

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  28E299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Hillcrest Shadow Lake LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>52170</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on interview and record reviews; the facility failed to report an allegation of abuse to the required State Agency (SA) within the required timeframe for 1 (Resident 15) of 1 sampled resident. The facility staff identified a census of 103.</p> <p>The findings are:</p> <p>Record review of a facility policy entitled Reporting Allegations of Abuse/Neglect/Exploitation dated revised 03/05/2025 revealed:</p> <p>-The facility must develop and operationalize policies and procedures for screening and training team members, protection of guest and for the prevention, identification, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control prevent occurrences.</p> <p>-7. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective action depending on the results of the investigation.</p> <p>-Procedure for Response and Reporting Abuse/Neglect/Exploitation, including allegations:</p> <p>-2. The Director of Clinical Services and Administrator, or Designee will:</p> <p>-a. Notify the appropriate agencies of all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>-i. Call Nebraska Department of Health and Human Services, Adult Protective Services (HHSS/APS) local office to file the report.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 15's Admission Record revealed the facility admitted the resident on 09/21/2023 with diagnoses of fibromyalgia, other specified depressive episodes, cognitive social or emotional deficit following cerebral infarction (stroke), and insomnia.</p> <p>Record review of Resident 15's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14/15. According to the MDS Manual, a score of 14 indicated the resident was cognitively intact. Further review of the MDS revealed the resident displayed physical and verbal behavioral symptoms on 1-3 days and the resident rejected care on 1-3 days.</p> <p>An observation on 4/16/25 at 3:33 PM of Resident 15's medial aspect of the right upper arm revealed an oval-shaped purple discolored area.</p> <p>An interview on 4/16/25 at 3:33 PM with Resident 15 revealed an allegation that the resident was grabbed, held down, and made me take a shot at the end of March. Resident 15 was unaware of the exact date. Resident 15 revealed that facility staff were aware of the allegation. Resident 15 further revealed that [gender] felt safe at the facility at the time of the interview.</p> <p>The facility Administrator (ADM) and Director of Nursing (DON) were notified by the surveyor of Resident 15's allegation on 04/16/2025 at 3:58 PM.</p> <p>Record review of Resident 15's Progress Notes revealed a note on 03/31/2025 that showed the resident called the police and stated that she had been beaten by a nurse two days ago, and tied up with blue rope, and had blood drawn.</p> <p>Record review of an Abuse, Neglect or Misappropriation document dated 04/01/2025 revealed that the ADM or DON were notified of Resident 15's allegation on 04/01/2025 at 9:30 AM. The document did not show that the SA had been notified.</p> <p>An interview on 04/22/2025 at 7:08 AM revealed that the facility staff reported Resident 15's allegation to the State Agency on 4/16/25 and completed an investigation. The ADM further revealed that the allegation was not reported as required at the time the resident reported the allegation on 03/31/2025.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>52170</p> <p>Nebraska Licensure Reference Number 175 NAC 12-006.09(h)(vi)(3)(g)</p> <p>Based on interview and record review; the facility failed to measure and record pulse rates before and after a breathing treatment was administered for 1 (Resident 42) of 1 sampled resident. The facility staff identified a census of 103.</p> <p>The findings are:</p> <p>Record review of a facility provided, undated Nebulizer Competency revealed:</p> <p>-Procedure:</p> <p>-3. Take client's pulse prior to treatment.</p> <p>-10. Take client's pulse rate at completion of treatment.</p> <p>Record review of Resident 42's Admission Record revealed the facility admitted the resident on 03/11/2025. Further review of the admission record revealed Resident 42 had diagnoses which included congestive heart failure, atrial fibrillation (irregular heartbeat), and chronic kidney disease.</p> <p>Record review of Resident 42's Order Summary Report printed 04/17/2025 revealed an order dated 04/14/2025 for albuterol sulfate inhalation nebulization solution to be administered by nebulizer twice daily for seven days.</p> <p>Record review of Resident 42's medical record revealed that the resident's pulse was measured and recorded one time daily for each day from 04/14/2025 through 04/21/2025.</p> <p>An interview on 04/22/2025 at 9:05 AM with the Director of Nursing (DON) revealed the facility did not have a policy for nebulized medication administration and the facility followed the Nebulizer Competency. The DON further confirmed that pulse rates were not measured and recorded before and after the administration of a nebulizer treatment and should have been.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>52170</p> <p>Licensure Reference Number 175 NAC 12.006.11(E)</p> <p>Nebraska 2017 Food Code 2-301.14</p> <p>Nebraska Food Code 2017 3-302.11(4)</p> <p>Based on observations, record review and interview; the facility staff failed to utilize handwashing and gloving techniques during meal service and failed to serve foods in a manner to prevent potential contamination. This had the potential to affect 44 residents. the facility census was 103.</p> <p>Findings are:</p> <p>Record review of a facility policy entitled Meal Tray Delivery Related to Infection Control dated 10/27/2017 revealed:</p> <p>-2. After a tray has been delivered, the server will exit the room and apply hand sanitizer that is provided in the service hallways (Per the hand sanitizing gel policy) prior to entering the next resident's room.</p> <p>-3. Once the server has returned to the kitchen, he/she will repeat the handwashing procedures (Per the handwashing policy) prior to the delivery of the next meal tray.</p> <p>Continuous observation in the assisted dining room and the Evergreen Hall on 04/17/2025 from 12:15 PM to 12:43 PM revealed Nurse Tech (NA)-K, with gloved hands, obtained a meal tray from the enclosed meal tray cart which stored multiple resident trays and delivered the tray to room E12. NA-K knocked on the door and entered the room. The resident declined the tray, without doffing (removing) gloves and without the benefit of hand hygiene, NA-K returned the tray to the meal tray cart, obtained another meal tray and delivered to room E8. NA-K knocked on the door and entered the room. The resident declined the tray. Without doffing gloves and without the benefit of hand hygiene, NA-K returned the tray to the meal tray cart and doffed gloves. Without the benefit of hand hygiene, NA-K donned (applied) gloves, obtained a meal tray from the enclosed meal tray cart and delivered the tray to room E1. The resident declined the meal tray. NA-K Without doffing gloves and without the benefit of hand hygiene, NA-K returned the tray to the tray cart. NA-K obtained a large tray of dishes that contained sliced cinnamon apples. Half of the dishes of cinnamon apples were covered with plastic wrap while the remaining dishes were uncovered. NA-K carried the tray and entered room E4 and delivered the cinnamon apples and exited the room.</p> <p>An interview on 04/17/2025 at 12:46 PM with NA-K confirmed that [gender] did not doff gloves and perform hand hygiene between resident rooms and should have. NA-K further confirmed that [gender] carried the entire tray of cinnamon apples into resident rooms and should not have.</p> <p>An interview on 04/22/2025 at 2:48 PM with the Clinical Care Coordinator (CCC) revealed that 44 residents received foods from the assisted dining room tray cart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45614</p> <p>Licensure Reference Number 175 NAC 12.006.18 (D)</p> <p>Based on record review, observation and interview, the facility staff failed to perform hand hygiene before and after using gloves during medication administration for 2 (Residents 33 and 66) of 4 residents observed during medication pass. The facility census was 103.</p> <p>Findings are:</p> <p>A. An observation on 4/17/2025 at 7:10AM of medication administration by Medication Aide (MA I) to Resident 33 revealed MA I donned gloves to assist Resident 33 to sit up, handed them their medication and a glass of water. MA I administered nasal spray and assisted Resident 33 to lie down on their bed. MA I applied powder to Resident 33's skin and covered the resident with a blanket. MA I removed their gloves and left the residents room to return to the medication cart and chart the medication administration. MA I did not wash their hands or use hand sanitizer before putting the gloves on, taking them off or when they exited the room.</p> <p>An interview with MA I on 4/17/2025 at 7:10AM confirmed they should have used hand sanitizer before and after using gloves, but they forgot to do so.</p> <p>B. An observation on 4/17/2025 at 7:30 AM of medication administration by Registered Nurse J (RN J) to Resident 66 revealed RN-J donned gloves in Resident 66's room to administer eye drops to Resident 66. RN-J did not wash their hands or use hand sanitizer prior to donning gloves.</p> <p>An interview on 4/17/2025 at 7:30 AM with RN J confirmed they should have used hand sanitizer or washed their hands before donning gloves and they had not done so.</p> <p>A record review of the facility Hand Hygiene Policy dated 3/1/2022 revealed the following:</p> <p>A. Hand Hygiene Guidance.</p> <p>1. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:</p> <p>a).Immediately before touching a patient.</p> <p>b).After touching a patient or the patients immediate environment.</p> <p>f). Immediately after glove removal.</p> <p>- Gloves and Hand Hygiene.</p> <p>1. Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potential infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment occur.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Gloves are not a substitute for hand hygiene.</p> <p>a). If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment.</p>		