STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285300	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C Based on record reviews, interviews and observations the facility failed to develop and implement a comprehensive person centered care plan to include a new [DIAGNOSES REDACTED]. finger amputation for Resident 16, This affected 4 of 12 residents reviewed. The facility identified a census of 48. Findings are: A. A record review of the baseline Comprehensive Care Plan (CCP - a document to include problems, goals and interventions needed to provide person-centered care of the resident) dated 7/7/20, for Resident 47, revealed it did not address a new [DIAGNOSES REDACTED]. An interview on 7/30/20 at 12:45 P.M with the facility Nurse Consultant confirmed that the baseline care plan for Resident 47 did address the use of anticoagulant medication but did not address the recent GI bleed. The interview revealed that the list of bleeding symptoms to watch for were listed on the TAR. B. A record review of the baseline CCP dated 7/24/20, for Resident 251 revealed it did not include the foley catheter or the PICC line that was in place upon admission. An interview on 7/29/20 at 1:45 P.M with the Director of Nursing (DON) confirmed that the baseline CCP for Resident 251 did not include the foley catheter or the PICC line and should have. An interview on 7/29/20 at 2:00 P.M with the facility Nurse Consultant confirmed that the baseline care plan for Resident 251 did not include the PICC line or interventions for the care of the PICC line and should have. C. A record review of the baseline CCP dated 7/25/20, for Resident 252 revealed an intervention to follow the facility Stage 3 wound protocol which did not exist. Through record review it was also revealed that the CCP dated 7/25/20 for Resident 252 did not address a left heel wound or the interventions for care of that wound. An interview on 07/30/20 at 10:22 AM with the facility nurse consultant confirmed that the facility did not have a Stage 3 wound protocol related to the listed intervention on Resident 252's CCP. D) Review of Resident 16's Progress Note dated 7/11/20 at 12:34 AM revealed the resident was transferred to the emergency room via ambulance for evaluation of nerve pain to the right arm. Review of Resident 16's Progress Note dated 7/17/20 at 9:39 PM revealed Resident 16 was readmitted to the facility with intact dressing to the resident's right hand. Review of Resident 16's Admission Evaluation dated 7/17/20 revealed Resident 16 had a surgical incision and amputation of the right index finger. Observation on 7/27/20 at 2:27 PM revealed Resident 16 had a dressing to the right hand, covering the site of the finger amputation. Review of Resident 16's Care Plan Report dated 7/28/20 revealed a focus of skin integrity (not pressure related) related to [MEDICAL TREATMENT] and Resident 16 picking at skin areas. No documentation related to amputation of the resident's right index finger was noted. Review of Resident 16's Nurse Tech Care Plan dated 4/28/20 revealed an absence of information related to amputation on the right hand. Review of Resident 16's EHR (Electronic Health Record) revealed no updates were made to the Nurse Tech Care Plan from 4/30/20 until 7/30/20. Review of Resident 16's Nurse Tech Care Plan dated 7/30/20 revealed documentation that Resident 16 had a new amputation on the right hand. Interview on 07/30/20 at 12:48 PM with the DON (Director of Nursing) revealed documentation of Resident 16's recent finger amputation was documented on the TAR (Treatment Administration Record), which the facility considered to be part of the Comprehensive Care Plan. Review of Resident 16's July 2020 TAR revealed documentation for incision care with direction to apply bactriacin (a topical antibiotic), apply [MEDICATION NAME] (a non-adhering dressing), apply 4x4 dressings (a gauze dressing), followed by ACE wrap (an elastic bandage). No documentation related to site or type of wound was noted on the TAR. Interview on 7/30/20 at 1:30 PM with CCC-J (Clinical Care Coordinator) revealed Resident 16's right index finger was amputated recently due to a quickly developing wound that caused severe pain for the resident. CCC-J revealed Resident 16 was non- compliant with wound care and often removed the dressing or chews on wounds/fingers, causing the other wounds on the hands. CCC-J revealed interventions to discouraging the chewing include using bitter nail polish, but Resident 16 would often refuse. Review of the Hillcrest Health Services Comprehensive Care Plan policy dated 10/18/18 revealed the comprehensive, person-centered care plan would include measurable objectives and timeframes, incorporate identified problem areas, incorporate risk factors associated with identified problems (for example, wounds), reflect the resident's preferences, and aid in preventing or reducing decline in the resident's functional status and/or functional levels. The interdisciplinary team must also review and update the care plan as needed when the resident had been readmitted to the facility from a hospital stay.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09 Based on observation, record review, and interview; the facility failed to ensure physician's orders were followed related to hypertension (high blood pressure) medication parameters for 1 resident (Resident 25) of 5 residents reviewed, related to CBD (cannabidiol - a chemical compound in marijuana with a variety of uses) administration orders for 1 resident (Resident 15) of 5 residents reviewed, related to missing TSH ([MEDICAL CONDITION]-stimulating hormone - a hormone that regulates [MEDICAL CONDITION] function) lab work for 1 resident (Resident 20) of 5 residents reviewed, and related to the volume and frequency of nutritional supplement administered for 1 resident (Resident 47) of 2 residents reviewed. The facility census was 48. Findings are: A) Review of Resident 25's [DIAGNOSES REDACTED]. Review of Resident 25's Physician's Orders dated 7/28/20 revealed Resident 25 was ordered [MEDICATION NAME] (a medication to treat high blood pressure) 50mg ER (extended release) 1 tab orally every morning with instructions that included withholding the medication if Resident 25's heart rate was less than 60. Review of Resident 25's MAR (Medication Administration Record) for July 2020 revealed the [MEDICATION NAME] was administered to Resident 25 every day from 7/1/20 - 7/28/20, including the following dates when the resident's heart rate was outside the prescribed parameters: - 7/4/20 when Resident 25's heart rate was 52 - 7/8/20 when Resident 25's heart rate was 59 - 7/11/20 when Resident 25's heart rate was 58 - 7/12/20 when Resident 25's heart rate was 56 - 7/18/20 when Resident 25's heart rate was 57 - 7/27/20 when Resident 25's heart rate was 57 - 7/28/20 when Resident 25's heart rate was 56 Interview on 07/29/20 at 12:10 PM with the DON (Director of Nursing) confirmed Resident 25's [MEDICATION NAME] order stated the medication should have been withheld if the resident's heart rate was less than 60. The DON also confirmed the MAR indicated [REDACTED]. B) Record review on 7/28/20 of the Monthly Drug Regimen Review (a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy) for Resident 20, dated 11/29/19 revealed, the Consulting Pharmacist comments and recommendations included updating TSH ([MEDICAL CONDITION] stimulating hormone test that measures how much of that hormone is in your blood). Record review on 7/28/20 of the Monthly Drug Regimen for Resident 20 with a review dated 12/23/19 by the Consulting Pharmacist revealed, TSH OK'd per Medical Doctor under the comments and recommendations section. Record review on 7/29/20 of signed Doctor's order for Resident 20,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) dated 12/2/19 revealed a signed order for TSH lab to be drawn next lab day and then every 6 months. Order was noted off by a nurse on 12/2/19. An interview on 7/28/20 at 2:30 P.M. with Administrator revealed Resident 20's order for TSH was noted off by DON (Director of Nursing) but not completed. Administrator confirmed the facility does not have the TSH lab results. Administrator revealed education was done with DON and the Physician was updated. C) Record review on 7/30/20 of current MAR (Medication Administration Record, [REDACTED]. An interview on 7/30/20 at 1:20 P.M. with LPN-I (Licensed Practical Nurse) confirmed Resident 15's order read, [MEDICATION NAME] 100/5ML 0.25 ML (5MG) PO/SL twice daily between CBD doses. LPN-I confirmed the current order did not match what they are giving Resident 15 and the order was changed on 4/8/20. Record review on 7/30/20 of Hospice (a type of health care that focuses on comfort and quality of life of terminally ill residents) order dated 4/10/20 revealed new order to administer [MEDICATION NAME] doses in between [MEDICATION NAME] (medication to treat anxiety) doses instead of CBD. Order was not signed off. An interview on 7/30/20 at 2:30 P.M. with Facility Nurse Consultant confirmed the [MEDICATION NAME] order was not updated, and did not match current order dated 4/10/20. Nurse consultant confirmed Resident 15 had not received CBD. Facility Nurse Consultant confirmed [MEDICATION NAME] order dated 4/10/20 from Hospice was not noted off. D) A record review of the active orders for Resident 47 revealed an order for [REDACTED]. with Resident 47 revealed that Resident 47 receives 1 box (8 ounces) of Boost Breeze (a nutritional supplement drink that contains calories and protein) daily. The interview revealed that Resident 47 preferred to drink the Boost at her leisure. An observation on 7/30/20 at 10:10 A.M. revealed Resident 47 to have 3 unopened boxes of Boost Breeze on the tray table. During the observation it was revealed that Resident 47 was taking their medications. An interview on 7/30/20 at 10:10 A.M. with Resident 47 confirmed that Resident 47 had not drank the Boost Breeze in a couple days. During the interview, Resident 47 revealed that the dietician had provided some new protein bars to be tried. An interview on 7/30/20 at 12:14 P.M. with LPN-C revealed that Resident 47 receives Boost Breeze three times daily. During the interview with LPN-C it was discussed that Resident 47 had 3 boxes of Boost remaining on the table. The interview revealed that Resident 47 takes 100% of the Boost provided by LPN-C because LPN-C makes Resident 47 take it. An interview on 7/30/20 at 12:25 P.M. with the facility Nurse Consultant confirmed that the TAR (Treatment Administration Record) for Resident 47 indicated 100% intake of Boost Breeze twice daily. During the interview it was confirmed that staff should follow up to ensure that Resident 47 drank the Boost provided.
F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C3 Based on record reviews, interviews and observations the facility failed to develop a discharge summary to include a recapitulations of the resident's stay, [DIAGNOSES REDACTED]. The facility identified a census of 48. Findings are: A record review of Resident 51's discharge summary titled IDT Discharge Summary (NE Required) Hillcrest Firethorn dated 10/2/19 did not contain a list of [DIAGNOSES REDACTED]. An interview on 8/3/20 at 12:38 P.M. with the Director of Nursing confirmed that the recapitulation for Resident 52 did not contain a pre or post discharge medication list and should have. An interview on 8/3/20 at 12:38 P.M. with the facility Nurse Consultant confirmed that the recapitulation for Resident 52 did not contain a pre or post discharge medication list and should have