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	04/11/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 42861 Based on record review and interview, the facility failed to ensure a Level II PASARR (A Level II is necessary to confirm the indicated Mental Illness (MI)/Intellectual Disability (ID) diagnosis and to determine whether placement or continued stay in a Nursing Facility is appropriate) was completed after receiving a new diagnosis of PTSD (Post Traumatic Stress Disorder), Major Depressive Disorder (MDD) and Anxiety Disorder, for 1 of 1 sampled residents (Resident 28). The facility identified a census of 60. Findings are: A record review of the demographic information dated 4/9/24 revealed that the facility had accepted Resident 28 for admission on 6/16/20 with a primary diagnosis of Spinal Stenosis, Lumbosacral region (when the space inside the backbone is too small causing pressure on the spinal cord). A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 1/29/24, Section C, revealed Resident 28 had a BIMS (Brief Interview for Mental Status, 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 15 indicating Resident 28 was oriented and had no confusion. A record review of the Level I PASARR (Preadmission Screening and Resident Review that is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) on file dated 6/13/2020 revealed that the document indicated no MD/ID for Resident 28 at the time of admission. A record review of the diagnosis list dated 4/9/24 revealed Resident 28 to have a PTSD diagnosis dated 8/11/23, MDD dated 8/11/23, and an Anxiety Disorder diagnosis dated 8/11/23. An interview on 4/9/24 at 2:30 PM with the Director of Transitions (Admissions), after review of the current diagnosis list for Resident 28, confirmed that Resident 28 did have MD/ID diagnoses and should have had a level II PASARR initiated in 8/2023 and did not. The Director of Transitions voiced (gender) would initiate the level II PASARR. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/10/24 at 3:22 PM revealed that the Director of Transitions had initiated a level II PASARR screen for Resident 28 and voiced that Resident 28 did in fact trigger for MD/ID and the need for a level II screen. A record review of the undated policy titled Identification Screen (PASRR) read as follows: Policy: An identification screen will be done prior to admission to see if the gest is eligible for placement. Identification screen (PASRR) will also be completed as needed for change in diagnosis or condition. 4. Resident's will be monitored for change in condition including diagnosis changes that would require a new PASRR to be completed.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.09C1c Based on record review and interview; the facility failed to review and revise the baseline care plan for 1 (Resident 68) of 1 sampled resident after a fall with major injury. The facility census was 60. Findings are: A record review of Resident 68's Medical Diagnosis sheet dated 4/9/2024 revealed the resident was admitted on [DATE] with diagnoses of ground level fall, fracture of second cervical vertebra (a bone in the neck), dorsalgia (back pain), major depressive disorder (persistently depressed mood or loss of interest in activities), congestive heart failure (the heard doesn't pump blood as well as it should), macular degeneration (loss in the center of the field of vision), osteoporosis (bones are brittle and weak), stress incontinence (involuntary, sudden loss of urine), muscle weakness, and polyneuropathy (numbness and tingling in the hands or feet). A record review of Resident 68's discharge Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/1/2024 identified Resident 68 exhibited moderately impaired cognition with a Brief Interview of Mental Status (BIMS score can range from 0 to 15, with lower scores indicating a decline in cognitive performance) score of 8 indicating Resident 68 is moderately cognitively impaired. A record review of Resident 68's Fall Risk assessment dated [DATE] indicated the resident was at risk for falls with a score of 10. A record review of Resident 68's Baseline Care Plan (BCP) dated 3/28/2024 indicated Resident 68 was admitted due to generalized weakness and history of a fall. The BCP further stated to encourage use of the call light prior to ambulation and to wait for assistance and to wear gripper socks. A record review of Resident 68's Comprehensive Care Plan (CCP) that was initiated on 3/28/2024 had no focus, goals, or interventions for falls. A record review of an Incident Report completed by the DON (Director of Nursing) dated 4/1/2024 at 12:10 PM revealed Resident 68 transferred [gender] self in the bathroom and fell reaching for the walker. The report stated Resident 68 was sent to the emergency room for evaluation and was admitted for a rib fracture. The report further revealed the plan of care will be updated with interventions for frequent checks and offer the bathroom. A record review of Resident 68's BCP on 4/9/2024 at 9:13 AM revealed no new fall interventions after the resident's fall on 4/1/2024 with resulting rib fracture. A record review of Resident 68's CCP on 4/9/2024 at 9:05 AM revealed no focus, goals, or interventions for falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 68's CCP on 4/9/2024 at 4:30 PM revealed a fall focus related to confusion, deconditioning, gait/balance problems and history of falls with fall interventions in place. An interview on 4/9/2024 at 2:30 PM with the NT-E (Nurse Tech) regarding which residents [gender] was caring for were at risk for falls on the unit, revealed [gender] was unaware that Resident 68 was at risk for falls. An interview on 4/9/2024 at 3:20 PM with the DON and ADM (Administrator) regarding what interventions were put in to place after the fall with major injury on 4/1/2024, as they were not present on the BCP or CCP, revealed the resident had a BCP. No response was received from either the DON or ADM in response to the BCP having no updated interventions in place or that the CCP initiated 3/28/2024 had no focus on falls. An interview on 4/10/2024 at 10:20 AM with LPN-D (Licensed Practical Nurse) regarding who can update the care plan, LPN-D stated anybody. LPN-D further revealed that if the nurse did not know how to update the care plan, the CCC (Clinical Care Coordinator)-A could assist. When asked how soon [gender] would update a care plan if [gender] had a resident fall, LPN-D said, right away. A record review of the facility policy Fall Risk Management Policy dated 1/1/2023 stated it is the policy of the facility that patients are assessed for their level of fall risk and implement appropriate interventions to mitigate the risk of falling and/or risk of injury with falls. The policy further revealed the following: 2. Determining appropriate interventions: e. fall risk interventions should be reviewed by the interdisciplinary team as needed and can be included in the Quality Assurance, Huddle, Risk, and/or All Team Meetings. f. care plan interventions are reviewed during interdisciplinary team meetings assuring interventions continue to be appropriate for the patient. g. care plan interventions should be monitored and/or audited for consistent application in the care of the patient. Care plan interventions can be listed on the MAR/TAR and/or nurse tech care plan according to the Plan of Care policy. A record review of the undated facility policy Comprehensive Care Planning stated: 9. Assessments of guests are ongoing and care plans are revised as information about the guest and the guest's conditions change. 10.The Interdisciplinary Team is responsible for the review and updating of care plans: a. when there has been a significant change in the guest's condition, b. when the desired outcome is not met, c. when the guest has been readmitted to the facility from a hospital stay.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC ,d+[DATE].11E Based on observation, interview, and record review; the facility kitchen staff failed to label and date opened packages of food in the walk-in refrigerator and dry storage, failed to dispose of expired food from the walk-in refrigerator, and failed to perform hand hygiene while prepping room trays for lunch to prevent the potential of spread of infection and cross contamination. This had the potential to affect all 60 residents. The facility census was 60. Findings are: A. An observation on [DATE] at 7:50 AM of the walk-in refrigerator revealed: -an open box of jalapeno peppers not dated, -an open box of lemons not dated, -an open bag of dried out carrots not dated, -container of lettuce dated [DATE], -an open container of coleslaw with open date of [DATE] and use by date of [DATE], -an open package of baby spinach with use by date of [DATE]. An observation on [DATE] at 8:00 AM of the dry storage room revealed: -a package of opened fettucine with a hole in it not dated, -a package of opened ziti noodles closed shut with a bread tie and not dated, -a large open bag of panko crumbs dated [DATE] not closed shut sitting on top of a bin. An interview on [DATE] at 8:30 AM with the DM (Dietary Manager) confirmed that all listed above were opened packages of food that should be labeled and dated, and all the above listed expired food should not be on the shelves available for use. All expired food items were removed by the CDM at this time. A record review of the facility policy Proper Food Storage dated [DATE] stated: 2. all food products must be covered, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. label all foods removed from their original container, 4. clearly label all food with product or item name, preparation date, use by, expiration or sell by date and prepared by, 10. perishable foods discarded after 3 days. B. An observation on [DATE] at 11:55 AM in the kitchen revealed DA (Dietary Aide)-F lick his bare fingers with [gender]'s tongue to separate meal tickets, rub [gender] nose with the back of [gender] bare hand while prepping room trays by setting drinks on the tray, pulling desserts from the cooler and setting them on the trays, setting wrapped silverware on the trays along with the plate of food served up by the cook. DA-F then stopped to wash hands at the sink with soap and water for 10 seconds and then immediately adjusts the ball cap on [gender] head while touching [gender] hair and continued rearranging meal tickets. At 12:15 PM, DA-F washed hands at the sink with soap and water for 20 seconds. At 12:18 PM, DA-F then licks [gender] fingers again to sort meal tickets and preps additional room trays for lunch. An interview on [DATE] at 1:05 PM with the DM confirmed that DA-F should have washed [gender] hands after licking fingers and touching hair before continuing to prep room trays for lunch and was not done. A record review of the Nebraska Food Code, ,d+[DATE].14, food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: A. after touching bare human body parts other than clean hands and clean, exposed portions of arms, F. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, I. after engaging in other activities that contaminates the hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.17D Based on observation, record review and interview; the facility failed to perform hand hygiene to prevent the spread of infection and prevent cross contamination during catheter care and wound care for 1 resident (Resident 14) of 1 sampled resident. The facility census was 60. Findings are: A record review of Resident 14's Clinical Resident Profile printed 4/10/2024 revealed an admitted [DATE] and readmitted [DATE] with the diagnoses of multiple fractures of the pelvis and lumbosacral spine, parkinsonism (a motor syndrome that manifests as rigidity, tremors, and slow movement), chronic kidney disease (progressive damage and loss of kidne function) and an in-house acquired pressure ulcer (localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) to the sacrum (a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis). An observation on 4/10/2024 at 7:45 AM with LPN (Licensed Practical Nurse)-B and NT (Nurse Tech)-C with CCC (Clinical Care Coordinator)-A in room, revealed NT-C transfer Resident 14 from the wheelchair to the bed in preparation for catheter care and wound care. Both LPN-B and NT-C were already gowned and gloved. NT-C pulled shorts and brief down to expose the area. NT-C took several incontinence wipes out of the package and washed along the resident's groin . NT-C used additional wipes to clean the resident's genitalia. NT-C reached into the package for additional wipe to wash the catheter tubing from the meatus on down the tubing. NT-C reached into the package again for a wipe and cleaned the catheter tubing again. A wipe was sticking out of the package and NT-C poked it back into the package. NT-C then pulled a wipe out of the package and washed between the resident's legs. NT-C shut the incontinence wipes package and partially pulled the residents brief up. NT-C then removed soiled gloves. NT-C put applied clean gloves without performing hand hygiene. NT-C then emptied the urinary drain bag into a graduate per protocol and emptied the graduate into the toilet and rinsed the graduate with water and emptied into the toilet. NT-C then removed soiled gloves. NT-C applied new gloves without performing hand hygiene. Resident 14 was then positioned to [gender] side and LPN-B washed sacral area with soap and water. LPN-B removed soiled gloves and applied new gloves without performing hand hygiene. LPN-B then applied calmoseptine cream to sacral area and inner buttocks. LPN-B then removed soiled gloves and applied new gloves without performing hand hygiene. LPN-B opened a package of 4x4 dressing. LPN-B then removed gloves and applied new gloves without performing hand hygiene. LPN-B applied the 4x4 dressing to the sacral area. The resident's brief was pulled up and the resident rolled onto [gender] back. LPN-B removed soiled gloves and applied new gloves without performing hand hygiene and placed the tube of calmoseptine on back of the toilet and emptied the water bins. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 4/10/2024 at 8:15 AM with the CCC-A confirmed that no hand hygiene was completed during catheter care or wound care after removal of soiled gloves and application of new gloves. The CCC-A also confirmed that NT-C should have performed hand hygiene after washing groin and genitalia and applied new gloves before wiping down the catheter tubing. The CCC-A further confirmed NT-C should not have reached back into the incontinence wipes package with soiled gloves. The CCC-A also confirmed LPN-B did not perform hand hygiene between cleansing of sacral area and application of clean dressing. An interview on 4/10/2024 at 8:25 AM with the ADM (Administrator) and DON (Director of Nursing) confirmed that hand hygiene should be performed between removal of soiled gloves and application of new gloves. An interview on 4/10/2024 at 8:50 AM with NT-C revealed [gender] performed hand hygiene when [gender] entered the room and when [gender] left the room. NT-C revealed [gender] didn't realize when gloves should have been removed or when hand hygiene should have been performed. NT-C revealed [gender] didn't want to break contact with the resident by having to go near the door for hand sanitizer. A record review of the facility policy Hand Hygiene Policy dated 2/23/2022 revealed: A.Hand Hygiene Guidance: 1.healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. immediately before touching a patient, b. before performing an aseptic task or handling invasive medical devices, c. before moving from work on a soiled body site to a clean body site on the same patient, d. after touching a patient or the patient's immediate environment, e. after contact with blood, body fluids, or contaminated surfaces, f. immediately after glove removal. D. Gloves and Hand Hygiene: 1. wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or potential infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment occur. 2. gloves are not a substitute for hand hygiene a. if your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment 3. change gloves and perform hand hygiene during patient care, if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. gloves have been damaged, b. gloves have become visibly soiled with blood or body fluids following a task, c. moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs.