

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 04/01/2025
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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271</p> <p>Licensure Reference Number 175 NAC 12-006.10(A)(i)</p> <p>Based on observations and interviews, the facility failed to assess the resident for safe self-administration (something is done or given by oneself, rather than by someone else, particularly in the context of medications or tests) of medications and obtain orders for bedside medication for 2 Residents (Resident 2 and 40) out of 6 sampled residents. The facility census was 56.</p> <p>Findings are:</p> <p>A record review of the facility policy Hillcrest Firethorn Medication Management Policy dated 1/1/23 revealed in the policy explanation and compliance guidelines:</p> <p>-Patients may self-administer medications if they are deemed competent to do so by the nursing team. A self-administer assessment should be completed to determine competency.</p> <p>Hillcrest Health Services Self-Administration of medication with no date policy: The Director of Clinical Services or designee will assess the ability to self-administer medications of residents requesting to self-administer.</p> <p>-The Director of Clinical Services or qualified designee will complete an assessment of competency.</p> <p>-An order will be obtained that resident can self-administer medications, stating that he resident is capable of self-medicating.</p> <p>-The nursing team members will observe resident for changes in behaviors or condition during their daily interactions with the resident.</p> <p>A.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Admission record with a printed date of 3/27/25 revealed Resident 2 was admitted to the facility on [DATE] with the diagnosis of fracture (broken bone) of right lower leg, depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed), anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hypertension (a condition in which the force of blood against the walls of the arteries is consistently too high) and edema (a medical condition characterized by the excessive accumulation of fluid in the body's tissues).</p> <p>A record review of the Minimum Data Set (MDS, a comprehensive assessment of each resident's functional capabilities) dated 3/7/25 revealed 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, which indicated the resident was cognitively intact.</p> <p>A record review of Resident 2's physician's orders with a printed dated of 3/27/25 revealed orders for:</p> <ul style="list-style-type: none"> -Breztri Aerosphere Inhalation (a prescription inhaler used to treat COPD, 2 puff inhale orally two times a day, -Fluticasone Propionate Nasal Suspension (corticosteroid medication used to treat inflammatory conditions such as allergic rhinitis (hay fever), nasal polyps, and asthma), 2 spray in each nostril one time a day, -lubricating Plus Eye Drops (provide moisture and relief for dry eyes due to temporary causes, like being tired or being in a dry climate) 0.5 % Instill 1 drop in both eyes every 6 hours as needed. <p>A record review of Resident 2's medical records revealed no evidence of a self-administration assessment being done or a doctor's orders to self-administer medications.</p> <p>An observation on 03/31/25 at 9:45 AM revealed Resident 2 sitting in a recliner with a medicine cup full of pills, an inhaler, eye drops, a nebulizer treatment (using a device to convert liquid medication into a fine mist (aerosol) that can be inhaled, delivering the medication directly to the lungs and respiratory system for conditions like asthma or COPD (a common lung disease causing restricted airflow and breathing problems) full of medicine, and a bottle of nasal spray sitting on tray table. Resident 2 stated (gender) does take (gender) medication after eating breakfast and will do the nebulizer treatment after taking (gender) pills. Resident 2 confirmed that (gender) had already done the nasal spray.</p> <p>An observation on 04/01/25 at 10:01 AM with Resident 2 sitting in recliner with a medicine cup full of pills in the cup sitting on the tray table with a glass of water, an inhaler, eye drops on side compartment of tray table and a bottle of nasal spray.</p> <p>An interview on 4/1/25 at 11:00 AM with Clinical Care Coordinator (CCC)-A confirmed that Resident 2 did not have an order for self-administration of medications and an assessment for safe self-administration of medications for Resident 2 had not been done and it should have been done.</p> <p>B.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the Admission Record with the printed date of 3/27/25 revealed Resident 40 was admitted to the facility on [DATE] with the diagnosis of pneumothorax (a medical condition where air enters the pleural space, the area between the lung and chest wall), Bronchiectasis (a chronic lung condition characterized by the permanent widening and thickening of the airways (bronchi) in the lungs), Respiratory failure (a condition where the lungs are unable to adequately perform their primary function of gas exchange, leading to either dangerously low oxygen levels (hypoxemia) or dangerously high carbon dioxide levels (hypercapnia) in the blood), and anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>A record review of the MDS dated [DATE] revealed a BIMS score of 12 indicating Resident 40 had moderate cognitive impairment.</p> <p>Record review of Resident 40's physician's orders with a printed date of 3/27/25 revealed orders for: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 ml (Ipratropium-Albuterol), 1 vial inhale orally via nebulizer four times a day.</p> <p>A record review of Resident 40's medical records revealed no evidence of a self-administration assessment for medication being done or of a doctor's order for Resident 40 to self-administer medication.</p> <p>An observation on 3/26/25 at 12:54 PM revealed Resident 40 sitting in recliner with a nebulizer treatment (using a device to convert liquid medication into a fine mist (aerosol) that can be inhaled, delivering the medication directly to the lungs and respiratory system for conditions like asthma or COPD) sitting on the side table with liquid medicine in nebulizer cup. Resident 40 confirmed that (gender) will do the nebulizer treatment in a little while. Resident 40 confirmed that (gender) does the nebulizer treatments 4 times a day.</p> <p>An observation on 3/27/25 at 12:30 PM revealed Resident 40 sitting in recliner with a nebulizer treatment sitting on the side table with liquid medicine in nebulizer cup.</p> <p>An interview on 3/27/25 at 12:31 PM with Registered Nurse (RN)-B confirmed that (gender) is not aware of any residents on the long-term side having any orders for the residents to self-administer medications.</p> <p>An interview on 3/27/25 at 1:00PM with CCC-A confirmed that there was medicine in the medication cup of the nebulizer treatment and that it should have not been left in the medication cup and not have the resident do the nebulizer treatment. CCC-A confirmed that there is no self-administration of medication with Resident 40 and Resident 40 does not have a physicians order to self-administered medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613</p> <p>Licensure Reference Number NAC 12-006.12(D)(i)</p> <p>Based on observation, interview and record review; the facility failed to ensure that medications were stored in locked compartments for 3 (Residents 38, 30, and 112) of 6 residents sampled for medication administration. The facility census was 56.</p> <p>Findings are:</p> <p>Record review of facility provided policy dated 1/1/23 titled Medication Management revealed:</p> <ul style="list-style-type: none"> -patients may self administer medications if they are deemed competent to do so by the nursing team. A self administer assessment should be completed to determine competency. -all medications that are requested to be available at bedside for patient self administration should be stored in a lockbox issued to the patient. The patient should be educated on the need for the medication safety and security and should be asked to notify the primary nurse of medications administered for documentation purposes. <p>Review of undated facility provided policy titled Self Administration of Medications revealed:</p> <ol style="list-style-type: none"> 1. DCS or qualified designee will complete an assessment of competency 2. an order will be obtained that resident can self administer medications, stating that the resident is capable of self medicating 3. nursing team member will observe resident for changes in behavior or condition 4. residents who choose to self medicate must keep their medications secured, by keeping the medications in a locked container in their room <p>A.</p> <p>Record review of Resident 38's Quarterly Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 1/27/25 revealed that the resident was admitted to the facility on [DATE] and had 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 15, which indicated the residents cognition is intact.</p> <p>Record review of Resident 38's physician order dated 7/1/2024 revealed an order for Systane complete ophthalmic solution and to instill one drop in left eye three times a day. Wait 5 minutes between drops.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/31/25 at 7:37 AM revealed an unlabeled bottle of artificial tears were on Resident 38's on the nightstand in (gender) room. The resident self-administered several drops in each eye.</p> <p>Record review of Resident 38's nursing assessments revealed no evidence of a self medication administration assessment being completed.</p> <p>Record review of Resident 38's physician orders revealed no order to keep medication at bedside.</p> <p>During an interview on 03/31/25 at 12:14 PM Registered Nurse (RN) - H corporate nurse consultant confirmed that Resident 38 did not have a self medication administration assessment completed and should have, it was further confirmed that the medication did not say may keep at bedside.</p> <p>In an observation on 04/01/25 at 8:18 AM Resident 38 had artificial tears on (gender) nightstand.</p> <p>In an interview on 04/01/25 at 8:18 AM Resident 38 Resident 38 stated (gender) used the eye drops when (gender) needs them.</p> <p>B.</p> <p>Record review of Resident 30's Admission MDS dated [DATE] revealed resident was admitted to the facility on [DATE] with a BIMS score of 15.</p> <p>Record review of Resident 30's physician orders dated 3/7/2025 revealed Deep Sea Nasal Spray solution 1 spray in each nostril four times a day, may keep at bedside and self administer.</p> <p>Observation on 03/31/25 at 9: 38 AM revealed an undated bottle of deep nasal spray floor stock in Resident 30's room on the tray table.</p> <p>During an interview on 3/31/25 at 9:39 AM Resident 30 stated (gender) uses it 4, 5, or 6 times everyday whenever (gender) needs it.</p> <p>During an interview on 3/31/25 at 12:34 PM RN - H corporate nurse consultant confirmed that Resident 30's medication was not secured and should have been.</p> <p>In an observation on 04/01/25 at 8:05 AM Resident 30's nasal spray on tray table in room.</p> <p>45484</p> <p>C.</p> <p>A record review of Resident 112's Admission Record revealed the resident was admitted on [DATE] with respiratory failure, heart failure, irregular heart rate, rectal cancer, high blood pressure, glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision), and diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 112's Admission MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 11, which indicated the resident had moderate cognitive impairment.</p> <p>An observation made on 03/26/2025 at 1:50 PM revealed two bottles of latanoprost (eye drops used to treat glaucoma) solution and a tube of combination diphenhydramine (an antihistamine that blocks a chemical in your skin that cause redness, itching, and pain) and zinc (a substance that can soothe the skin and help with wound repair) cream in a plastic basin on the bathroom counter, and two bottles of miconazole (an anti-fungal medication) powder on the bathroom counter.</p> <p>A record review of Resident 112's Order Summary Report dated 03/27/2025 revealed the following orders:</p> <p>Latanoprost Solution 0.005 % Instill 1 drop in both eyes at bedtime for GLAUCOMA, and</p> <p>Antifungal External Powder 2 % (Miconazole Nitrate (Topical)) Apply to abd [abdominal] folds topically every shift for Excoriation [redness and irritation]</p> <p>The orders did not include directions for the resident to keep the medications at bedside or self-administer them, and there was no order for the diphenhydramine-zinc cream.</p> <p>An observation made on 03/27/2025 at 12:21 PM revealed two bottles of latanoprost solution and a tube of combination diphenhydramine and zinc cream in a plastic basin on the bathroom counter, and two bottles of miconazole powder on the bathroom counter.</p> <p>An observation on 03/31/2025 at 8:00 AM revealed two bottles of latanoprost solution and a tube of combination diphenhydramine and zinc cream in a plastic basin on the bathroom counter, and two bottles of miconazole powder on the bathroom counter.</p> <p>An interview on 03/31/2025 at 8:00 AM with the Clinical Care Coordinator (CCC) B confirmed there were two bottles of latanoprost eye drops, a tube of diphenhydramine-zinc cream, and two bottles of miconazole powder were unsecured in Resident 112's bathroom. CCC B confirmed that the resident was not capable of self-administration of medication, and the medications should not be unsecured in the resident's room.</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>48271</p> <p>Licensure Reference Number 175 NAC 12-006.11(E)</p> <p>Based on observations and interview the facility failed to label and date opened packages of food in the walk- in freezer and failed to cover items in the walk in refrigerator and to discard processed food items passed the 7 day date to prevent the potential for food borne illness. This had the potential to affect all 56 residents. The facility census was 56.</p> <p>Findings are:</p> <p>An observation on 3/26/25 at 7:30 AM of the walk-in freezer revealed:</p> <ul style="list-style-type: none"> -An open box of beef patties not dated and open to air, -An open box of chicken patties not dated and open to air, -An open box of chicken fillets not dated and open to air, -An open box of breakfast potatoes not dated and open to air. <p>An observation on 3/26/25 at 7:30 AM of the walk-in refrigerator revealed:</p> <ul style="list-style-type: none"> -A serving pan of soup with a ladle notch dated 3/16. No saran wrap over the serving pan or the area for the ladle notch to sit in. -A serving pan of rice with no saran wrap or tin foil coving rice that appeared dried with a lid with a ladle notch dated 3/17. <p>An interview on 3/26/25 at 8:15 AM with the DM (Dietary Manager) confirmed that the items listed above were opened packages of food that should have been labeled, dated and sealed.</p> <p>A record review of the facility policy Proper Food Storage dated 2/22/22 revealed:</p> <ul style="list-style-type: none"> -all food products must be covered -clearly label all food with product or item name, preparation date, used by, expiration date or sell by date and prepared by. -perishable foods discarded after 3 days. <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>A record review of the Nebraska Food Code dated 2017 revealed revealed that 81-2.282(2)(c) Food shall be deemed to be adulterated (unsafe) if it has been manufactured, processes, packages, stored, or held under unsanitary conditions where it may have become unsafe for use as food and 3-501.14 and: P (i) Cooled to 1 C (34 F) within 48 hours of reaching 5 C (41 F) and held at that temperature until consumed or discarded within 30 days after the date of PACKAGING; P (ii) Held at 5 C (41 F) or less for no more than 7 days, at which time the food must be consumed or discarded.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52171</p> <p>Licensure Reference Number 175 NAC 1-005.06(D)</p> <p>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP- Specifically gowning and gloving to prevent the spread of bacteria resistant infection), for 4 (Resident 26, 17, and 34) of 7 sampled residents. The facility staff identified census of 56.</p> <p>Finding are:</p> <p>A record review of the facility Hand Hygiene Policy dated 03/01/2022 revealed:</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> <ul style="list-style-type: none"> - Immediately before touching a patient - Before performing an aseptic (practice and procedure to prevent infection (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal <p>2. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritation to hands and, in the absence of a sink, are an effective method of cleaning hands.</p> <p>B. Non-Surgical Hand Hygiene Technique</p> <p>1. Handwashing with soap and water (either non-antimicrobial or antimicrobial)</p> <ul style="list-style-type: none"> - Wet hands with running water-avoid using hot water, to prevent drying of skin - Apply hand washing agent to hand - Vigorously rub hands together for at least 15-20 seconds, covering all surfaces <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>- Dry hands thoroughly with a disposable towel(s)</p> <p>- Use disposable towel to turn of the water.</p> <p>C. Gloves and Hand Hygiene</p> <ol style="list-style-type: none"> 1. Gloves are not a substitute for hand hygiene prior to donning gloves, before touching the patient or the patient environment 2. Change gloves and perform hand hygiene during patient care, <ol style="list-style-type: none"> a. Gloves have been damaged b. Gloves have become visible 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 4. Never wear the same pair of gloves in the care of more than one patient 5. Carefully remove gloves to prevent hand contamination. <p>Record review of the facility Infection Prevention and Control Policy Effective date 03/01/2022 revealed:</p> <p>Infection Control Program Requirements:</p> <ol style="list-style-type: none"> 1. All team members will adhere to Standard Precautions to reduce the risk of exposure and prevent the transmission of infection of guests and personnel. 2. Gowns or aprons: Must be impervious and worn when there is a potential for blood or body fluid spatters or sprays. Examples may include venipunctures, catheter, or ca care of an incontinent guest. <p>Record review of Resident 34's medical record revealed Resident 34 was admitted to the facility on [DATE] with a BIMS (Brief Interview of Mental Status 0 lowest to 15 highest) score of 6, suggesting severe cognitive impairment and a diagnosis of Neuromuscular Dysfunction of Bladder, unspecified (Loss of bladder control from nerve damage to bladder.)</p> <p>Resident 34's plan of care revealed Resident 34 needed AM (morning) peri-care, (soap and water or wet wipes to clean the genital areas on male or female) suprapubic catheter care (Urinary tube to drain the bladder through the location in lower abdomen), and transfer to the recliner using an EZ-Stand Lift (Lift used to allow the resident to stand on lift and be moved by staff).</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>An observation on 3/31/2025 at 8:40 AM revealed Nurse Tech NT-C and NT-D (Nursing Technician) entered Resident 34's room to perform peri-cares, suprapubic catheter care and to transfer resident from the bed to the chair using an EZ Stand-Lift. NT-C and NT-D put on a gown and gloves to provide suprapubic catheter care to Resident 34 who was lying in bed. NT-C and NT-D proceeded to provide peri care using front to back wiping technique with wet wipes per facility policy and procedure. NT-D and NT-C then went into the bathroom to perform hand hygiene. NT-D washed hands for 12 seconds and then put on clean gloves and NT-C washed hands for 14 seconds and then put on clean gloves. NT-C and NT-D proceeded to get the Resident 34 dressed and used the EZ-Stand lift sling to transfer resident from the bed to the chair.</p> <p>NT-D cleaned the EZ-Stand lift with sanitizer wipes but did not clean the EZ -Stand lift sling that was used on this Resident. The lift sling was placed on the EZ-Stand lift bar and pushed out of the room into the hallway. NT-C went into the bathroom and removed (gender) gloves and gown and washed hands with soap and water for 10 seconds before drying them with a paper towel. NT-D went into the bathroom and removed gloves and gown and (gender) washed hands with soap and water for 14 seconds before drying them with a paper towel.</p> <p>An interview on 04/01/2025 at 09:10 AM with NT-D revealed that staff use the EZ-Stand lift and lift sling on all the Residents in the facility that need it.</p> <p>A record review of the Admission Record with the printed date of 9/9/24 revealed Resident 45 was admitted to the facility on [DATE] with the diagnosis of Unspecified Hydronephrosis (excessive fluid in a kidney,) Obstructive and Reflux Uropathy (Blockage in the urinary tract) Retention of urine, Disorientation (feeling lost, confused, or having a reduced sense of time, place, direction), Other Amnesia (loss of memory).</p> <p>A Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 03/03/2025 revealed that Resident 45 had a BIMS (Brief Interview for Mental Status) of 10 for a scale of (00-15) suggesting moderate cognitive impairment and needed morning Foley catheter care (Cleaning the tube that is in the bladder and drains urine, typically into a bag).</p> <p>A record review of Admission Record revealed Resident 17 admitted with diagnosis of Obstructive Uropathy, Kidney Disease, Benign Prostatic Hyperplasia without lower urinary tract symptoms (Enlargement of prostate (Gland below the bladder in a male) that can cause urinary difficulty), and muscle weakness.</p> <p>An observation of Resident 17 on 04/01/2025 at 10:37 AM revealed:</p> <ul style="list-style-type: none"> - Licensed Practical Nurse (LPN)-F washed hands for 35 seconds and put on gloves and gown and then put soap and hand towels on bedside table covered with towel. - LPN-F put water in basin with washcloths and sat on bedside table and then LPN-F took off gloves and cleaned hands with sanitizer and put on clean gloves - LPN-F put towel over Resident 17's lower abdomen just below (gender) supra pubic catheter site. - LPN-F took off Slit Sponge with dried area size of a dime and colored light brown from catheter site. <p>(continued on next page)</p>		

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 04/01/2025
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.			
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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>- LPN-F used the same gloves put and put hands in clean water basin and took out a wash cloth and cleaned around suprapubic catheter site.</p> <p>- LPN-F used the second wash cloth from basin and rinsed off catheter site and catheter tubing and dried area with clean towel.</p> <p>- LPN-F changed gloves and sanitized hands and put on clean gloves.</p> <p>- LPN-F opened 4x4 Slit Sponge dressing and applied it around the catheter tubing at opening on abdomen and then removed gloves and gown and performed hand hygiene.</p> <p>Interview on 04/01/2025 at 11:06 AM with CCC-A revealed:</p> <p>When providing catheter care and cleaning the skin for Resident 17's suprapubic catheter site the staff member should have changed gloves after handling the dirty Slit Site 4x4 dressing and put on clean gloves after hand hygiene was performed prior to putting hands into the clean basin of water to wash the catheter site.</p> <p>48271</p> <p>A record review of the Admission Record with the printed date of 3/31/25 revealed that Resident 26 was admitted to the facility on [DATE] with the diagnosis of Multiple Sclerosis (Chronic autoimmune disease that affects the central nervous system which includes the brain and spinal cord),Edema (swelling caused by fluid in your body's tissues), Neuromuscular Dysfunction of the bladder (damage to the nerves involved in the bladder control ,disrupts the communication between the brain and the bladder leading to various urinary problems), Hypertension (a condition where the force of blood against the artery walls is consistently too high), Peripheral Vascular Disease (a condition that affects the blood vessels outside of the heart and brain), Colostomy (a Surgical procedure that creates and opening (stoma)in the abdominal wall to divert stool from the colon (large intestine) to an external bag), Urostomy (a surgical procedure that creates an opening (stoma) in the abdomen to divert urine from the kidneys directly to a collection bag on the outside of the body), Above the knee amputation of both right and left leg, Pressure Ulcer of /Sacral Region (a localized area of skin and underlying tissue damage that occurs over the bony prominence of the sacrum) Stage 3, and Depression(a common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy levels that can significantly impact daily life.</p> <p>A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities dated 1/13/25 revealed a BIMS (Brief Interview for Mental Status, a test 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 was 15 indicating the resident is cognitively intact.</p> <p>An interview on 3/26/25 at 10 AM with Resident 26 confirmed that (gender) prefers to sleep in the power wheelchair.</p> <p>An observation on 03/26/25 at 11:04 AM revealed that Resident 26 was sleeping in (gender) power wheelchair.</p> <p>A record review of the Physicians orders with the printed date of 3/31/25 revealed orders for:</p> <p>(continued on next page)</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Apply Calmoseptine to right ischial (buttock) area Twice a day and PRN (when needed), may cover with gauze to promote adherence.</p> <p>-Colostomy Bag and Wafer, change two times a week and PRN</p> <p>-Change Urostomy on Tuesday and Friday (bath days) and PRN</p> <p>A record review of the Care Plan (written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) dated 8/19/24 indicated the need for Enhanced Barrier Precautions.</p> <p>An observation on 03/27/25 at 9:25 AM with NT-D revealed (gender) washed hands for 20 seconds and applied gloves. NT-D then unhooked catheter tubing from catheter bag before transferring Resident 26 to lay down in bed for wound care treatment. NT-D did not put on a gown. CCC-A and NT-D did not have gowns on when transferring Resident 26 to lay down in bed for the wound treatment to (genders) buttocks. Both CCC-A and NT-D had rolled Resident 26 side to side. Resident 26 did not have on a brief or underwear. CCC-A confirmed that the gowns were locked up in the bottom drawer and did not know why the drawer was locked. CCC-A confirmed that there was an Enhanced Barrier Precaution sign taped to the closet door. Observation of RN-B performing hand hygiene and gathered supplies for the wound treatment. RN-B did apply gloves. RN-B did not put on the gown. RN-B did not wash the old cream off the buttocks of Resident 26, and (gender) applied the new cream. NT-D and CCC-A assisted Resident 26 back into wheelchair. NT-D then reattached the catheter tubing to the catheter bag. Both CCC-A and NT-D washed hands before leaving the room.</p> <p>A record review of the sign attached to the closet door revealed Enhanced Barrier Precautions: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also wear gloves and a gown for the following High contact Resident Care Activities. Dressing, Bathing/showering, transferring, changing linens. Providing hygiene, changing briefs, or assisting with toileting. Device care or use: central lines, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing.</p> <p>A record review of the Hillcrest Firethorn Enhanced Barriers Precautions Effective date 4/1/24 revealed Initiation of Enhanced Barrier Precautions:</p> <p>A) The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO (Multidrug-Resistant Organism) that is not currently targeted by CDC (Center for Disease Control).</p> <p>B) An order for Enhanced Barrier Precautions will be obtained for residents with any of the following, wounds (e.g., chronic venous stasis ulcers) and or indwelling medical devices (e.g central lines, urinary catheters, tube feeding, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>An interview on 3/27/25 at 10:00 AM with RN-B confirmed that (gender) did not wear a gown while performing the wound cares and should have put on a gown. RN-B confirmed that (gender) should of cleaned Resident 26 bottom before applying the new cream to Resident 26's bottom.</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>An interview on 3/27/25 at 10:00 AM with NT-D confirmed that (gender) should have put on a gown before performing cares for Resident 26.</p> <p>An interview on 3/27/25 at 10:00 AM with the CCC-A confirmed that Resident 26 is in Enhanced Barrier Precautions. CCC-A confirmed that any staff member taking care of Resident 26 wounds, colostomy or urostomy should be in Enhanced Barrier Precautions. CCC-A confirmed that (gender), RN-B and NT-D should have been in Enhanced Barrier Precautions and was not in Enhanced Barrier Precautions. CCC-A confirmed that RN-B did not clean off the old barrier cream to Resident 26 bottom and should of been cleaned off before applying the new cream to Resident 26's bottom.</p>		