STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review the facility failed to ensure residents had the proper supplies for urinary independence for 1 of 1 residents reviewed (Resident #17). The facility reported a census of 57 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #17 documented diagnoses of morbid obesity and heart failure. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment Interview on 3/18/2026 at 11:29 a.m., with Resident #17 revealed she uses a female urinal and she uses it on a daily basis. Observation of her urinal was noted to have brown areas on the outside and noted to have a urine scale in the bottom of the urinal. She explained the brown areas on the outside of the urinal is feces that has been there awhile. She explained the facility has not changed the urinal for approximately 3 months and does not clean it weekly. Observation of the urinal top also showed a bend in the top of the urinal and she stated that it does not work as well when it has the bend. The facility did not provide a policy on urinal care. Interview on 3/25/2026 at 3:23 p.m., with the Director of Nursing (DON) revealed she doesn't know what the facility staff does with Resident #17's urinal. The DON revealed the male urinals are changed monthly so hers should be as well. She is unsure if the facility has any new urinals for her in the facility at this time but they should.

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: 165245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026

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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	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** Based on Electronic Health Records (EHR) review, staff interview, family interview and policy review the facility failed to notify the resident's representative / family / Power of Attorney (POA) when a resident had a change in condition that lead to a transfer to the Emergency Department (ED) for 1 of 3 residents (Residents #10) reviewed. The facility reported a census of 57 residents.Findings included:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. Review of Resident #10's EHR titled, Census documented Resident #10 was transferred to the hospital 1/7/26 and returned 1/22/26.Review of Resident #10's EHR titled, Progress Note documented an entry at 5:40 AM on 1/7/26 by Staff E, Licensed Practical Nurse (LPN) on-call provider gave orders to send Resident #10 to the ED via ambulance for evaluation and supply oxygen, updated resident on orders as resident is own POA.Review of Resident #10's EHR titled, Progress Note documented an entry at 11:31 AM on 1/7/26 by Staff D, LPN had spoken with ED nurse with report that Resident #10 was transferred to another hospital in Sioux Falls because of urosepsis and kidney failure. Staff D documented she called and notified Resident #10's Daughter.Review of Resident #10's EHR titled, Profile documented Daughter as emergency contact #1, POA, care conference person. On 3/17/26 at 10:56 AM Resident #10 Daughter/POA stated when Resident #10 went to the ED on 1/7/26 she was not notified till he went to the second hospital. Resident #10's Daughter/POA explained Resident #10 was life flighted to second hospital and she was not notified until after Resident #10 was in second hospital. Resident #10's Daughter/POA stated she was called by the nursing home about 30 minutes before the second hospital notified her. Resident #10's Daughter/POA stated she spoke to Staff D, Licensed Practical Nurse. Resident #10's Daughter/POA stated she told Staff D she was not notified her father was sent to the hospital and Staff D apologized. On 3/24/26 at 1:35 PM Staff D, LPN stated she called Resident #10's daughter / POA and notified her that Resident #10 was transferred to the ED. Staff D stated when she arrived the previous nurse Staff E, LPN had not notified the Resident #10's Daughter and Resident #10's daughter was upset. Staff D stated if the resident was their own POA Staff D would ask to notify the emergency contact. Staff D explained if the ambulance was called it would be an emergency and the emergency contact should be notified. On 3/25/26 at 6:10 PM Staff E, LPN stated she was familiar with Resident #10. Staff E explained Resident #10 was his own POA. Staff E stated if Resident #10 was not his own POA; she would notify the emergency contact. Staff E explained she did not notify Resident #10's POA when transferred to the hospital on 1/7/26. Staff E acknowledged she sent Resident #10 out right at 6:00 AM. Staff E said she texted Staff D to let Resident #10's daughter know Resident #10 was transferred. Staff E acknowledged that she should have let the daughter know but she did not at that time. On 3/18/26 at 10:54 AM the Director of Nursing (DON) stated Resident #10 was transferred to the hospital via emergency ambulance on 1/7/26. The DON stated Resident #10 was his own POA at the time but Resident #10's daughter was emergency contact #1 and should have been notified of the transfer to the ED and was not.Review of policy with review date of 7/24 titled, Change of Condition Reporting documented a licensed nurse will inform family/responsible party of change of condition and document notification. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response.

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NAME OF PROVIDER OR SUPPLIER Hillcrest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Avenue L Hawarden, IA 51023	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Records (EHR) review, observations, resident interview, and staff interview the facility failed to provide the residents with a comfortable / clean homelike environment when bed linens were not applied to beds in a timely manner and rooms were not clean for 3 for 20 residents reviewed (Resident #17, #30 and #55). The facility reported a census of 57 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #30 documented a Brief Interview of Mental Status (BIMS) of 14 indicating no cognitive impairment. An observation on 3/18/26 at 10:20 AM revealed the linen on Resident #30's bed rolled up at the foot of the bed and the bed was not made. On 3/18/26 at 10:20 AM Resident #30 explained she would like her bed to be made in the morning. Resident #30 said it would be nice if it was made by the time breakfast was over but for sure before the lunch meal. An observation on 3/18/26 at 10:42 AM revealed the linen on Resident #30's bed remained rolled up at the foot of the bed and the bed remained unmade. 2. The MDS dated [DATE] for Resident #55 documented a BIMS of 9 indicating moderate cognitive impairment. The MDS documented Resident #33 had diagnoses of unspecified intellectual disabilities, muscle weakness and need for assistance with personal care. An observation on 3/18/26 at 11:37 AM revealed Resident #55's lying in bed with a small lap blanket on and all bedding at the bottom of his bed wrapped up. On 3/18/26 at 11:38 AM Resident #55 stated a lady placed all the bedding at the bottom of the bed that morning and had not been back to make the bed. An observation on 3/18/26 at 11:41 AM revealed down hall G bedding not on the bed at all in Resident #40 and #58 On 3/18/2026 3:06 PM Staff F, Certified Nurse Assistant (CNA) stated she usually made the resident's bed when she got the resident up in the morning. On 3/18/26 at 3:17 PM Staff G, CNA stated it was the first time he had worked at the facility. Staff G explained the morning was very busy and he was working on the hardest hall. Staff G acknowledged he worked on hall G that morning. Staff G explained he was all over the place that morning and had to do so many bed strips. Staff G explained he was pulled away from the hall at 10:00 PM. Staff G stated he tried to get beds made before 10:00 AM but did not have the time. On 3/18/26 at 3:34 PM Staff D, Licensed Practical Nurse (LPN) stated each day of the week they strip certain beds on certain halls and wash them. Staff D explained she had noticed frequently that resident beds are not made until after 11:00 AM. Staff D said she usually told the staff to make the bed or she will make the bed herself. On 3/18/26 4:21 PM Staff H, CNA stated he came in at 10:00 AM on 3/18/26. Staff H stated when he (continued on next page)

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	165245	A. Building B. Wing	03/26/2026

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Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	came in that morning the beds had been stripped, linen was not changed and beds were not made on hall G. Staff H explained he had to help with resident care and was unable to make the beds until after care for all the residents was completed. On 3/25/26 at 2:18 PM the Director of Nursing (DON) stated the resident's beds are stripped and house keeping will come behind, clean the mattress and remake the bed on certain days of the week. The DON acknowledged 3/18/26 was not the day that hall G was supposed to have the beds stripped, the mattress cleaned and bed remade by housekeeping. The DON acknowledged she would expect the beds would have been made by 10:30 AM. On 3/26/26 at 12:00 PM the Administrator stated she expected the linen would have been placed on the bed and the beds made for the residents on hall G by 10:40 AM. Review of a facility provided policy revised on 05/07 titled, Homelike Environment documented it was the policy of this facility to provide a homelike environment, and to encourage and provide opportunities for each resident to occupy an area reflecting his/her interests, family, and/or is made personalized by bringing photos or items from home. 3. Observation on 03/18/2026 at 11:29 a.m., of Resident # 17's room. The room was noted to have the bed pulled away from the wall and the floor was noted to have streaks of dried fluid. The baseboard heat was noted to have brown debris scattered along the area next to the bed. The baseboard heat was also noted to have a white object in the baseboard. The wall above the baseboard heat noted to have several areas of brown debris on the wall. Resident #17 confirmed the areas had been there for a while and unsure what the debris is. Review of the facility provided policy titled Homelike Environment with a revised date of 5/2007 revealed it is the policy of this facility to provide a homelike environment Interview on 03/25/26 at 2:59 p.m., with the Administrator revealed the rooms should be clean.

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on clinical record review, facility record review, resident and resident family interviews, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 2 out of 3 residents (Resident #3 and #50) reviewed from abuse. The facility reported a census of 57 residents.Findings include:

1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of muscle weakness, stroke and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.

Review of facility provided Incident Report dated 3/8/26 at 3:21 p.m., revealed Staff I, Registered Nurse (RN) was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated, just letting you know Resident #2 was in this resident room attempting to get in bed with her. This writer hung up and immediately rushed down the hall with a caregiver. Staff I met Resident #3 in her bed, resting in bed, and call light within reach. Resident #3 stated, I was in bed, my door was halfway closed when this man came in and just kept coming towards me. He touched my leg and I told him to stop immediately. He moved my bedside table away from me and I thought he wanted to take my dentures on the table, but he had this weird look you know, placed his hand under my blanket and tried to touch me. I pushed my call light and screamed twice. My neighbor heard me and pushed his call light as well, and he took off then the aide came in and I told them.

Interview on 3/17/2026 at 11:08 a.m., with Resident #3 revealed she had been laying in bed and her door opened and a guy in a wheelchair came into her room and touched her feet. He then moved her tray over that was next to the bed and all of a sudden his wheelchair was going up the side of her bed and his hand was going up her leg. She stated she screamed twice and pushed the call light. After she screamed he scooted out of her room. Resident #3 further revealed it is not a secret that she is trying to get out of here because he is still in the. There are times she cannot sleep when she sees him and she feels he is just a creep. She has told everyone that she will kill him if he touches her again. Resident #3 stated that it isn't that she feels unsafe in the facility but it bothers her that he also violated another person and it is sad to think about it wasn't just me. She continues that her heart starts to race when she is in the dining room when he is there and sees him. She doesn't understand why the facility allows him to sit at the table where they assist people with eating as they are not able to defend themselves from him. The facility was really short that night and they would have been able to handle it better with more people.

2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, hypertension and unspecified symptoms and signs with cognitive functions and awareness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment.

Review of facility provided Incident Report dated 3/8/26 at 3:22 p.m., revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22
(continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Review of Resident #50's Progress Notes revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Resident #50 was unable to state or describe what happened. Both residents were separated immediately. Notified Director of Nursing (DON) immediately via phone call. 3. The MDS dated [DATE] for Resident #2 documented a BIMS of 11 indicating moderate cognitive impairment. On 3/17/26 at 9:33 AM Resident #3's Daughter stated her mother was still living at the facility. Resident #3's Daughter stated her mother was in bed and Resident #2 entered her room and put his hands under the blanket. Resident #3's Daughter stated her mother called her first and the facility called 6 hours later. Resident #3's Daughter stated it was Staff I, Registered Nurse (RN) who called her. Resident #3's Daughter stated did not know which nursing staff her mother had talked to. Resident #3's Daughter stated her understanding was the police were called. Resident #3's Daughter stated the police were not called until 7:00 PM and after they left she was called by the facility. Resident #3's Daughter stated there was a second assault the same day and the nurse had to pull Resident #2 off the resident. Resident #3's Daughter stated from what she understood the second incident was worse than the incident with her mother. Resident #3's Daughter stated the trauma advocate told her about the second assault. Resident #3's Daughter stated the incident occurred on 3/8/26. Resident #3's Daughter stated another CNA told her mother the DON told the nurse not to do anything about it. Resident #3's Daughter stated the nurse said she needed to because she was worried about her license. Resident #3's Daughter stated her mother said she was able to scare the resident before he fondled her. Resident #3's Daughter stated he did not put his hands up her shirt or down her pants. Resident #3's Daughter stated her mother acted like she was not scared but inside she felt she was. Resident #3's Daughter stated her mother seemed to have some increased sadness since the incident. Resident #3's Daughter stated there was no penetration. Resident #3's Daughter stated her mother felt assaulted but not abused or sexually abused. On 3/26/26 at 8:08 AM Resident #3's Daughter stated her mother had called her at 2:15 pm on 3/8/26 and told her about the incident and the facility called her at 8:17 PM on 3/8/26 to tell her. Resident #3's Daughter stated previously her mother would talk to another resident frequently and now after the incident her mother was much more self isolating. Resident #3's Daughter stated her mother left the faciity on 3/24/26. The incident had increased her want to leave as soon as possible. On 3/24/26 at 1:17 PM Staff I, Registered Nurse (RN) acknowledged she worked 3/8/26 when the incident with Resident #2, #3 and #50. Staff I stated she called Resident #2's family. Staff I stated she called Resident #3 and #50's family. Staff I stated she called the police also. Staff I explained that (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she called the Director of Nursing (DON) immediately and did not remember what the DON said. Staff I stated the DON said that since Resident #2 had not penetrated the resident's vagina then she just needed to call the police later. Staff I explained that the DON stated the police would probably only take the report over the phone. Staff I explained that when she called the police they said they were going to come up. Staff I stated she called all the resident's families after that. Staff I stated Staff J, LPN was the other nurse working with her on 3/8/26. Review of Resident #2's EHR dated 3/8/26 at 3:21 PM entered by Staff I documented Staff I was at the nursing station when a Certified Nurse Assistant (CNA) came to the nurse station and stated Resident #2 was in another resident's room trying to get into bed with Resident #3. Staff I immediately went down the hall Resident #2 was seen in Resident #50's room in her bed with the door locked at 3:22 PM, Resident #50's pants were halfway down her buttocks with Resident #2's left hand on Resident #50's buttocks. Resident #2's wheelchair was backed in front of the bed. Resident #50 was unable to state what had happened. Resident #2 was immediately moved out of Resident #50's bed to his wheelchair and out of the room. Staff I assessed both Resident #3 and #50. DON was notified at 3:22 PM. Resident #2 was taken to the nursing station for 1:1 monitoring. Resident #50 stated bathroom and was helped to the bathroom. Staff I documented Staff J explained Resident #2 was last seen about 2:20 PM when she administered his medications. Sheriff was notified at 7:09 PM, Resident #2's Power of Attorney (POA) notified at 8:30 PM. Resident #2's POA stated if Resident #2 took Carbidopa-levodopa, then the resident would get sexual. On 3/24/26 at 2:58 PM Staff N, Licensed Practical Nurse (LPN) stated she was working the day of 3/8/26 and received a report from Staff I. Staff N explained that she worked at 6:00 PM that evening. Staff N stated the incident with Resident #2, #3 and #50 had happened several hours before she came in. Staff N stated Staff I was the nurse that completed an assessment on Staff #50 and on Resident #2. Staff N stated Staff I was told not to document the incident because they did not know what he was exactly doing. Staff N stated she was not going to take the assignment at the facility unless Staff I reported the incident because it needed to be reported. Staff N stated the Administrator and the DON did not come to the building. Staff N explained Staff I called the family members after that and the police. Staff N stated the police were at the facility for an hour or two. Staff N stated there was also another resident involved Resident #3. Staff N stated Resident #2 did not get as far with Resident #3 as with Resident #50. Staff N explained Resident #3 was very upset. Staff N stated Resident #50 was probably unaware of what was happening because of her lower cognitive function. Staff N stated Resident #3 was very upset that Resident #2 was allowed to stay at the facility. Staff N explained Resident #3 was in therapy room one day and they brought Resident #2 in and she asked to leave. Staff N stated Resident #3 was planning on going to another facility because Resident #2 remained at the facility. On 3/25/26 at 11:28 AM Staff J, Licensed Practical Nurse (LPN) stated it was about 2:00 PM on 3/8/26. Staff J explained she had taken 2 or 3 residents outside and Staff I came out and asked when she had last seen Resident #2 and she said last time she medicated him. Staff J stated she was outside around 3:00 PM or 3:15 PM and gave him his medication at 2:30 PM and saw him about 15 minutes later. Staff J stated he appeared to be sleeping when she last saw him. Staff J stated she had not seen Resident #2 for about 30 minutes. Staff J stated she came inside at that time and gave Staff I a brief statement about what was going on. Staff J stated she went back outside with the residents. Staff J stated Staff I was on the phone with the DON. Staff J stated all the residents were brought in and she was still talking to the DON about the incident. Staff J stated Staff I said she was told by the DON not to make a note of it because they could not be sure what actually happened with the residents. Staff J stated Resident #3 used to participate in activities, sit in the dining room with (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	other residents and talk before the incident with Resident #2. Staff J explained Resident #3 very rarely comes out to participate in activities now. Staff J stated Resident #3 asked to be taken back to her room during the meal the other day when Resident #2 came out and that was not normal for her. Staff J stated where Resident #3 normally sits her back would be towards Resident #2. Staff J stated Resident #3 usually would stay out and chat with the other residents but left because she was uncomfortable. Staff J stated there were no attempts to call the police, the family, or the physician because it was not physically witnessed. Staff J stated Staff I said it was witnessed she had witnessed it at the time. Staff J stated the DON told her it did not need to be reported. Staff J stated Staff N said if Staff I did not report the incident to the police, the POA's and the physicians she was going to have to. Staff J said that was when Staff I reported the incident. Review of a policy provided by the facility reviewed on 1/22 titled, Abuse: Prevention of and Prohibition Against documented it was the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. To assist the Facility's staff members in recognizing incidents of possible abuse, neglect, misappropriation of resident property, or exploitation, the following definitions are provided: Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse is non-consensual sexual contact of any type with a resident.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 2 of 4 residents reviewed for abuse (Resident #3 and #50). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of coronary artery disease, diabetes mellitus and muscle weakness. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12 indicating no cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:21 p.m., revealed Staff I, Registered Nurse (RN) was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated, just letting you know Resident #2 was in this resident room attempting to get in bed with her. This writer hung up and immediately rushed down the hall with a care giver. Staff I met Resident #3 in her bed, resting in bed, and call light within reach. Resident #3 stated, I was in bed, my door was halfway closed when this man came in and just kept coming towards me. He touched my leg and I told him to stop immediately. He moved my bedside table away from me and I thought he wanted to take my dentures on the table, but he had this weird look you know, placed his hand under my blanket and tried to touch me. I pushed my call light and screamed twice. My neighbor heard me and pushed his call light as well, and he took off then the aide came in and I told them. Interview on 3/17/2026 at 11:08 a.m., with Resident #3 revealed she had been laying in bed and her door opened and a guy in a wheelchair came into her room and touched her feet. He then moved her tray over that was next to the bed and all of a sudden his wheelchair was going up the side of my bed and his hand was going up my leg. She stated she screamed and pushed the call like. After she screamed he scooted out of my room. 2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, lack of coordination and hypertension. The MDS showed the BIMS score of 6 indicating severe cognitive impairment. Review of facility provided Incident Report dated 3/8/26 at 3:22 p.m., revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door was locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Review of Resident #50's Progress Notes revealed revealed Staff I, RN was at the nursing station paging at about 3:21 p.m., to get update on another resident when caregiver came up to nurse and stated just letting you know, Resident #2 was in Resident #3's room attempting to get in bed with her. Staff I immediately rushed down the hallway to make sure the resident was safe. Staff I and caregiver check rooms to make sure Resident #2 is out of the hallway and is safe. At about 3:22 p.m., Staff I and caregivers found Resident #2 in bed with Resident #50 with her pant and brief halfway down and Resident #2's left hand was in this resident's pants on her buttocks. Resident #2's wheelchair was parked in front of Resident #50's bed and door were locked. Resident #50 was lying in bed on her right side facing the window half asleep and Resident #2 was on bed and not moving. Resident #50 was unable to state or describe what happened. Both residents were separated immediately. Notified Director of Nursing (DON) immediately via phone call. Review of the facility provided policy titled Abuse: Prevention of and Prohibition Against with a reviewed date of 1/2022 revealed the following:a. All allegations of abuse, neglect, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriation of resident property, or exploitation should be reported immediately to the Administrator. b. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. Interview on 3/24/2026 at 2:11 p.m., with the Administrator revealed once she became aware of the situation that evening she immediately reported it to the state. It should have been reported sooner. Interview on 3/24/2026 at 2:26 p.m., with the DON revealed she did not know about the incident until later in the evening about the touching or being in bed with another resident. The DON confirmed she had been called around 3:00 p.m., but the staff never told her about the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Hillcrest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Avenue L Hawarden, IA 51023	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview and facility policy review the facility failed to provide bathing assistance twice weekly for 2 of 3 residents reviewed for bathing (Resident #20 and #50). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #20 documented diagnoses of anxiety disorder and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of facility provided documentation titled Follow Up Question Report dated 1/19/26-3/19/26 revealed the following information:2/7/26- bathing was documented as refused. Resident received a bath on 2/4/26 and again on 2/11/26. Resident went 6 days without a bath. 3/11/26- bathing was documented as not applicable. Resident received a bath on 3/7/26 and again on 3/14/26. Resident went 6 days without a bath. Review of Care Plan with a revision date of 2/7/25 revealed resident is totally dependent on staff to provide a bath as necessary. 2. The MDS assessment dated [DATE] for Resident #50 documented diagnoses of need for assistance with personal care, lack of coordination and hypertension. The MDS showed the BIMS score of 6 indicating severe cognitive impairment. Review of facility provided documentation titled Follow Up Question Report dated 1/19/26-3/19/26 revealed the following information:1/24/26- bathing was documented as resident refused. Resident received a bath on 1/21/26 and again on 1/27/26. Resident went 6 days with no bath. 2/9/26- bathing was documented as not applicable2/12/26- bathing was documented as not applicable. Resident had a bath on 2/6/26 and again on 2/13/26. Resident went 6 days with no bath. 3/2/26- bathing was documented as not applicable. Resident had a bath on 2/23/26 and again on 3/3/36. Resident went 7 days with no bath. 3/10/26- bathing was documented as resident refused. 3/11/26- bathing was documented as not applicable3/12/26- bathing was documented as not applicable3/13/26- bathing was documented as not applicable3/14/26- bathing was documented as not applicable3/16/26- bathing was documented as not applicable. Resident received a bath on 3/6/26 and received a bath again on 3/17/26. Resident went 11 days with no bath. Review of the facility provided policy titled Bath, Shower with a revised date of 5/2007 revealed It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. Clinical staff members will offer residents a shower at minimum of 2 times per week. If a resident is unable to shower on a specific day, the resident will be offered a shower on the next available day. Interview on 3/24/2026 at 2:23 p.m., with the Director of Nursing revealed when the resident refused their shower the staff need to continue to offer. They need to try multiple times and try a different person. If they still do not take it that day the staff need to continue to try the next day until they bathe.