

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Hillcrest Millard LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference: 175 NAC 12-006.09(H)(iv)(6) Based on record review and interview, the facility failed to ensure an assessment was completed of pressure ulcers on admission and readmission for 1 [Resident 3] of 4 sampled residents. The facility had a total census of 61 residents. Findings are: A. A review of facility policy dated 1/1/26 titled Skin Integrity and Wound/Pressure Injury assessment, Treatment and Documentation Policy revealed the following: - 1. A full body skin assessment should be conducted by a licensed nurse upon admission and then weekly- 2. The assessment may be performed after a change in condition or after any newly identified alterations in skin integrity.- 3. When a skin integrity/wound concern is present upon admission, identified during a weekly skin assessment, or any time during a stay the nurse needs to notify the physician for a treatment plan if one is not already in place. The nurse will complete and document the weekly skin assessment finding.- 4. Assessment and documentation: a. A registered nurse may stage and determine the etiology of a wound. An LPN can stage a wound but an RN/licensed provider is needed to determine the etiology and make a comprehensive assessment of the wound based off of the LPN's data/information gathered. b. If a pressure injury is identified after admission assessment is completed, the nurse may consult with the wound care nurse/designee. c. When a pressure injury is present, daily monitoring may include the following: i. If not dressing is present, evaluation of the ulcer, to include wound bed, undermining and tunneling, exudate and surrounding skin. ii. If dressing is present; evaluation of dressing if it is intact drainage present. iii. The color/condition of surrounding skin iv. Presence of complications, such as, signs of ulceration or soft tissue infection (redness or swelling, warmth) v. Pain or increase in pain vi. Result of current treatment/interventions d. Routine measurements are completed on areas of impaired skin integrity. Hillcrest's best practice is using a clock-face-method. i. Length-head to toe orientation. 12-6 clock face orientation ii. Width-hip to hip orientation. 3-9 clock face orientation iii. Depth-if there is not depth, this equals zero. Deepest part(s).Wound baseUnderminingTunneling.e. Discussion with the interdisciplinary teams on the status of the wounds should occur if the wound is not showing progress toward healing within 2-4 weeks and as needed to determine the need for change of treatment recommendations and interventions. B. A review of Resident 3's admission Record revealed Resident 3 admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record included the following diagnoses for Resident 3: pressure ulcer of sacral region, unstageable, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side [stroke], small cell B-cell Lymphoma [non-[NAME] lymphoma], unspecified site, unspecified severe protein-calorie malnutrition, and Adult Failure to Thrive. A review of Resident 3's admission Minimum Data Set [a comprehensive assessment used for care planning] dated 6/13/26 revealed the following:-A Brief Interview for Mental Status score of 14 which indicated Resident 3 was cognitively intact-Resident 3 had a stage 4 pressure ulcer that was (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present on admission-Resident 3 had an unstageable pressure ulcer present on admission A review of Resident 3's Care Plan revealed a focus area related to Resident 3 being admitted with a sacral pressure injury and a pressure injury to their (gender) left heel dated 6/13/26 with the following interventions:- Assess/record/monitor wound healing per protocol/order. Measure length, width and depth where possible. Report improvements and declines to the MD [Medical Doctor]. Initiated 6/13/26- If the resident refuses treatment, confer with the resident, IDT [Interdisciplinary Team] and family to determine why and try alternative methods to gain compliance. Document alternative methods. Initiated 6/13/26- Prafo boots per order. Initiated 6/13/26- The resident has an air mattress in place. Initiated 6/13/26- The resident needs assistance to turn/reposition at least every 2 hours. Initiated on 6/13/26- Treat pain as per orders prior to treatments/turning etc. to ensure the resident's comfort. Initiated 6/13/26- Weekly treatment documentation by facility wound nurse. Initiated on 6/13/26- Wound healing supplements as ordered, see MAR/TAR [Medication Administration Record/Treatment Administration Record]. Administer treatments as ordered, see TAR. Monitor for tx [treatment] effectiveness per protocol/order. Initiated on 6/29/26 A review of Resident 3's hospital wound consult notes dated 5/19/26 revealed the following description of Resident 3's wound:-Suspected deep tissue injury located on coccyx measures 5 cm x 3.5 cm x unknown-The wound is considered a deep tissue injury- The wound bed is described as contained contain dark purple/maroon discoloration, slough, and eschar and has no exposed subcutaneous tissue, muscle, tendon, and bone.- The skin around the wound is dry and intact.- There is minimal amount of serosanguinous exudate draining from the wound. A review of Resident 3's admission assessment dated [DATE] revealed the following under the skin section:-Right lower front leg skin tear-Left lower front leg skin tear-Left heel pressure ulcer-Sacrum pressure ulcer-The admission assessment dated [DATE] did not include any measurements or descriptions of any of the wounds. A review of Resident 3's 5/26 MAR [Medication Administration Record] revealed the following treatment ordered for Resident 3's sacrum: - Coccyx 1. Cleanse with wc [wound cleaner] 2. Pat dry 3. Apply [NAME] thick Santyl [an ointment that clears dead tissue from skin ulcers] to wound bed. 4. Top with moisten gauze 5. Cover with ABD [bandage] - Secure with paper or medipore tape only bid [twice per day] and prn [as needed].-Treatment order was dated 5/28/26 and documented as completed A review of Resident 3's Skin Evaluation dated 5/31/26 revealed the following regarding coccyx pressure wound:-Stage: unstageable [depth is hidden by slough or eschar]-Wound bed: slough-Wound exudate: None-Peri wound condition: within normal limits-Dressing saturation: none-Wound odor: no-Tissue: painful- Unstageable pressure ulcer noted to coccyx area. Slough tissue noted to center of wound. No noted redness to surrounding wound. No noted drainage/bleeding noted to site.-The Skin Evaluation on 5/31/26 did not include any measurements of the coccyx wound. A review of Resident 3's Progress Note dated 6/3/26 at 6:28 PM as a late entry revealed wound rounds were completed with the following evaluation:- Coccyx described as unstageable PI [Pressure injury] present on admit wound noted to be deteriorating since admit 100% black slough to entire wound bed with heavy purulent drainage and strong foul odor present guest c/o [complains of] increased pain and discomfort to wound, peri wound noted to be macerated pink/white in color. Pain medication and offered to give guest breakfast and wound complete wound measurements and TX [treatment] at a later time when pain had subsided, guest declines and would like TX to be completed at this time approximate measurements 7.0 x 6.0 unable to determine depth d/t [due to] amount of slough in wound bed TX was completed per orders to wash with WC [wound cleaner], pat dry apply nickel thick Santyl to wound top with moist gauze and cover with ABD [wound dressing] and secured with medipore tape. A further review of Resident 3's Progress Note dated 6/3/26 at 6:28 PM as a late (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the admission assessment should include a description of the wound and some type of measurement or description of the size of the wound. The Director of Nursing confirmed the charge nurses have been trained on measurement of wounds. The Director of Nursing confirmed that Resident 3's wound should have been assessed with the first wound vacuum change after admission on [DATE] and the first wound vacuum change was completed on 6/11/26. In an interview on 7/21/26 at 2:58 PM, the Director of Nursing reported not having any additional information to provide at that time.		

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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 12-006.18(D) Based on record review, observation, and interview, the facility failed to follow infection control standards of practice regarding hand hygiene and glove use during wound care for Resident 2. This affected 1 of 3 residents observed for wound care. The facility census was 61. Findings are:Record review of facility policy titled Hand Hygiene Policy dated 1/1/26 revealed that healthcare personnel should use an alcohol-based hand rub or wash their hands with soap and water for the following clinical indications: -Immediately before touching a patient -Before moving from work on a soiled body site to a clean body site on the same patient -After touching a patient or the patient's immediate environment -After contact with blood, body fluids, or contaminated surfaces -Immediately after glove removalIf the task required gloves; perform hand hygiene prior to donning (putting on) gloves, before touching the patient, or the patient environment. Record review of the admission Assessment dated 07/15/2026 revealed that Resident 2 had a penny size area of redness to the coccyx, charted as pressure. Record review of the skin only assessment dated 07/17/2026 revealed that Resident 2 had an open lesion on their coccyx. An observation of wound care was completed on 07/20/2026 from 11:10AM to 11:20AM by Licensed Practical Nurse- A (LPN-A) on Resident 2. Present in the room was also Certified Nursing Aide- B (CNA-B). The observation went as follows:-LPN-A and CNA-B entered Resident 2's room and donned (put on) gloves. Both LPN-A and CNA-B did not perform hand hygiene prior to, upon entrance, or prior to donning gloves for patient care. -Resident 2 required a brief change prior to Calmoseptine (a moisture barrier that protects surrounding skin from wound drainage and treats partial-thickness wounds) application. -LPN-A used bath wipes to complete peri care, using a new wipe with each pass, and wiped front to back. -LPN-A wiped off the previous Calmoseptine that was on Resident 2's coccyx wound. -LPN-A did not remove Resident 2's brief after completion of peri care and did not doff (remove) their gloves at that time. -LPN-A used their finger with the soiled glove to apply the Calmoseptine after inspection of the coccyx wound. -LPN-A removed the soiled brief from beneath Resident 2 and placed a clean brief at that time. -After repositioning the resident, LPN-A doffed their gloves, no hand hygiene was completed.-LPN-A removed the soiled garbage with ungloved hands. -LPN-A exited Resident 2's room and did not complete hand hygiene. An interview on 7/20/2026 at 11:20 AM with LPN-A confirmed that hand hygiene was not completed prior to donning gloves and after doffing gloves during patient cares in Resident 2's room. LPN-A confirmed that they did not change their gloves or perform hand hygiene when moving from a soiled body surface to a clean body surface. LPN-A then confirmed that they used a soiled glove to apply Calmoseptine to the coccyx wound. LPN-A confirmed that they used non-gloved hands to empty the soiled garbage and exited Resident 2's room without performing hand hygiene for the entirety of the observation. An interview on 7/21/2026 at 8:40 AM with LPN-C revealed that the process to apply Calmoseptine was to complete hand hygiene, then don gloves, and assess the wound. They revealed that they would then doff their gloves, perform hand hygiene, and don new gloves. After donning new gloves, LPN-C reported they would then apply a thin layer of Calmoseptine, doff their gloves, and perform hand hygiene. An interview on 7/21/2026 at 9:01 AM with the Clinical Care Coordinator (CCC) confirmed that the expectation of the staff when applying ointments or creams to wounds was to perform hand hygiene, don gloves, remove the previous cream or ointment, assess the wound, doff gloves, perform hand hygiene, don gloves, apply thin layer of cream/ointment, doff gloves, and perform hand hygiene.		