STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285302	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Millard	13225 Westwood Lane Omaha, NE 68144

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 12-006.04C3a(6) Based on record review and interview, the facility failed to ensure the medical provider was notified of blood sugar levels outside of parameters for 1 [Resident 4] of 4 sampled residents. The facility had a total census of 72 residents. Findings are: A review of Admission Record revealed Resident 4 was admitted to the facility on [DATE] with a readmitted [DATE] with a primary diagnoses of end stage renal disease, dependence on renal dialysis, and a type 2 diabetes mellitus without complications. A review of Resident 4's 4/2024 MAR [Medication Administration Record] revealed an order for blood glucose monitoring 4 times per day with the physician to be notified of blood sugars of less than 70 or greater than 400. A review of Resident 4 Progress Notes dated 4/8/24 at 4:39 PM revealed Resident 4's Aspart insulin [rapid acting insulin] was held due a blood sugar of 67 with a snack given. Progress note did not reveal that Resident 4's medical provider was notified of blood sugar outside of parameters. A review of Resident 4's Progress Note dated 4/4/24 at 7:49 PM revealed Resident 4's blood sugar was 59 in PM. The Progress Note stated that a snack was given as well as dinner. According to Resident 4's Progress Note dated 4/4/24 at 7:49 PM Resident 4's Blood sugar was 124 now. Resident 4's Progress Note did not reveal Resident 4's medical provider was notified of blood sugar outside of parameters. In an interview on 4/18/24 at 4:02 PM, the Director of Nursing confirmed there was no evidence of Resident 4's medical provider being notified of blood sugars being outside of parameters and that medical provider should have been notified. A review of facility policy with effective date of 2/1/23 titled Blood Glucose Testing Procedure revealed the following: -Notify the provider,, if needed, of abnormal findings.

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure Reference Number 175 NAC 12-006.09 Based on observation, interview, and record review, the facility failed to ensure coordination of medication administration with dialysis schedule for 2 [Residents 2 and 4] of 2 sampled residents requiring dialysis. The facility had a total census of 72 residents. Findings are: A. A review of a Admission Record revealed Resident 2 was admitted to the facility on [DATE] with a readmitted [DATE]. The Admission Record for Resident 2 listed a primary diagnosis of pneumonia [an infection in the lungs] and diagnoses of type 2 diabetes mellitus [a disorder in which the body has trouble controlling blood sugar] without complications and end stage renal disease [a condition in which the kidneys lose the ability to remove waste and balance fluids]. A review of Resident 2's 4/2024 MAR [Medication Administration Record] revealed Resident 2 had an appointment for dialysis at 6:15 AM every Tuesday, Thursday, and Saturday with Resident 2 to arrive at the dialysis facility at 5:45 AM. In an interview on 4/18/24 at 9:14 AM, LPN A reported that Resident 2 was to have a blood sugar check and insulin but Resident 2 had already left for dialysis. In an interview on 4/18/24 at 9:20 AM, Medication Aide D confirmed Medication Aide D had not provided medications to Resident 2 before Resident 2 left for dialysis. In an interview on 4/18/24 at 9:22 AM, LPN Unit Manager C reported Resident 2 leaves for dialysis at 4:30 AM. Observations on 12/18/24 at 12:15 PM revealed Resident 2 had returned from dialysis. A check of Resident 2's blood sugar by LPN A revealed a blood sugar of 249. LPN A administered 5 units of Aspart insulin [Rapid acting insulin] to back of Resident 2's right arm. In an interview on 4/18/24 at 12:15 PM, Resident 2 reported returning from dialysis at 10:30 AM and that Resident 2 had eaten lunch. Resident 2 reported that Resident 2 received 2 medications before going to dialysis. A review of Progress Notes revealed Resident 2 was admitted to the hospital on 4/9/24 and was readmitted on [DATE]. A review of Resident 2's 4/2024 MAR revealed the following medications were documented as not being given due to Resident 2 being out of facility or at dialysis: -Amlodipine Besylate 10 Milligrams (mg) [medication for hypertension] scheduled for AM; not administered on 4/2/24, 4/6/24, and 4/18/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aspirin 81 mg scheduled for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Calcitrate Plus D 315 mg 5 mcg [Calcium and Vitamin D] oral tablet scheduled for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Cholecalciferol [a vitamin D supplement] 1000 units; not administered on 4/2/24, 4/6/24 and 4/18/24 -Glargine insulin [long acting insulin] 10 units scheduled for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Potassium Chloride ER 10 MEQ scheduled for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Toresemide [diuretic] 100 mg scheduled for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Valsartan [medication for high blood pressure] 20 mg scheduled for AM; not administered on 4/2/24 and 4/18/24 -Acidophilus [probiotic] 1 capsule schedule for AM; not administered on 4/2/24, 4/6/24 and 4/18/24 -Amoxicillin-Pot Clavulanate [antibiotic] 875-125 mg scheduled for AM and hour of sleep; not administered on 4/18/24 AM -Carvedilol [a medication for high blood pressure] scheduled for AM and PM; not administered in AM on 4/2/24, 4/6/24 and 4/18/24 -Entresto [a medication for heart failure] oral tablet 24-26 mg .5 tablet scheduled for AM and hour of sleep; not administered in AM on 4/6/24 -Insulin Aspart [rapid acting insulin] 3 units scheduled for AM, Noon, and PM; not administered in AM on 4/2/24, 4/6/24, and 4/18/24 -Insulin Aspart sliding scale insulin scheduled for AM, Noon and PM; not administered in AM on 4/2, 4/6/24, and 4/18/24 A review of Resident 2's 4/2024 MAR and care plan did not reveal any directions on how to provide medications when Resident 2 was going out to dialysis. In an interview on 4/18/24 at 3:06 PM, LPN B reported that residents that leave between 4-5 AM for dialysis are not back to the facility until noon. LPN B reported morning medications are not given to the residents and that noon medications, blood sugar checks and noon insulin are administered to residents when they get back to the facility according to LPN B. In an interview on 4/18/24 at 3:15 PM, LPN A reported if a resident is gone from the facility at the time medications are to be provided, out of the facility is documented, and medications are resumed when the resident returns to the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/18/24 at 3:17 PM, LPN Unit Manager C reported administration of medications for residents going to dialysis varies based on provider direction and could be provided after return from dialysis or scheduled around dialysis. In an interview on 4/18/24 at 4:34 PM, the Director of Nursing (DON) reported had started to work with providers on adjustment of times of medications for residents going to dialysis. According to the DON, physicians are to be notified of medications not provided to residents. B. A review of Admission Record revealed Resident 4 was admitted to the facility on [DATE] with a readmitted [DATE] with a primary diagnoses of end stage renal disease, dependence on renal dialysis, and a type 2 diabetes mellitus without complications. A review of Resident 4's 4/2024 MAR revealed Resident 4 had an appointment for dialysis at 5:30 AM on Tuesdays, Thursdays, and Saturdays. In an interview on 4/18/24 at 9:14 AM, LPN A reported that Resident 4 is to have a blood sugar check and insulin but Resident 4 leaves for dialysis prior to the start of the shift. In an interview on 4/18/24 at 9:20 AM, Medication Aide D confirmed Medication Aide D had not provided medications to Resident 4 before Resident 4 left for dialysis. In an interview on 4/18/24 at 9:22 AM, LPN Unit Manager C reported Resident 4 leaves for dialysis at 5:45 AM. Observations on 4/18/24 at 12:44 PM revealed Resident 4 eating lunch. A check of Resident 4 of Resident 4's blood sugar revealed a blood sugar of 108. LPN A administered 7 units of Aspart insulin in the back of Resident 4's right arm. In an interview on 4/18/24 at 12:44 PM, Resident 4 reported taking 1 medication before going to dialysis and stated that Resident 4 doesn't want anything to eat before dialysis. A review of Resident 4's 4/2024 MAR revealed the following medications were documented as not being given due to Resident 4 being out of facility or at dialysis: -CertaVite Senior Oral Tablet [vitamin with minerals] 1 tablet scheduled to be administered in AM; was not administered on 4/4/24, 4/9/24, 4/11/24, and 4/13/24 due to Resident 4 being out of facility; medication was documented as held on 4/2/24 and 4/6/24 with note that medication is held due to Resident 4 was at dialysis -Sertraline [medication for depression] 50 mg scheduled to be administered in AM; was not administered on 4/4/24, 4/9/24, 4/11/24, and 4/13/24 due to Resident 4 being out of the facility; medication was documented as held on 4/2/24 and 4/6/24 with note that medication is held due to Resident 4 being at dialysis -Tracrolimus [antirejection medication] .5 mg scheduled to be administered in AM and PM; AM dose was not administered on 4/4/24, 4/9/24, 4/11/24, and 4/13/24 due to Resident 4 being out of the facility; medication was documented as held on 4/2/24 and 4/6/24 with note that medication is held due to Resident 4 being at dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Calcium Citrate plus D oral table 315 mg, 6.25 mcg 2 tablets scheduled for AM and PM; AM dose was not administered on 4/4/24, 4/9/24, 4/11/24, and 4/13/24 due to Resident 4 being out of the facility; medication was documented as held 4/6/24 with note that medication is held due to Resident 4 being at dialysis -Cholestyramine [medication to lower cholesterol] oral packet 4 gram scheduled for AM and PM; AM dose was not administered on 4/4/24, 4/11/24 due to Resident 4 being out of the facility and was documented as held on 4/6/24 and 4/13/24 -Medroxyprogesterone [medication used to stop uterine bleeding] 10 mg scheduled to be administered in AM; AM dose was not administered on 4/4/24 due to Resident 4 being out of the facility and held on 4/2/24 and 4/6/24 due to dialysis -Mycophenolate sodium oral tablet delayed release [anti-rejection medication] scheduled to be administered AM and PM; AM dose was not given on 4/4/24, 4/9/24, 4/11/24, 4/13/24 due Resident 4 being out of the facility and held on 4/2/24 and 4/6/24 due to Resident 4 being at dialysis -Nystatin Powder [treats fungal or yeast infections] scheduled to be administered AM and PM; AM dose was not given on 4/4/24, 4/9/24, 4/11/24, 4/13/24, 4/18/24 due to Resident 4 being out of the facility and was held on 4/6/24 due to Resident 4 being at dialysis -Aspart insulin 7 units to administered AM, noon, and PM; AM dose was not given on 4/4/24, 4/6/24, 4/9/24, 4/11/24 and 4/16/24; insulin was held on 4/2/24 and 4/13/24 -Sildenafil Citrate 20 mg [medication for pulmonary hypertension] scheduled to be administered AM and PM; AM dose was not given to Resident 4 being out of the facility on 4/4/24, 4/9/24, 4/11/24, 4/13/24, and was held on 4/2/24 and 4/6/24 A review of Resident 4's 4/2024 MAR and care plan did not reveal any directions for administration of medication on dialysis days. In an interview on 4/18/24 at 3:06 PM, LPN B reported that residents that leave between 4-5 AM for dialysis are not back to the facility until noon. LPN B reported morning medications are not given to residents on dialysis. LPN B reported noon medications, blood sugar checks and noon insulin are administered to residents when they get back to the facility from dialysis. In an interview on 4/18/24 at 3:15 PM, LPN A reported if a resident is gone from the facility at the time medications are to be provided, out of the facility is documented, and medications are resumed when the resident returns to the facility. In an interview on 4/18/24 at 3:17 PM, LPN Unit Manager C reported administration of medications for residents going to dialysis varies based on provider direction and could be provided after return from dialysis or scheduled around dialysis. In an interview on 4/18/24 at 4:34 PM, the DON reported had started to work with providers on adjustment of times of medications for residents going to dialysis. The DON reported the physicians are to be notified of medications not provided to residents. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. A review of facility policy dated 1/1/2023 titled Dialysis Monitoring Policy revealed the following: -The facility will co-ordinate care with the dialysis provider in developing an appropriate plan of care to include, but not limited to: .b. Any recommended medication schedule change.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 04577 Licensure reference: 175 NAC 12-006.12E1 Based on observations, interview, and record review, the facility failed to ensure insulin pens were labeled with date opened for 3 [Residents 2, 3, and 4] of 4 sampled residents with orders for insulin. The facility had a total census of 72 residents. Findings are: A. Observations on 4/18/24 at 12:15 PM revealed Resident 2's Aspart [rapid acting insulin] and Glargine [long-acting insulin] insulin pens were not dated with date opened. LPN A obtained a new Aspart insulin pen from the facility emergency medication stock for administration of insulin to Resident 2. In an interview on 4/18/24 at 12:15 PM, LPN A indicated both insulin pens would be disposed of due to not being dated when opened. A review of Resident 2's 4/2024 MAR [Medication Administration Record] revealed insulin pen is to be discarded 28 days after initial use. B. Observations on 4/18/24 at 7:19 AM revealed Resident 3's Glargine insulin pen was not labeled with date opened. LPN A obtained a new Glargine insulin pen from the facility emergency medication stock for administration of insulin to Resident 3. In an interview on 4/18/24 at 7:19 AM, LPN A confirmed Glargine insulin pen was not dated and would be discarded. A review of Resident 3's 4/2024 MAR revealed insulin pen is to be discarded 28 days after initial use. C. Observations on 4/18/24 at 12:44 PM revealed Aspart pen had no label with Resident 3's name on it or dated with date opened. LPN A disposed of pen and obtained a new insulin pen from medication refrigerator for Resident 3. A review of Resident 4's 4/2024 MAR [Medication Administration Record] revealed insulin pen is to be discarded 28 days after initial use. D. In an interview on 4/18/24 at 4:02 PM, RN [Registered Nurse] Consultants E and F confirmed insulin pens are to be dated when first used.