STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E299	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Shadow Lake LLC	1507 E Gold Coast Road Papillion, NE 68046

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-009.06 (H)(iii). Based on observation, interview and record review the facility failed to ensure vascular wounds were monitored to promote healing for 1 (Resident 2) of 1 residents sampled. The facility census was 95. Findings are:Record review of the facility policy titled Skin integrity, Wound, Ulcer Assessment Prevention Treatment Documentation Policy dated 02-11-2021 revealed all team members are responsible for preventing, caring for, and providing treatment to any guest that has altered skin integrity. A licensed nurse/physician/therapist may stage a wound and determine etiology. Measurement of the wound must be completed upon identification. For admissions, wounds must be measured when completing the admission skin assessment. Wounds are measured in 3 dimensions: length, width, and depth. Measurements must be completed routinely and documented on a wound progress assessment form on all identified impaired skin integrity issues.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 12-11-2025 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with upper body dressing.-required total assistance with lower body dressing, hygiene, toileting, bathing, bed mobility and transfers.-had 2 venous and or arterial wounds. Record review of Resident 2's Comprehensive Care Plan (CCP) dated 12-12-2023 revised on 12-19-2024 revealed Resident 2 was at risk of an alteration in skin integrity related to poor nutritional intake related to gastric bypass surgery, intolerance to nutritional supplements, and Resident 2's preference to stay in bed most of the time. The CCP also identified on 12-24 Resident 2 had venous ulcers to both lower extremities and the right lower extremity ulcers were worse than the left. The goal was Resident 2's venous ulcers to both lower extremities would show progression or be healed by the review date. The interventions were as follows:-encourage and assist to reposition in bed and in the chair at routine intervals for pressure relief.-encourage good nutrition and hydration in order to promote healthier skin.-keep skin clean and dry. Use lotion on dry skin. Do not apply on any site of injury. -monitor and document location, size and treatment of any skin injury, issue or change when noted, then weekly thereafter until healed. Report abnormalities, failure to heal, signs and symptoms of infection to the physician.-pressure reduction mattress on bed and pressure reduction cushion in w/c when up in wheelchair.-provide treatments to venous ulcers as ordered. Notify the physician of changes when noted. Record review of Resident 2's Electronic Health Record under the assessments section revealed the absence of wound evaluations with a description and measurements of Resident 2's venous ulcers. Record review of Resident 2's Progress Notes (PN) from 10-01-2025 to 01-20-2026 revealed the absence of wound evaluations with a description and measurements of Resident 2's venous ulcers. Record review of Resident 2's EHR under the section documents revealed a document from the vascular clinic dated 12-05-2025 with orders for (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued treatment of Resident 2's venous ulcers, orders to return to the vascular clinic on 01-09-2026. The document did not include any wound descriptions or measurements. Record review of Resident 2's EHR under the document section revealed an After Visit Summary (AVS) dated 01-09-2026 from the vascular clinic with orders for continued care of Resident 2's venous ulcers and to return to the clinic on 03-06-2026. The AVS did not include a description or measurements of Resident 2's venous ulcers. An interview with Resident 2 on 01-15-2026 at 9:50 AM revealed Resident 2 had been going to a vascular clinic for management of (gender) venous ulcers. An observation conducted on 01-15-2026 at 2:00 PM revealed Resident 2 was sitting in the wheelchair and both lower legs had gauze bandages from the ankles to the knees. An interview conducted with the Assistant Director of Nursing (ADON) on 01-20-2026 at 8:50 AM revealed Resident 2 had declined the wound care treatment for today and confirmed the absence of wound evaluations in Resident 2's EHR was because (gender) venous ulcers are measured and assessed at the vascular clinic. An interview conducted with the Director of Nursing on 01-20-2026 at 3:00 PM confirmed Resident 2 went to the vascular clinic on 12-05-2025 and 01-09-2026 and the facility had not obtained a description or measurements of Resident 2's venous ulcers from either appointment. An interview conducted on 01-20-2026 at 3:50 PM with the Director of Compliance (DOC) confirmed Resident 2's venous ulcers should have been evaluated weekly and confirmed monitoring of the wound needed to be done in between appointments at the vascular clinic. The facility staff were unable to provide additional information on Resident 2's venous ulcers prior to exiting the facility on 01-20-2026.

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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 0686 Level of Harm - 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 Number 175 NAC 12-006.09(H)(iii)(1) & 12-006.09(H)(iii)(2). Based on observation, interview and record review the facility failed to evaluate, monitor, and implement interventions for pressure ulcer prevention and promotion of wound healing for 2 (Resident 1 and 3) of 4 residents sampled. The facility census was 95. Findings are:A. Record review of the facility policy titled Skin integrity, Wound, Ulcer Assessment Prevention Treatment Documentation Policy dated 02-11-2021 revealed all team members are responsible for preventing, caring for, and providing treatment to any guest that has altered skin integrity. A licensed nurse/physician/therapist may stage a wound and determine etiology. Measurement of the wound must be completed upon identification. For admissions, wounds must be measured when completing the admission skin assessment. Wounds are measured in 3 dimensions length, width, and depth. Measurements must be completed routinely and documented on a wound progress assessment form on all identified impaired skin integrity issues. B. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 11-21-2025 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had a diagnosis of quadriplegia and Multiple Sclerosis (MS). -Brief Interview of Mental Status (BIMS) was scored as 12. According to the MDS Manual a score of 8 to 12 indicates moderate cognitive impairment. -required total assistance with eating, dressing, bathing, hygiene, bed mobility and transfers. -was at risk of developing a pressure ulcer. - had a stage 4 pressure ulcer. According to the MDS Manual a stage 4 pressure ulcer is full thickness tissue loss with exposed bone, tendon or muscle and often includes undermining (the destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface) and tunneling (a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound). Record review of Resident 3's Nursing admission Screening/History (NASH) dated 05-09-2025 revealed Resident 3's skin was intact upon admission. Record review of Resident 3's Electronic Health Record (EHR) revealed a Braden Scale (a pressure ulcer risk tool) dated 05-09-2025 revealed Resident 3 scored a 13, indicating moderate risk of developing a pressure ulcer. Record review of Resident 3's Baseline Care Plan (BCP) dated 05-21-2025 revealed Resident 3 was at risk for skin breakdown/issues due to impaired mobility, dependence on team for all cares and to keep skin clean and dry. - Encourage adequate nutritional intake. - Encourage and assist to reposition in chair and in bed at routine intervals for pressure relief. - Notify PCP of any changes noted in skin condition.Further review of the BCP revealed there was no indication that pressure-reducing surfaces were provided to the bed or the wheelchair. Record review of Resident 3's Comprehensive Care Plan (CCP) printed on 01-20-2026 revealed Resident 3 had a potential or actual impairment to skin integrity due to dependence on the team for all activities of daily living (ADLS), mobility, catheter use, colostomy use, feeding tube in place but not currently and had a stage 2 pressure ulcer (According to the MDS Manual a Stage 2 pressure ulcer is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising and may also be an intact or open/ruptured blister) to the left buttock. Date initiated 05-21-2025. The goal was Resident 3 will maintain or develop clean and intact skin by the review date. Interventions in reaching this goal were:-encourage and assist to reposition in bed and in the chair at routine intervals for pressure relief.-encourage good nutrition and hydration in order to promote healthier skin.-keep skin clean and dry. Use lotion on dry skin. Do not apply on any site of injury. -monitor and document location, size and treatment of any skin injury, issue or change when noted, then weekly thereafter until healed. Report abnormalities, failure to heal, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	signs and symptoms of infection to the physician.-pressure reduction mattress on bed and pressure reduction cushion in w/c. Record review of Resident 3's Skin Only Evaluations ([NAME]) revealed no skin evaluation from 05-09-2025 to 5-23-2025, a 14 day span of time. Record review of Resident 3's Treatment Administration Record (TAR) for May 2025 revealed an order dated 05-21-2025 to remove old dressing, cleanse area place xeroform to size of area, cover with mepilex (a type of wound dressing) and change the dressing on Monday, Wednesday and Friday. The order did not identify where the location of the wound was. Record review of Resident 3's [NAME] dated 05-23-2025 revealed Resident 3 had no skin issues. Record review of Resident 3's [NAME] dated 05-31-2025 revealed Resident 3 had a stage 2 pressure ulcer to the left buttock without measurements or a description of the wound. An interview conducted with the Director of Nursing (DON) on 01-20-2026 at 3:00 PM confirmed Resident 3 should have had an [NAME] on 05-16-2025 and hadn't and confirmed interventions to prevent pressure ulcer development were not implemented until 05-21-2025 after Resident 3 developed a pressure ulcer to the left buttock and confirmed an initial evaluation of the wound was not conducted. Record review of Resident 3's Progress Notes (PN) revealed wound documentation for the following dates:-06-13-2025 Skin issue: Pressure ulcer to the left buttock stage 2 without measurements. -07-18-2025 Skin issue: Pressure ulcer to the left buttock stage 2 and pressure ulcer to left heel without measurements. Record review of Resident 3's PN revealed wound documentation for the following dates:-07-25-2025 Skin issue: Pressure ulcer to the right buttock stage 3 with full thickness skin loss and tunneling present. -07-28-2025 Resident 3 had a pressure ulcer stage 3 to the right buttocks measuring 2.5 centimeters (cm) by 1.8 cm x 1.2 cm with tunneling at 10 o'clock measuring 3.5 cm and the wounds to the left heel and left great toe are healed. Record review of Resident 3's CCP printed on 01-20-2026 revealed no new interventions were implemented for Resident 3's stage 3 pressure ulcer to the right buttock. An observation conducted on 01-20-2026 at 8:00 AM of Licensed Practical Nurse (LPN) D and the Assistant Director of Nursing (ADON) performing wound care for Resident 3 revealed an oval shaped wound approximately 2 cm in length by 3 cm width by 1 cm depth and a tunnel at 1 o'clock to the right gluteal fold, there was a moderate amount of red and brown drainage on the old dressing, the wound bed was pink and the skin around the wound was pink. An interview conducted with the ADON on 01-20-2026 at 3:10 PM revealed orders were obtained for the treatment of the right buttock and causal factors for Resident 3's pressure ulcer to the right buttock had not been identified. An interview conducted with the DON on 01-20-2026 at 3:50 PM confirmed Resident 3 had 2 separate pressure ulcers one on the right buttock and one on the left buttock. C. Record review of the Operation Manual for the Protekt Aire 4000DX/5000DX air mattress revealed the mattress can be adjusted to the desired firmness according to user's weight or the suggestion from a health care professional. Record review of Resident 3's EHR under the section weights and vitals revealed Resident 3's the most recent weight was 178.0 lbs. on 01-09-2026. An observation conducted on 01-15-2026 at 9:20 AM revealed Resident 3 had an air mattress on the bed set at 240 pounds (lbs). An observation conducted on 01-15-2026 at 11:15 AM revealed Resident 3 had an air mattress on the bed set at 240 lbs. An observation conducted on 01-20-2026 at 6:05 AM revealed Resident 3 was in bed and the air mattress was on and set at 270 lbs. An observation conducted on 01-20-2026 at 12:30 PM with Nursing Assistant (NA) A confirmed Resident 3's air mattress was set at 270 lbs. Record review of Resident 3's EHR revealed no order for an air mattress or air mattress settings.An interview conducted with the DON on 01-20-2026 at 3:00 PM confirmed having the air mattress set for a person that weighs 270 lbs. would cause increased pressure for a person weighing 178 lbs. An interview with the Director Of Compliance on 01-20-2026 at 3:55 PM confirmed the air mattresses should be set according to the resident's weight or according to practitioner (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ordered settings. D. Record review of Resident 1's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE]-BIMS was scored as 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with bed mobility.-required extensive assistance with dressing and bathing.-required total assistance with toileting and transfers.-was always incontinent of bladder.-was frequently incontinent of bowel.-was at risk of developing a pressure ulcer.-had a stage 2 pressure ulcer. Record review of Resident 1's EHR revealed a Braden scale evaluation conducted on 11-21-2025 revealed Resident 1 scored a 13, indicating moderate risk of pressure ulcer development. Record review of Resident 1's CCP printed on 01-20-2026 dated 12-09-2024 revealed the following for Resident 1:-was at risk for the potential or actual impairment of skin integrity due to incontinence, decreased mobility, at risk per Braden risk assessment, previous issues with Moisture Associated Skin Damage (MASD) to groin and abdominal folds and excoriation to the buttocks. -on 04-22-2025 unstageable pressure ulcer to the right heel.- The goal was Resident 1 will maintain clean and intact skin by the review date. -Interventions to reach the goal were:-encourage and assist to reposition when in bed and in chair at routine intervals throughout each shift for pressure relief. -encourage good nutrition and hydration in order to promote healthier skin. -keep skin clean and dry. Use lotion on dry skin. Do not apply on any site of injury. -monitor and document location, size and treatment of any skin injury, issue or change when noted, then weekly thereafter until healed. Report abnormalities, failure to heal, signs and symptoms of infection to the physician.-pressure reduction mattress on bed and pressure reduction cushion in w/c. Record review of Resident 1's PN revealed on 04-22-2025 Resident 1 had an unstageable pressure ulcer to the right heel; orders were received for treatment of the wound and for a protective boot. Record review of Resident 1's CCP revealed new interventions for skin integrity dated 04-22-2025:-heel protectors on at all times as resident will allow-treatment to skin areas as ordered see Medication and Treatment Administration Records and notify physician of any changes as needed. Record review of Resident 1's PN dated 12-01-2025 revealed Resident 1 had a stage 2 pressure ulcer to the right heel measuring 2.2 cm by 1.3 cm. Record review of Resident 1's [NAME] dated 12-04-2025 revealed Resident 1 had a diabetic foot ulcer and redness to the buttocks. Record review of Resident 1's EHR revealed no [NAME] on or around 12-11-2025. Record review of Resident 1's PN dated 12-08-2025 revealed Resident 1 had a stage 2 pressure ulcer to the right heel measuring 1.8 cm by 1 cm and a large fluid filled blister to the top of the right foot measuring 4.5 cm by 4.5 cm. Record review of Resident 1's PN dated 12-15-2025 revealed Resident 1 had a stage 2 pressure ulcer to the right heel measuring 1 cm by 1 cm and the large fluid filled blister, now open due to resident having telfa (a type of wound dressing) on the blister to the top of the right foot measuring 5.5 cm by 6.5 cm. Record review of Resident 1's PN dated 12-15-2025 at 8:04 PM revealed Resident 1 had slurred speech and was behaving abnormally and had been sent to the emergency room (ER). Record review of Resident 1's Emergency Department Provider Notes (EDPN) dated 12-15-2025 at 8:08 PM revealed Resident 1 had a wound to the right posterior thigh with surrounding redness, foul rotting fruit odor, mild drainage and additional skin breakdown was identified to the right posterior heel, and a large fluid-filled blister to the lateral aspect of the right foot without abnormal drainage or surrounding redness. Record review of Resident 1's Hospital History and Physical (H&P) dated 12-16-2025 at 5:02 AM revealed Resident 1 presented to the ER on [DATE] with encephalopathy (a broad term for any disease, damage, or malfunction that alters brain function or structure, leading to an altered mental state, confusion, memory loss, or personality changes, with potential causes including infections, toxins, metabolic issues, lack of oxygen, or head trauma, and it can range from temporary to permanent) from (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a skilled nursing facility. Resident 1 had lab work that was suggestive of a urinary tract infection and possible cellulitis from a pressure sores. Resident 1 was started on an antibiotic and was admitted to the hospital. Record review of Resident 1's Hospital Wound Ostomy Care Consult note dated 12-16-2025 at 4:25 PM revealed Resident 1 had 3 wounds identified with the descriptions as follows:- wound characteristic of unknown etiology located to the right posterior thigh measuring 6 cm by 6.8 cm by unknown depth. The wound was described as a full-thickness wound, extending through the top 2 layers of skin. The wound had a boggy center, dark purple/maroon discolorations, pink granular, red granular, slough and eschar. The skin around the wound was indurated around the edges and reddened. There was a moderate amount of purulent and malodorous exudate draining from the wound. -wound was characterized as a chronic pressure ulcer stage 2 located on the right posterior heel measuring 2.0 cm by 1 cm x 0.1 cm.-wound is characterized as a pressure ulcer stage 2 to the top of the right foot measuring 6.8 cm by 7.0 cm. Record review of Resident 1's Hospital Progress note dated 12-17-2025 revealed Resident 1 had a soft tissue infection of the pressure ulcer to the hip. Record review of Resident 1's Hospital Operative Note dated 12-18-2026 revealed Resident 1 had an operative procedure for the debridement of the wound to the right posterior thigh and for placement of a wound vac to the wound. The note also revealed the surgeon had to remove a 7 cm by 4 cm area of necrotic (dead) skin, the subcutaneous fat was absent exposing the thigh fascia (connective tissue) and the depth of the wound was 2 cm. An interview conducted on 01-20-2026 at 2:00 PM with NA B revealed NA B was aware of Resident 1 having a skin issue to the right thigh near buttocks and the area was covered with a square bandage, prior to discharge to the hospital on [DATE]. An interview conducted on 01-20-2026 at 2:10 PM with Registered Nurse (RN) C revealed RN C knew Resident 1 was starting to get a pressure ulcer to the thigh but could not recall whether a treatment was in place prior to discharge to the hospital on [DATE]. An interview conducted with the ADON on 01-20-2026 at 8:50 AM revealed the floor nurses perform the [NAME] every week and the ADON performs wound evaluations weekly with measurements. An interview conducted with the DON on 1-20-2026 at 3:00 PM revealed Resident 1 should have received an [NAME] on 12-11-2026 and confirmed Resident 1's last [NAME] prior to discharge to the hospital was on 12-4-2026, a span of 11 days. An interview conducted with the ADON on 01-20-2026 at 3:10 PM revealed causal factors for the wound to the top of Resident 1's right foot had not been identified. An interview with the Director of Compliance (DOC) on 01-20-2026 at 3:45 PM confirmed [NAME] are to be conducted weekly. The facility staff were not able to provide additional information regarding the wounds for Resident 3 or Resident 1 prior to exiting the facility on 01-20-2026.