STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285300	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Firethorn	8601 Firethorn Lane Lincoln, NE 68520

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 45641

Licensure Reference Number 175 NAC 12-006.04(F)(i)(5)

Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 1) of 4 sampled resident's provider and resident's representative were notified of an emergent (unexpected) significant change in medical condition. The facility census was 65.

Findings are:

A record review of the facility's undated Change In Condition Or Status Of Guest/Elder/Resident policy revealed the nurse would notify the resident's attending physician or on-call physician when there has been an accident or incident involving the resident, a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, the need to transfer the resident to a hospital/treatment center, or a discovery of injuries of an unknown source. Notification to the resident and/or representative would be made when there was a significant change in the resident's physical, mental, or psychosocial status. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. The nurse should document pertinent information in the medical record.

A record review of Resident 1's Clinical Census dated 02/19/2025 revealed the resident was admitted to the facility on [DATE].

A record review of Resident 1's Medical Diagnosis dated 02/19/2025 revealed the resident had diagnoses of Neuromuscular Dysfunction of the Bladder (nerves controlling the bladder were damaged), Paraplegia (paralysis of the legs or lower body), and Spinal Stenosis, Lumbar Region (spinal canal narrows and compresses nerves in lower back).

A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 01/23/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 13 which indicated the resident was cognitively aware. The resident required supervision or touching assistance with personal and oral hygiene (cleaning), partial moderate assistance with lower body dressing and bathing, substantial/maximal assistance with upper body dressing, and the resident was dependent on staff for toileting and footwear. The resident had an indwelling catheter (cath)(a tube inserted in the bladder to help restore urine output).

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Firethorn		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Firethorn Lane Lincoln, NE 68520	

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	A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident had a suprapubic (SP)(a tube inserted in through the skin into the bladder to allow urine flow) cath related to Neurogenic Bladder (lack of bladder control due to brain, spinal cord, or nerve damage), SP cath was removed 02/05/2025 and a Foley cath was placed on 02/05/2025. A record review of the facility's Grievance Log dated 11/25/2024 - 02/10/2025 revealed Resident 1's family/Healthcare Durable Power of Attorney (POA)(a person designated to make medical decisions for the resident) submitted a grievance on 02/05/2025 related to Resident 1's SP cath being removed when not ordered - only ordered to remove the stitch from the SP cath and the POA was upset because the facility did not notify the POA prior to the Urologist's (a physician that specializes in the urine system) office calling the POA. The grievance was taken by the Director of Nursing (DON), but it did not reveal a time. The resolution was Foley cath placed, antibiotic started, guest okay and concerns from guest. APRN (Advanced Practical Registered Nurse-APRN's are Registered Nurses who have advanced education and training in a specific area of nursing. They can diagnose and treat patients/residents, order tests and prescribe medication) there and visited with guest and family. Family requested a transfer to another facility and was transferred on 02/06/2025. A new surgery was scheduled with Urology. Administration followed up with POA and resident doing well. A record review of the facility's Concern Form dated 02/05/2025 revealed the same as above. The Concern Form had a Receipt Of Concern date of 02/05/2025, but did not reveal the time blank had been completed. A record review of Resident 1's Order Summary dated 02/19/2025 revealed that the physician ordered: Please remove SP suture on 02/05/2025. One time only, for 1 day. A record review of Resident 1's Urologist's Orders dated 01/29/2025 revealed that the Urologist ordered: Please remove SP suture on 02/05/2025 per discharge paperwork on 01/22/2025. A record review of Resident 1's Urologist's Urologic Surgery Operative Note dated 01/22/2025 revealed the resident had a SP cath placed and the cath was secured to the skin with a suture. Suture removal in 2 weeks. Catheter to be exchanged for the first time in 6 weeks, then monthly thereafter. A record review of Resident 1's Progress Notes dated 02/19/2025 revealed an entry on 02/05/2025 at 5:43 AM that Licensed Practical Nurse (LPN)-E removed Resident 1's SP cath and there was 900 milliliters (ml) output. A record review of Resident 1's Progress Notes dated 02/20/2025 revealed that multiple late entries were added in Resident 1's progress notes on 02/20/2025 regarding the events that occurred on 02/05/2025. A record review of Resident 1's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2025 revealed Registered Nurse (RN)-F marked completed on the 02/05/2025 at 6:00 AM order to: Please remove SP suture on 02/05/2025, one time only for 1 day. A record review of Resident 1's Activities of Daily Living (ADL) - Bed Mobility task dated 01/20/2025 - 02/06/2025 revealed on 02/05/2025 at 9:07 AM the staff performed Bed Mobility on the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hillcrest Firethorn		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Firethorn Lane Lincoln, NE 68520	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's ADL - Toilet Use task dated 01/20/2025 - 02/06/2025 revealed on 02/05/2025 at 9:08 AM the staff assisted the resident with toileting. A record review of Resident 1's Monitor - Skin Observation task dated 01/20/2025 - 02/06/2025 revealed on 02/05/2025 at 9:09 AM the staff observed the resident's skin and documented the resident did not have a new skin condition. A record review of Resident 1's Advanced Practice Registered Nurse (APRN)-D's Acute visit follow-up note dated 02/05/2025 at 8:45 AM revealed nursing did communicate that the resident was not feeling well and was concerned about having Influenza (flu). The Acute visit note revealed that APRN-D examined the resident about 11:00 AM and the resident had complaints of some dizziness, headache, body ache, and congestion. The resident was further assessed, and it was noted that the resident's SP cath was inadvertently (accidentally) removed by nursing early that morning and a dressing was covering the site. Nursing did a bladder scan, and the resident had 150 cubic centimeters (cc) per the bladder scan. A foley catheter was placed and the resident had immediate drainage of about 200cc. The Acute visit did not reveal what time the Foley cath was placed. APRN-D reported having multiple conversation with the Urology office regarding scheduling the resident to have the SP cath replaced. APRN-D did discuss the SP cath inadvertently being removed with the resident's family and POA, but it did not reveal a time for the conversation. In a telephone interview on 02/19/2025 at 10:05 AM, Resident 1's family/POA confirmed on 02/05/2025 Resident 1 had a spinal cord injury and underwent surgery. At that time a SP cath was placed and resident spent some time at a sub-acute hospital before being transferred to the facility on [DATE]. The resident had an order that was clearly written (per conversation with staff of the facility) to remove the SP cath suture in 2 weeks, but the LPN removed the entire catheter. The POA was upset because the staff did not put another cath back in right away, the nurse that removed the SP cath didn't say anything, and no other staff that worked with the resident noticed the SP cath was removed. The POA confirmed somehow the APRN noticed it, scanned the bladder, and said there was 100cc in bladder. When the POA arrived at the facility, the POA told the facility the POA didn't care how much was in the bladder, they wanted something in the resident to allow the resident to urinate. The POA confirmed at 11:30-11:45 AM the APRN called the Urologist's office and the Urologist's called the POA, the facility did not. At 12:30 PM the daughter arrived at the facility and there was still no cath in Resident 1, so the POA told the staff the POA wanted a meeting with the Administrator and DON and requested a Foley cath be put in. The POA confirmed the Foley was placed within 20 minutes of that. The resident was transferred to another facility on 02/06/2025 and Resident 1 had a second surgery for a new SP cath to be inserted without sutures on 02/10/2025. The POA confirmed the resident was supposed to move back home on 02/17/25, but now the family is hoping to get the resident home by 03/03/2025. The POA confirmed the POA and the resident was upset because of the pain and discomfort of have the Foley cath placed and another surgery to place another SP cath, not to mention the financial burden of the surgery and the additional time that the resident had to stay in a nursing facility. In a telephone interview on 02/19/2025 at 10:33 AM, a staff member at the Urologist's office confirmed the order for suture removal was sent to the facility 01/29/2025, the Urologist sent an order for a Foley cath placement on 02/05/2025 at 11:51 AM, and Resident 1 underwent a new SP cath insertion surgery on 02/10/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hillcrest Firethorn		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Firethorn Lane Lincoln, NE 68520	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 02/20/2025 at 7:05 AM, RN-F confirmed RN-F was the nurse that marked completed on the suture removal order, but RN-F was not the nurse that removed it. LPN-E was the night nurse that removed the SP cath. RN-F confirmed LPN-E told RN-F in report that the SP cath had been removed and RN-F confirmed RN-F didn't think it was supposed to be removed but went on with RN-F's day passing meds and cares for the residents. RN-F found out the SP cath was not supposed to be removed from the Clinical Care Coordinator (CCC) and Resident Assessment Instrument Coordinator (RAIC). CCC and RAIC called the Urologist's office, and the nurse was very upset and informed CCC and RAIC that a Foley cath would have to be inserted because they would not be able to get a SP cath back in Resident 1's insertion site because it had been too long at that point. CCC inserted the Foley cath. RN-C confirmed RN-C thought it was 10:00 AM - 10:30 AM when CCC and RAIC notified RN-F the SP was not supposed to be removed. The nursing assistants (NA)'s did not say anything about the cath not being there during their cares. She said the NA's were supposed to drain the bag every 2 hours or so. LPN-E came in later that same day and did mention LPN-E got wrote up and worked that night shift. In a telephone interview on 02/20/2025 at 8:08 AM, LPN-E confirmed LPN-E was passing meds to Resident 1 and looked at the SP cath site. Resident 1 told LPN-E the resident couldn't wait until the SP cath was removed that day. LPN-E later looked at order and the order said remove SP cath. LPN-E confirmed LPN-E did not click to enlarge the order on the computer screen and did not see it said remove SP cath suture. LPN-E confirmed LPN-E did proceed to remove the suture and SP cath. Resident 1 did not question why LPN-E was removing the SP cath. LPN-E confirmed LPN-E did not realize the error until later that day when the DON called LPN-E. LPN-E came to work later that day and was talked to and written up. LPN-E was given verbal education regarding if a resident had an SP cath it was usually in forever, enlarge order to read through, and make sure LPN-E did what the order said and not what the resident said. LPN-E confirmed it was an honest mistake. In an interview on 02/20/2025 at 11:35 AM, the DON confirmed there was not an order to remove the SP cath and it should not have been removed, just the suture that was placed in the SP cath. In an interview on 02/19/2025 at 2:40 PM, APRN-D confirmed that APRN-D discovered that the SP cath was pulled inadvertently. APRN-D confirmed APRN-D was shocked to discover it. The resident told APRN-D that the nurse took out the SP cath. APRN-D confirmed the resident's brace was removed and seen just a dressing there. That was about 11:30 AM. The resident just said it didn't feel good. APRN-D confirmed it was removed at 5:30 AM. APRN-D told staff to call the Urologist. APRN-D confirmed that APRN-D stepped in and facilitated the process to get the resident scheduled for replacement SP cath. APNR-D confirmed it was discovered between 11:00 AM - 11:15 AM the SP cath had been removed and the family/POA showed up at the facility at 12:30 PM. The Urologist said to put a Foley cath in, and it was not inserted until 12:30 PM - 1:00 PM. She told the staff to call the family and the Urologist when APRN-D discovered the SP cath had been removed. APRN-D confirmed the facility did not contact the APRN-D about the SP cath removal, APRN-D discovered it during the resident assessment. (continued on next page)

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	285300	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Firethorn	8601 Firethorn Lane Lincoln, NE 68520

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/20/2025 at 11:26 AM, the DON confirmed the resident's representative was not notified of the SP cath removal until 12:00 PM when the family arrived at the facility and had a meeting with the facility's administration. The urology clinic had notified the POA, not the facility. The DON confirmed it was less than an hour from when the facility's administration was notified of the SP cath removal until the facility notified the family. The DON confirmed it was the DON's expectation that the nurse would notify the family immediately of an emergent significant change in the resident's medical condition. The DON did not confirm the SP cath being removed was an emergent significant change, but confirmed it was not a need to call 911 situation, but it was a situation that required medical attention. In an interview on 02/20/2025 at 1:00 PM, CCC confirmed CCC had been entering late entries in the progress notes on 02/20/2025 regarding the timelines CCC thought was accurate on the events that occurred on 02/05/2025. CCC confirmed that if the day shift nurse questioned if the SP cath was removed, RN-F should have immediately contacted the CCC, provider and resident's representative. CCC confirmed that after the CCC was notified the SP cath had been removed, they did not contact the resident's representative immediately, and they wanted to formulate a plan before contacting family between 11:20 AM and 12:30 PM. The CCC confirmed the facility formulated the plan without the resident's representative's input. CCC confirmed the resident was able to make the resident's own decisions and they told the resident during the bladder scan that they were probably going to have to re-insert the Foley cath.

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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 0684 Level of Harm - 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** 45613 Licensure Reference Number 174 NAC 12-006.09(H)(iv) Based on record review and observation, the facility failed to provide the facility's outlined bowel management program for 1 (Resident 3) of 3 residents sampled and instead provided digital stimulation for Resident 3. The facility also failed to provide prompt medical attention for 1 (Resident 1) of 4 sampled residents. Facility census was 65. Findings are: A. A record review of Resident 3's progress notes dated 2/16/2025 revealed that at 3:00 AM the resident was placed on the bedpan, and with digital stimulation, expelled large, formed stool. Interview on 2/19/25 at 4:16 PM with Resident 3 confirmed that it was definitely uncomfortable when that nurse stuck (gender) finger in my butt and that the resident prefers to have a bowel movement while sitting on a bedpan and not laying in bed. A record review of Resident 3's Admission Minimum Data Set (MDS -a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 1/30/25 revealed that the resident was admitted to the facility on [DATE], with a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 12 which indicates moderate cognitive impairment, frequently incontinent of bowel, dependent for transfers, no bowel toileting program, and that constipation was not present. A record review of Resident 3's Comprehensive Care Plan (CCP - written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) dated 2/3/2025, revealed no focus area related to constipation. A record review of Resident 3's Medical Administration Record (MAR) from 2/1/25 through 2/19/25 revealed that the resident did not receive any bowel meds as needed to promote a bowel movement. A record review of Resident 3's current physician orders revealed that the resident had orders for a suppository and enema to be used if needed to promote bowel movement. Resident 3 had no other bowel medication orders to be used as needed. In an interview on 2/19/25 at 3:47 PM, Registered Nurse (RN) - A confirmed they were not supposed to do digital stimulation on any residents. In an interview on 2/19/25 at 3:51 PM, RN - B confirmed that digital stimulation should not be done unless the resident is a quadriplegic and cannot move their own bowels and that this resident does not have those diagnosis. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

In an interview on 2/19/25 at 3:57 PM, the Clinical Care Coordinator (CCC) confirmed that digital stimulation should not have been done to this resident.

In an interview on 2/19/25 at 4:41 PM, the Director of Nurses (DON) revealed that the night nurse checked Resident 3's rectum and that BM was present. The nurse then gave the resident a suppository. It was further confirmed that the suppository was not documented as given in the resident's MAR and should have been documented.

In an interview on 2/20/25 at 8:59 AM the DON confirmed there was no staff education completed regarding bowel management, prevention of constipation or digital stimulation.

In an interview on 2/20/25 at 8:43 AM, Medication Technician (MT) - C confirmed that on the night of 2/16/25 the night nurse came out of Resident 3's room and said (gender) had digitally stimulated the resident and assisted the resident onto (gender) left side to have a bowel movement. MT - C was instructed to go back in the resident's room and check on the resident in a little bit. The resident was not on a bedpan.

In an interview on 2/20/25 at 9:25 AM, Resident 3 revealed that (gender) likes to sit up in bed on the bedpan to have a bowel movement (BM) and that he doesn't like to have a BM while laying down in bed and the nurse did not put him on the bedpan the night of 2/16/25.

A record review of the facility policy dated 1/1/2023, titled Bowel Management Policy revealed that interventions to promote bowel movements include a well balanced diet, encourage adequate fluids, encourage exercise, allow enough time for adequate evacuation and review medications causing constipation, and to check for daily stool softener.

In an interview on 2/20/25 at 11:34 AM with DON confirmed there was not a bowel assessment performed for Resident 3 and agreed that digital stimulation would cause discomfort and that no new interventions were put into place after hard stool had been identified on 2/14/25 with the resident.

In an interview on 2/20/25 at 2:04 PM Licensed Practical Nurse (LPN) - G confirmed that (gender) stuck (gender) finger approximately 1 inch into resident's 3's rectum and that the resident yelled ow during the process and LPN - G continued to insert finger to remove hard stool.

45641

B.

A record review of Resident 1's Clinical Census dated 02/19/2025 revealed the resident was admitted to the facility on [DATE].

A record review of Resident 1's Medical Diagnosis dated 02/19/2025 revealed the resident had diagnoses of Neuromuscular Dysfunction of the Bladder (nerves controlling the bladder were damaged), Paraplegia (paralysis of the legs or lower body), and Spinal Stenosis, Lumbar Region (spinal canal narrows and compresses nerves in lower back).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 01/23/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 13 which indicated the resident was cognitively aware. The resident required supervision or touching assistance with personal and oral hygiene (cleaning). partial moderate assistance with lower body dressing and bathing, substantial/maximal assistance with upper body dressing, and the resident was dependent on staff for toileting and footwear. The resident had an indwelling catheter (cath)(a tube inserted in the bladder to help restore urine output). A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident had a suprapubic (SP))(a tube inserted in through the skin into the bladder to allow urine flow) cath related to Neurogenic Bladder (lack of bladder control due to brain, spinal cord, or nerve damage), SP cath was removed 02/05/2025 and a Foley cath was placed on 02/05/2025. A record review of the facility's Grievance Log dated 11/25/2024 - 02/10/2025 revealed Resident 1's family/Healthcare Durable Power of Attorney (POA))(a person designated to make medical decisions for the resident) submitted a grievance on 02/05/2025 related to Resident 1's SP cath being removed when not ordered - only ordered to remove the stitch from the SP cath and the POA was upset because the facility did not notify the POA prior to the Urologist's (a physician that specializes in the urine system) office calling the POA. The grievance was taken by the Director of Nursing (DON), but it did not reveal a time. The resolution was Foley cath placed, antibiotic started, guest okay and concerns from guest. APRN there and visited with guest and family. Family requested a transfer to another facility and was transferred on 02/06/2025. A new surgery was scheduled with Urology. Administration followed up with POA and resident doing well. A record review of the facility's Concern Form dated 02/05/2025 revealed the same as above. The Concern Form had a Receipt Of Concern date of 02/05/2025, but did not reveal the time blank had been completed. A record review of Resident 1's Order Summary dated 02/19/2025 revealed that the physician ordered: Please remove SP suture on 02/05/2025. One time only, for 1 day. A record review of Resident 1's Urologist's Orders dated 01/29/2025 revealed that the Urologist ordered: Please remove SP suture on 02/05/2025 per discharge paperwork on 01/22/2025. A record review of Resident 1's Urologist's Urologic Surgery Operative Note dated 01/22/2025 revealed the resident had a SP cath placed and the cath was secured to the skin with a suture. Suture removal in 2 weeks. Catheter to be exchanged for the first time in 6 weeks, then monthly thereafter. A record review of Resident 1's Progress Notes dated 02/19/2025 revealed an entry on 02/05/2025 at 5:43 AM that Licensed Practical Nurse (LPN)-E removed Resident 1's SP cath and there was 900 milliliters (ml) output. A record review of Resident 1's Progress Notes dated 02/20/2025 revealed that multiple late entries were added in Resident 1's progress notes on 02/20/2025 regarding the events that occurred on 02/05/2025. (continued on next page)

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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 - Actual harm Residents Affected - Few	A record review of Resident 1's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2025 revealed Registered Nurse (RN)-F marked completed on the 02/05/2025 at 6:00 AM order to: Please remove SP suture on 02/05/2025, one time only for 1 day. A record review of Resident 1's Advanced Practice Registered Nurse (APRN)-D's Acute visit follow-up note dated 02/05/2025 at 8:45 AM revealed nursing did communicate that the resident was not feeling well and was concerned about having Influenza (flu). The Acute visit note revealed that APRN-D examined the resident about 11:00 AM and the resident had complaints of some dizziness, headache, body ache, and congestion. The resident was further assessed, and it was noted that the resident's SP cath was inadvertently (accidentally) removed by nursing early that morning and a dressing was covering the site. Nursing did a bladder scan, and the resident had 150 cubic centimeters (cc) per the bladder scan. A foley catheter was placed and the resident had immediate drainage of about 200cc. The Acute visit did not reveal what time the Foley cath was placed. APRN-D reported having multiple conversation with the Urology office regarding scheduling the resident to have the SP cath replaced. APRN-D did discuss the SP cath inadvertently being removed with the resident's family and POA, but it did not reveal a time for the conversation. In a telephone interview on 02/19/2025 at 10:05 AM, Resident 1's family/POA confirmed on 02/05/2025 Resident 1 had a spinal cord injury and underwent surgery. At that time a SP cath was placed and resident spent some time at a sub-acute hospital before being transferred to the facility on [DATE]. The resident had an order that was clearly written (per conversation with staff of the facility) to remove the SP cath suture in 2 weeks, but the LPN removed the entire catheter. The POA was upset because the staff did not put another cath back in right away, the nurse that removed the SP cath didn't say anything, and no other staff that worked with the resident noticed the SP cath was removed. The POA confirmed somehow the APRN noticed it, scanned the bladder, and said there was 100 cc's in bladder. When the POA arrived at the facility, the POA told the facility the POA didn't care how much was in the bladder, they wanted something in the resident to allow the resident to urinate. The POA confirmed at 11:30-11:45 AM the APRN called the Urologist's office and the Urologist's called the POA, the facility did not. At 12:30 PM the daughter arrived at the facility and there was still no cath in Resident 1, so the POA told the staff the POA wanted a meeting with the Administrator and DON and requested a Foley cath be put in. The POA confirmed the Foley was placed within 20 minutes of that. The resident was transferred to another facility on 02/06/2025 and Resident 1 had a second surgery for a new SP cath to be inserted without sutures on 02/10/2025. The POA confirmed the resident was supposed to move back home on 02/17/25, but now the family is hoping to get the resident home by 03/03/2025. The POA confirmed the POA, and the resident was upset because of the pain and discomfort of have the Foley cath placed and another surgery to place another SP cath, not to mention the financial burden of the surgery and the additional time that the resident had to stay in a nursing facility. In a telephone interview on 02/19/2025 at 10:33 AM, a staff member at the Urologist's office confirmed the order for suture removal was sent to the facility 01/29/2025, the Urologist sent an order for a Foley cath placement on 02/05/2025 at 11:51 AM, and Resident 1 underwent a new SP cath insertion surgery on 02/10/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Firethorn		STREET ADDRESS, CITY, STATE, ZIP CODE 8601 Firethorn Lane Lincoln, NE 68520	

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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 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/19/2025 at 2:40 PM, APRN-D confirmed that APRN-D discovered that the SP cath was pulled inadvertently. APRN-D confirmed APRN-D was shocked to discover it. The resident told APRN-D that the nurse took out the SP cath. APRN-D confirmed the resident's brace was removed and seen just a dressing there. That was about 11:30 AM. The resident just said it didn't feel good. APRN-D confirmed it was removed at 5:30 AM. APRN-D told staff to call the Urologist. APRN-D confirmed that APRN-D stepped in and facilitated the process to get the resident scheduled for replacement SP cath. APRN-D confirmed it was discovered between 11:00 AM - 11:15 AM the SP cath had been removed and the family/POA showed up at the facility at 12:30 PM. The Urologist said to put a Foley cath in, and it was not inserted until 12:30 PM - 1:00 PM. APRN-D told the staff to call the family and the Urologist when APRN-D discovered the SP cath had been removed. In a telephone interview on 02/20/2025 at 7:05 AM, RN-F confirmed RN-F was the nurse that marked completed on the suture removal order, but RN-F was not the nurse that removed it. LPN-E was the night nurse that removed the SP cath. RN-F confirmed LPN-E told RN-F in report that the SP cath had been removed and RN-F confirmed RN-F didn't think it was supposed to be removed but went on with RN-F's day passing meds and cares for the residents. RN-F found out the SP cath was not supposed to be removed from the Clinical Care Coordinator (CCC) and Resident Assessment Instrument Coordinator (RAIC). CCC and RAIC called the Urologist's office, and the nurse was very upset and informed CCC and RAIC that a Foley cath would have to be inserted because they would not be able to get a SP cath back in Resident 1's insertion site because it had been too long at that point. CCC inserted the Foley cath. RN-C confirmed RN-C thought it was 10:00 AM - 10:30 AM when CCC and RAIC notified RN-F the SP was not supposed to be removed. The nursing assistants (NA)'s did not say anything about the cath not being there during their cares. She said the NA's were supposed to drain the bag every 2 hours or so. LPN-E came in later that same day and did mention LPN-E got wrote up and worked that night shift. In a telephone interview on 02/20/2025 at 8:08 AM, LPN-E confirmed LPN-E was passing meds to Resident 1 and looked at the SP cath site. Resident 1 told LPN-E the resident couldn't wait until the SP cath was removed that day. LPN-E later looked at order and the order said remove SP cath. LPN-E confirmed LPN-E did not click to enlarge the order on the computer screen and did not see it said remove SP cath suture. LPN-E confirmed LPN-E did proceed to remove the suture and SP cath. Resident 1 did not question why LPN-E was removing the SP cath. LPN-E confirmed LPN-E did not realize the error until later that day when the DON called LPN-E. LPN-E came to work later that day and was talked to and written up. LPN-E was given verbal education regarding if a resident had an SP cath it was usually in forever, enlarge order to read through, and make sure LPN-E did what the order said and not what the resident said. LPN-E confirmed it was an honest mistake. In an interview on 02/20/2025 at 1:00 PM, CCC confirmed CCC had been entering late entries in the progress notes on 02/20/2025 regarding the timelines CCC thought was accurate on the events that occurred on 02/05/2025. In an interview on 02/20/2025 at 9:43 AM, the DON confirmed the facility did not have a following provider's order policy, that would be per best practice. In an interview on 02/20/2025 at 11:35 AM, the DON confirmed there was not an order to remove the SP cath and it should not have been removed, just the suture that was placed in the SP cath.