

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER Hilltop Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 Avenue M Gothenburg, NE 69138	

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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)</p> <p>Based on observation interview and record review the facility failed to observe 1 (Resident 41) of 1 sampled resident for changes in their psychosocial or mood state and failed to monitor the resident for adverse effects from their psychotropic medication in accordance with the resident's plan of care. The facility census was 44.</p> <p>Findings are:</p> <p>Review of a facility policy titled Behavioral Health Services and dated 10/24/2022 revealed it is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. The facility will ensure that necessary behavioral health care services are person centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, psychosocial adjustment difficulty and trauma.</p> <p>A record review of a Resident Face Sheet revealed Resident 41 was admitted to the facility on [DATE] with diagnoses of Polyosteoarthritis (a condition where multiple joints are affected by a degenerative joint disease), Macular Degeneration (a disease of the eye resulting in lack of vision), and Depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities).</p> <p>A record review of Resident 41's admission 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) with an Assessment Reference Date (ARD) of 01/17/2025 revealed Resident 41 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11/15 indicating the resident was moderately cognitively impaired. The resident had a Patient Health Questionnaire (PHQ-2 to 9, A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder) score of 6/27 indicating mild depression. The resident indicated during the interview for daily preferences that listening to music, keeping up with the news, going outside when the weather is good, and participating in religious services or practices were very important to them. The resident was dependent on staff assistance using a wheelchair for mobility over long distances.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 285163
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 41's Care Plan revealed a problem of psychosocial well being stating the resident was experiencing a decline in their psychosocial wellbeing and or mood state dated 01/29/2025 with a goal stating the resident would not show a decline in their psychosocial well being through the next review date. Approaches were listed including being involved with telehealth for medication management and mental health therapy, to observe the resident for changes in their psychosocial or mood state and report changes to their physician and facility social worker, and target behaviors of social isolation poor appetite and difficulty coping with adjustment to placement and loss of husband all dated 01/29/2025. Resident 41 also had a problem of psychotropic drug use due to depression dated 01/24/2025 with a goal that the resident would not exhibit signs of drug related sedation or anticholinergic symptoms (dry mouth, blurred vision, confusion, hallucinations, delirium and heat intolerance). An approach was listed to assess and record effectiveness of drug treatment and monitor and report signs of sedation, hypotension, or anticholinergic symptoms dated 01/24/2025.</p> <p>A record review of Resident 41's Electronic Medical Health Record revealed an order for Duloxetine (a medication used to treat depression) 20 milligrams once daily.</p> <p>In an interview conducted on 03/12/2025 at 4:30 PM with Resident 41, Resident 41 stated they had recently lost their spouse and moved into the facility due to not being able to care for themselves. The resident reported feeling sad and lonely most of the time and feeling like they were sleeping more than normal. The resident stated they enjoyed the exercise activity and sitting with a family member at mealtime and visiting with them. The resident reported enjoying the bible on tape but could not operate the recorder in the room due to a decline in vision function.</p> <p>In an interview conducted on 03/17/2025 at 2:10 PM with the facility Activity Director (ACTD), the ACTD stated that Resident 41 was participating in activities daily after admission. The ACTD confirmed that the resident, over the past couple of weeks, had started declining to go to activities that the resident had attended previously. The ACTD confirmed they did not report this change to nursing or social service staff.</p> <p>In an interview conducted on 03/17/2025 at 3:50 PM with the facility Social Service Director (SSD), the SSD denied being made aware of Resident 41's recent change of not coming out to meals and attending activities that had previously.</p> <p>In an interview conducted on 03/18/2025 with Medication Aide (MA)-H, MA-H revealed that Resident 41 had previously been going to the dining room for meals but started refusing to come to the dining room for a while. The MA confirmed that they had not reported this to the nurse or social services.</p> <p>In an interview conducted on 03/18/2025 at 1:15 PM with Registered Nurse (RN)-C, RN-C stated that Resident 41 was not being monitored for any mood or behavior problems or changes.</p> <p>In an interview conducted on 03/18/2025 at 3:00 PM with the Director of Nursing (DON), the DON confirmed that Resident 41 was not being monitored for the changes of not regularly attending activities and meals as they had previously and should have been.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observation, interview, and record review the facility failed to maintain a medication error rate of 5% or less with an actual medication error rate of 12%. This affected 2 residents (Resident 9 and Resident 37) of 4 sampled residents. The facility census was 44.</p> <p>Findings are:</p> <p>A record review of a facility policy titled Preventing Medication Errors dated 01/2018 revealed the facility must ensure that it is free of medication error rates of 5% or greater.</p> <p>A.</p> <p>A record review of Resident 9's Electronic Medical Record revealed Resident 9 had physician's orders to receive Sennosides-Docusate Sodium (a medication used to promote bowel movements) one tablet twice daily every day and Viactive Chewable (a vitamin and mineral supplement) once daily every day.</p> <p>An observation of medication administration by Licensed Practical Nurse A (LPN-A) completed on 03/13/2025 at 7:35 AM revealed the following:</p> <p>-LPN-A removed 2 round orange tablets from a white bottle labeled Senna Plus (sennosides-docusate sodium) and placed them in a clear plastic cup containing other medications. LPN-A then removed a white oblong tablet from a white plastic bottle labeled Calcium with Vitamin D (a vitamin and mineral supplement) and placed it in the clear plastic cup with the other medications. LPN-A proceeded to administer all the medications in the cup to Resident 9. Resident 9 ingested all the medications.</p> <p>In an interview completed on 03/13/2025 at 2:06 PM with LPN-A, LPN-A confirmed that Resident 9 had an order to receive 1 Senna Plus tablet and not 2 Senna Plus tablets. The LPN also confirmed that Resident 9 did not have an order to receive the Calcium with Vitamin D tablet that they administered. LPN-A confirmed that these were medication errors.</p> <p>In an interview completed on 03/13/2025 at 3:30 PM with the Director of Nursing (DON), the DON confirmed the resident receiving 2 tablets and not the prescribed 1 tablet was a medication error.</p> <p>B.</p> <p>A record review of Resident 37's Electronic Medical Record revealed Resident 37 had a physician's order to receive Acetaminophen (a pain-relieving medication) 500 milligrams (MG), one tablet three times a day, every day.</p> <p>An observation of medication administration by LPN-A completed on 03/13/2025 at 7:40 AM revealed the following:</p> <p>-LPN-A removed 2 oblong white tablets from a white bottle labeled Acetaminophen 500 MG tablets. The LPN placed the tablets in a clear plastic cup with other medications. LPN-A proceeded to administer all the medications in the cup to Resident 37. Resident 37 ingested all the medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview completed on 03/13/2025 at 2:08 PM with LPN-A, LPN-A confirmed that Resident 18 had an order to receive 1 Acetaminophen 500 MG tablet and not 2 Acetaminophen 500 MG tablets. The LPN confirmed that this was a medication error.</p> <p>In an interview completed on 03/13/2025 at 3:30 PM with the Director of Nursing (DON), the DON confirmed the resident receiving 2 tablets and not the prescribed 1 tablet was a medication error.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Licensure Reference Number 175 NAC 12-006.11(E)</p> <p>Based on observations and interviews, the facility failed to ensure the walk-through refrigerator maintained safe temperatures and failed to ensure the dishwashing machine reached the required temperatures during cycles to prevent the potential for foodborne illness. This had the potential to affect all facility residents eating out of the kitchen. The facility census was 44.</p> <p>Findings Are:</p> <p>A.</p> <p>A record review of the Nebraska Food Code, dated 2017, revealed ready to eat foods should be held at a temperature of 41 degrees Fahrenheit (F) or below.</p> <p>On 03/12/2025 at 8:44 AM an initial observation of the kitchen revealed a walk-through refrigerator with a temperature log labeled March with annotations of greater than 41 degrees F on the following dates:</p> <p>-On March 5th: 42,</p> <p>-On March 9th: 42,</p> <p>-On March 11th: 45.</p> <p>An observation on 03/12/2025 at 8:45 AM the reading outside of the walk-through temperature gauge revealed 44 degrees Fahrenheit.</p> <p>An interview on 03/12/2025 at 8:45 AM with the Dietary Manager-I (DM-I) revealed that the temperature reading on the refrigerator revealed a reading outside of the parameters for safe food handling and suggested that continuous in and out of the walk-through refrigerator was the reason for the increase in temperature. DM-I agreed to keep a watch on the temperature readings and stated they would recheck the gauges again shortly.</p> <p>On 03/12/2025 at 9:45 AM the facility Administrator (ADMIN) was interviewed on the walk-through refrigerator temperatures. The surveyor, DM-I and the ADMIN observed the refrigerator gauge outside of the walk-through refrigerator reading 46 degrees F. Upon entering the walk-through refrigerator, a zip-tie attached manual temperature (temp) gauge was observed reading 46 degrees F. An opened gallon of milk was taken out of the walk-through refrigerator and was poured into a cup and temped and observed to reach a maximum temperature reading of 56 degrees F. The ADMIN then threw away the milk and stated they would temp an unopened gallon of milk which was taken out of the walk-through refrigerator, poured into a cup and read a maximum temperature reading of 46 degrees F. The ADMIN then asked DM-I what a safe temperature reading would be for milk and other refrigerated products, upon which DM-I revealed 41 degrees F or below. The ADMIN agreed that the refrigerator was not maintaining safe temperatures for food at that time.</p> <p>B.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 03/12/2025 at 9:30 AM revealed Dietary Aide (DA)-F and DA-G in the dishwashing soiled area moving dishware from the dining area into the soiled dishware area. DA-F stacked soiled dishware onto a rack and pushed out dishes from inside the high temperature dishwasher. Racks of other dishes were then moved forward onto the clean side of the dishwasher while dirty dishes were being stacked and moved into the high temperature dishwasher simultaneously.</p> <p>A record review of a facility document Dishwasher Temperature Log, which was labeled March, had annotations for AM and PM temperatures which were to be written for initial rinse temperature, wash temperature and final rinse temperature readings. The log revealed many missing temperature annotations for several days.</p> <p>A record review of a sticker on the temperature gauge of the facility's dishwashing machine revealed a statement of, Minimum Rinse Temperature 180 degrees Fahrenheit (F) on the sticker.</p> <p>On 3/12/2025 at 9:32 AM an observation of the high temperature dishwasher cycle readings revealed the temperature was maxing out at 140 degrees F for the high temperature dishwasher's initial rinse temperature, wash temperature, and final rinse temperature cycle.</p> <p>On 3/12/2025 at 9:35 AM DA-F was asked if the high temperature dishwasher was reaching temperatures appropriate for meeting standards. DA-F stated that the cycle typically needs to be ran several times to reach temperature, upon which DA-F ran the cycle again. The cycles continued to reach a maximum temperature of 140 degrees F. DA-F was then asked if this is acceptable, DA-F then inquired with DA-G on the temperature readings. DA-G revealed a second gauge below the dishwasher and stated this is the gauge that is to be read when reaching temperature ranges acceptable for the high temperature dishwasher. DA-F ran the cycle a third time revealing the second gauge which is a digitalized reading, revealing a maximum temperature reading up to 141 degrees F. DA-F and DA-G stated they were not 100% certain what to do, upon which they notified their supervisor and stopped processing dishes in the dishwasher.</p> <p>On 03/12/2025 at 9:40 AM the Administrator (ADMIN) was observed watching a cycle run on the high temperature dishwasher revealing a maximum temperature reading of 140 degrees F. The ADMIN agreed that the dishwasher was not maintaining safe temperature readings to prevent foodborne illness and instructed the kitchen staff to stop using the high temperature dishwasher until the machine was fixed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Licensure Reference Number 175 NAC 12-006.04(A)(ii)</p> <p>Based on observation, record review, and interview the facility failed to ensure an insulin pen tip was cleansed prior to use for 1 (Resident 20) of 1 sampled resident, ensure the glucometer was disinfected after use for 1 (Resident 20) of 1 sampled resident, and failed to ensure an employee health screening was completed and reviewed for 2 of 5 sampled staff. The facility census was 44.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of a facility policy titled Insulin Pen dated 01/2020 revealed to remove the cap from the insulin pen and wipe the rubber seal with an alcohol pad, then screw on the needle cap to the insulin pen.</p> <p>In an observation completed on 03/17/2025 at 11:50 AM, Medication Aide (MA)-D was preparing an insulin pen to administer insulin to Resident 20. MA-D removed the cap from the insulin pen with gloved hands. MA-D then screwed on the needle cap to the insulin pen. The MA did not cleanse the tip of the insulin pen with an alcohol wipe prior to screwing on the needle cap. The MA then administered the dose of insulin to the resident.</p> <p>In an interview completed on 03/17/2025 at 12:10 PM with MA-D, MA-D confirmed that they did not cleanse the tip of the insulin pen with an alcohol wipe prior to applying the needle cap. The MA confirmed that they should have cleansed the tip of the insulin pen with an alcohol wipe prior to applying the needle cap.</p> <p>In an interview completed on 03/17/2025 at 1:00 PM with the facility Director of Nursing (DON), the DON confirmed that MA-D should have cleansed the tip of the insulin pen with an alcohol wipe prior to applying the needle cap.</p> <p>B.</p> <p>A record review of a facility policy titled Glucometer Disinfection dated 08/16/2023 revealed that glucometers will be cleaned and disinfected after each use by using disinfectant wipes.</p> <p>In an observation completed on 03/17/2025 at 11:50 AM, MA-D used a glucometer to obtain Resident 20's blood sugar. MA-D then placed the glucometer back into a plastic drawer and placed the plastic drawer into the medication cart parked in the hall outside of Resident 20's room. The MA did not disinfect the glucometer by using disinfectant wipes prior to putting it away after using it to obtain Resident 20's blood sugar.</p> <p>In an interview completed on 03/17/2025 at 12:10 PM with MA-D, MA-D confirmed that they should have used a disinfectant wipe to cleanse the glucometer prior to placing it back in the drawer and returning it to the medication cart.</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 - Many</p>	<p>In an interview completed on 03/17/2025 at 1:00 PM with the DON, the DON confirmed that the glucometer should have been cleansed with a disinfectant wipe prior to being placed back into the drawer and being returned to the medication cart.</p> <p>C.</p> <p>A record review of a facility supplied document titled Employee Health Checklist dated 11/22/2024 revealed the form being completed with MA-I's signature present on the document. No other signature was present on the form.</p> <p>Record review of Dietary Aide (DA)- J's employee file revealed no document present titled Employee Health Checklist. No other documents were present indicating an employee health screen was completed.</p> <p>On 03/17/2024 at 2:10 PM in an interview with Human Resources (HR), HR revealed that each employee is to complete the document titled Employee Health Checklist and this form is the employees' health screen. HR stated that they then review and sign the document verifying the employee has completed the health screen. HR confirmed that the Employee Health Checklist for MA-I was not signed indicating it had been reviewed by facility staff member and DA-J did not have the document present in their file indicating they had completed the employee health screen.</p>		