

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Eventide Williamsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 South 34th Street Lincoln, NE 68516	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference 175 NAC 1-005.06(D)Based on record review, observation and interviews, the facility failed to ensure infection control standards of practice were followed during wound care for Resident 27. This affected 1 of 1 resident observed for wound care. The facility census was 26.Findings are:A record review of the facility's Hand Hygiene policy revised 11/24 revealed that hand hygiene should be performed before and after resident contact including before leaving the room, before every clean procedure, after every dirty procedure, and as needed. Further review revealed that handwashing should take at least 20 seconds.A record review of the facility's Guidelines for Wearing Gloves policy revised 4/23 revealed that gloves should be changed between dirty and clean procedures on the same resident, and that hand hygiene should be performed before putting gloves on and after removing gloves.A record review of Resident 27's admission Record printed 12/03/20205 revealed the resident was admitted on [DATE] and had a diagnosis of cellulitis (a bacterial infection of the skin and deeper tissue underneath the skin) of the left arm.A record review of Resident 27's Order Summary printed 12/03/2025 revealed a current order for a daily dressing change to the wound on Resident 27's left arm as follows: DRESSING CHANGE TO LEFT ARM daily cleanse wound with Vashe [a brand of wound cleanser] wound cleanser moisten 4x4 gauze with Vashe cleanser and apply to wound bed leave on the wound bed for 3-5minutes apply Vaseline gauze to skin tear and cover with Mepilex [an absorbent foam dressing] every day shift for skin with a start date of 11/25/2025.An observation on 12/02/2025 from 10:58 AM to 11:10 AM revealed that Registered Nurse (RN) A entered Resident 27's room, used hand sanitizer and put gloves on, and opened a cupboard door to retrieve wound care supplies. Wearing the same gloves, RN A took the wound care supplies to the overbed table next to the table and put them directly on the surface of the table. RN A then pushed Resident 27's sleeve up to access the left elbow. Without performing hand hygiene or changing gloves, RN A opened the Vashe wash, applied it to a gauze sponge, used it to wipe the surface of the wound, then left the gauze to sit on the wound. After two minutes, the RN stated they had not measured the wound, removed the gauze, measured the wound, and replaced the gauze. Wearing the same gloves, RN A opened the Vaseline gauze and foam dressing packages. The RN then patted their uniform and reached into their pockets, then walked across the hall into the nurse's station and reached into a black bag, then pulled scissors out of a front pocket of their scrubs. RN A then removed their gloves, went to the sink and washed their hands with soap and water for 12 seconds. As the RN reached for paper towels, their hand brushed against a pile of coats under the paper towel dispenser. RN A then went back across the hall to Resident 27's room, put gloves on, then reached into their pockets to retrieve an alcohol wipe and cleaned the scissors. Wearing the same gloves, RN A used the scissors to cut a piece of the Vaseline gauze, then removed the gauze with Vashe on it from the left elbow wound and applied the Vaseline gauze. RN A then applied the foam dressing, then reached into their pockets, retrieved a pen and put the date and their initials on the dressing. Wearing the same gloves, RN A then opened the cupboard door, put wound care supplies away, and locked the cupboard door with a key on a key ring with multiple other keys.An interview on 12/02/2025 at 11:15 AM with RN A confirmed that the overbed table had not been clean, and that there should have been a barrier placed between the table (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the wound care supplies. The RN further confirmed that they should have performed hand hygiene and changed their gloves between touching objects such as a cupboard door, keys, clothing or a bag and touching the resident or the wound care supplies, and between removing the old dressing, cleaning the wound, and applying the new dressing. RN A confirmed they should not have been in the hall with the gloves on, and that handwashing should take at least 20 seconds. An interview on 12/03/2025 at 2:45 PM with the Administrator (ADM) confirmed the facility did not have a policy for wound care.		