at 1:00 PM the facility Administrator confirmed medications that are crushed for administration require a doctor's order, and should be reviewed by the pharmacist to determine if the medication was safe to be crushed, or should be given in an alternate form such as liquid. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 10:40 AM the Director of Nursing (DON) confirmed the facility should not crush medications without a physician's medication crush order, and Resident 3's FeSo and Ziprasidone should not have been crushed. In addition, staff providing medications should abide by administration directions specific to all residents/medications, including residents taking slow-release medications, enteric coated medications, and medications indicated by the MAR that had been identified as Do Not Crush.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 29638 Licensure Reference Number: 175 NAC 12-006.04D2a Based on record review and interview; the facility failed to have a qualified Dietary Manager (DM). This had the potential to affect all residents who consumed food from the kitchen. The facility census was 17 with a total sample size of 10. Findings are: Review of the facility undated Job Description for the role of Dietary Manager revealed the necessary qualification included the completion of a Dietary Manager certification course. A review of an undated staff list revealed DM-K was listed as the Dietary Manager. During an interview on 4/29/24 at 07:10 AM, the facility Administrator confirmed the current DM did not have the required training to meet the qualification for the DM position.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 29638 Licensure Reference Number 175 NAC 12-006.11A Based on observation, record review and interview; the facility staff failed to follow a recipe when preparing pureed foods for 1 (Resident 8) sampled resident. The facility census was 17. Findings are: A. Review of an undated facility menu revealed the following was to be served for the noon meal on 4/30/24: -lasagna, -Caesar salad, -garlic toast, and -pumpkin dessert. B. During an observation on 4/30/24 at 12:04 PM, Dietary Cook (DC)-I opened a can of pork and beans and placed the contents of the can into a blender. DC-I proceeded to blend until the beans reached a smooth consistency. DC-I then obtained a clear measuring cup with approximately 1 to 1 1/2 cups of hot water and without measuring portion size, added a pork-based bouillon/paste to the water. DC-I stirred the mixture until the pork paste was dissolved and proceeded to add an unmeasured amount to the pork and beans mixture and blended. DC-I placed the puree pork and beans into a red bowl for Resident 8's noon meal. No other food items were provided for the resident's room tray. During an interview on 4/30/24 at 12:20 PM, DC-I indicated Resident 8 had the only puree diet in the facility. DC-I confirmed no recipe was used and/or available for preparing the pork and beans and to determine the portion size to be provided for the resident. In addition, DC-I indicated the resident had requested only the puree pork and beans, so no other food items were provided for the noon meal. During an interview with the Registered Dietician (RD) on 4/30/24 at 3:00 PM, the RD verified a recipe should have been available and used when preparing puree food items for Resident 8.