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	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and policy review, the facility failed to provide dignity to residents during personal care for 2 of 13 residents (Residents #1, #7). The facility reported a census of 50 residents. Findings Include: 1. Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS documented the resident required partial/moderate assistance with toilet hygiene. The document indicated the resident was continent of bowel and bladder. The MDS revealed diagnoses of lymphedema, morbid obesity and other disorders of electrolyte and fluid imbalance. The Care Plan revised 4/3/26 identified the resident had self care deficits directing staff the resident required 2-4 staff for toilet transfers, and used disposable briefs.On 5/4/26 at 3:00 PM Resident #1 stated she felt like she had not been provided with dignity and respect during personal care during the overnight shift. The resident stated an unnamed male staff member was completing her perineal care and she requested the staff complete the task in a different manner to ensure she was thoroughly cleaned. Resident #1 stated following her request, the staff member removed his gloves, walked to the door stating you are telling me how to do my job?. The resident stated the comment upset her and she tried explaining why she wanted the task completed a certain way with the staff moving closer to the door, staring at her and replying to the resident not to yell at him and proceeded to walk off. The resident stated no other staff had done this to her before.2. Resident #7's MDS dated [DATE] revealed a BIMS of 15/15 indicating normal cognition. The MDS documented that the resident required substantial/maximal assistance with toilet hygiene, partial/moderate assistance with lower body dressing and substantial/maximal assistance for transfers. The document included the resident had an indwelling catheter, always incontinent of bowel, had impairments of movement of bilateral upper and lower extremities, and utilized a wheelchair. The MDS revealed the resident had diagnoses of hemiparesis following a stroke affecting her left non-dominant side, neuromuscular dysfunction of the bladder, aphasia, anxiety and depression. The Care Plan revised 4/24/26 identified the resident had bowel incontinence related to confusion, impaired mobility and inability to communicate with staff directives to provide use of brief and incontinence care with each episode. The document identified self care performance deficits with staff interventions that required total dependence on staff for toilet use and used a dependent non weight bearing mechanical lift (Hoyer) for transfers. The clinical record's Physician Orders revealed the indwelling catheter was discontinued on 4/22/26.A facility posted document dated 1/5/26 above Resident's 7 bed revealed the resident could use the weight bearing standing lift (EZ Stand) for transfers with the assistance of 2 staff. The facility failed to update the Care Plan to reflect the change in resident's transfer status and discontinuation of the catheter.Continuous observation on 4/29/26 at 3:45 PM of Staff B Certified Nurse Assistant/Certified Medication Aide (CMA)/Housekeeping Supervisor and Staff I, CNA, provided transfers and personal care to Resident #7. The staff positioned the EZ Stand in front of the resident and her wheelchair. The resident notified Staff B she had a secret, told the staff and then began to cry. The resident indicated she had been incontinent and was upset. Staff B and Staff I completed the waist harness (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and leg straps prior to initiating the lift. Staff B and Staff I worked together and moved the resident in the lift into the bathroom. When the resident was positioned at the toilet, Staff B provided a verbal cue that she was going to lower the resident's pants to which the resident stated no. The staff stopped and questioned whether the resident wanted to stop the transfer with toileting and be completed later. The resident responded that she was joking and the staff could continue. Staff B removed the resident's pants and brief, and lowered the resident onto the toilet. As soon as the resident was seated on the toilet, she indicated she was finished as she had been incontinent prior to the initiation of the lift. Staff B raised the resident in the lift into a standing position to complete perineal care during which the resident did state ow followed by it's ok. Staff B completed dressing with a tabbed brief and pulling up the resident's pants and Staff I moved the resident with the lift to the wheelchair for positioning. The staff worked together to position the resident in the wheelchair. On 4/29/26 at 1:00 PM Resident #7 with the Director of Nursing (DON) and Social Services Director present indicated she required staff assistance for self care and transfers. The resident stated she required 2 staff for transfers but mostly had only 1 staff. Resident #7 stated she was mostly incontinent of bowel and bladder, and had recently had her catheter discontinued. The resident stated on 4/22/26 Staff J, CNA, was assisting her alone with personal care. The resident stated the staff connected her to the lift, moved her into a standing position, and lowered her pants/brief. Resident #7 stated Staff J patted my butt. The resident reiterated she did not have her pants on. The resident stated the staff continued to provide perineal care as she had been incontinent and that she felt her care was rough. The resident stated she did not tell the staff that it was uncomfortable, caused discomfort or she did not like being patted on her bottom. The resident did acknowledge that Staff J was not the only staff member she felt was rough at times during her perineal care. The resident was observed during the interview to become teary eyed and require a moment for recomposing. On 4/29/26 at 1:30 PM the Social Services Director stated on 4/24/26 at approximately 4:30 PM she was notified that Resident #7 wanted to speak with her. The staff stated Resident #7 stated Staff J patted her on the butt while providing care and wiped her too hard. The staff stated the resident originally did not state whether her pants were up or down when she was patted. The Social Services Director indicated the resident appeared upset during her conversation and was not known to make false statements.On 4/29/26 at 1:40 PM the DON stated she had been made aware of the resident's complaint about the care she had received by Staff J. The DON stated the resident had not made any previous complaints or voice concerns about other staff that she was aware of. On 4/29/26 at 4:00 PM Staff F, Licensed Practical Nurse (LPN), stated she had been told by Resident #7 that Staff J tapped her on the bottom. The staff stated the resident did not indicate whether her pants were up or down. On 4/30/26 at 8:33 AM Staff K, LPN, stated Resident #7 called her into her room during her shift and told her Staff J had put the resident in the stand assist and had patted her on the bottom. Staff K stated Resident #7 made the statement of couldn't do anything about it and had cried. The staff stated she made sure the resident knew that if something was uncomfortable she needed to talk to staff. On 5/6/26 1:55 PM The DON stated 2 staff were to present with the use of the EZ lift. The DON stated it was her expectation that residents be treated with dignity and respect during all cares. The DON stated residents have the right to express how they would like their cares to be completed and staff need to respect their wishes. On 5/6/26 at 3:30 PM the Administrator acknowledged residents were to be treated with dignity and respect during care.The facility's undated Resident Rights Dignity and Privacy Policy disclosed all residents were to be treated with dignity, respect, and privacy. The document revealed staff shall provide respect to residents when providing care as constant affirmation of their individuality and dignity as human beings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, staff interviews and facility policy review the facility failed to complete skin assessments to include measurements and wound status for 2 of 3 residents (Resident #1 and #2) reviewed with pressure ulcers. The facility also failed to sign out wound treatment orders and being completed for 1 of 3 residents (Resident #1) reviewed with pressure ulcers. The facility reported a census of 50 residents.Findings include:According to Resident #1's quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/23/2026, she had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 suggested mild cognitive impairment. The MDS documented she had two unstageable pressure ulcers/injuries present on admission. The following diagnoses were documented for Resident #1: lymphedema, respiratory failure, morbid obesity, persistent mood (affective) disorder, sleep apnea, venous insufficiency, and cellulitis of left lower limb.The Care Plan Focus Area with an initiated date of 3/2/2026 documented Resident #1 had impaired skin integrity. The Care Plan directed staff to assess, record, and monitor wound healing. Staff are to: measure length; width; and depth where possible; assess and document status of wound perimeter; wound bed and healing process.Review of Resident #1's Assessment tab for skin assessments from 4/8/2026 to 4/30/2026 revealed skin checks were completed on 4/14/2026, 4/21/2026, 4/28/2026, and 4/30/2026. Assessment completed on 4/14/2026 failed to include measurements when her coccyx, left lateral thigh, and left shin were assessed. Assessment completed on 4/21/2026 and 4/28/2026 failed to include measurements when her coccyx was assessed. The assessments documented the area was previously deteriorating, wound characteristics plateaued.On 4/29/2026 the facility provided skin and wound assessments for Resident #1 from 4/8/2026 to 4/29/2026 related to non-fluid filled blister like areas to her coccyx. Assessments completed on 4/16/2026, 4/21/2026, and 4/28/2026 failed to include measurements.On 4/29/2026 the facility provided skin and wound assessments for Resident #1 from 4/8/2026 to 4/29/2026 related to a stage 1 pressure ulcer/injury to her left shin: non-blanchable erythema of intact skin. Assessments completed on 4/16/2026 and 4/21/2026 failed to include measurements. Assessment completed on 4/28/2026 documented the following measures to the pressure ulcer/injury to her left shin: 2-centimeter (cm) x 2cm.On 4/29/2026 the facility provided skin and wound assessments for Resident #1 from 4/8/2026 to 4/29/2026 related to a stage 1 pressure ulcer/injury to her left lateral thigh. Assessment completed on 4/16/2026 failed to injury measurements.Review of Resident #1's April 2026 Treatment Administration Record (TAR) revealed the following orders were not signed out as being completed:Keep drigo wicking cloths to folds: leg, feet, under abdomen and groin folds. Utilize pillow cases if resident refuses wicking clothes, change daily and as needed. Order not signed out as being completed on 4/24/2026, 4/26/2026, 4/27/2026, and 4/29/2026.Apply Aquaphor to bilateral lower legs every shift for skin treatment. Order not signed out as being completed on 4/17/2026, 4/22/2026, 4/24/2026, 4/26/2026, 4/27/2026, and 4/29/2026.Left medial thigh wound care: cleanse with vashe wound cleanser-apply vashe moistened gauze compress to wounds and allow to soak 3-5 minutes, cleanse wound and peri-wound skin. Cover wound bed with maxorb alginate dressing, secured with a bordered foam dressing, two times a day for wound care. Order not signed out as being completed on 4/15/2026, 4/17/2026, 4/22/2026, 4/24/2026, 4/26/2026, 4/27/2026, and 4/29/2026.Zinc oxide external paste: apply to coccyx/buttocks topically every shift for skin irritation. Order not signed out as being completed on 4/24/2026, 4/26/2026, 4/27/2026, and 4/29/2026.Cleanse area to right knee with wound wash, apply mepilex to wound; change every 3 days. Order not signed out as being completed on 4/15/2026, 4/24/2026, and 4/27/2026.According to Resident #2's 5-day MDS assessment tool with a reference date of 4/20/2026, Resident #2 had a BIMS score of 9. A BIMS score of 9 suggested mild cognitive impairment. The MDS documented he had one stage 3 pressure ulcer/pressure injury present on admission. The following diagnoses were documented for Resident #2: urinary tract infection (UTI), (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cancer, neurogenic bladder, diabetes mellitus, malnutrition, sepsis, bactermia, and mild cognitive impairment.The Care Plan Focus Area with an initiated dated of 3/13/2026 documented Resident #2 had pressure ulcers present upon admission. The care plan directed staff to monitor areas weekly.Review of Resident #2's Assessment tab of skin check assessments from 4/8/2026 to 4/21/2026 revealed a skin check was completed on 4/16/2026. The skin check failed to include measurements and characteristics.On 4/30/2026 the facility provided skin and wound assessments for Resident #2 from 4/8/2026 to 4/21/2026, related to a pressure ulcer/injury: stage 4 full-thickness skin and tissue loss to his sacrum. This pressure ulcer/injury was present on admission. An assessment was completed on 4/18/2026 with no measurements documented. The reason for measurements not documented was due to the wound spreading to his back with necrotic tissue at the center.On 4/29/2026 at 3:47 PM Staff F Licensed Practical Nurse (LPN) stated if an order is not signed out on a resident's TAR the order did not get completed or it was completed but did not sign it out as completed.On 4/30/2026 at 12:25 PM Staff E Nurse Consultant requested to look through Resident #1 and Resident #2's skin assessments with the surveyor. She acknowledged the skin assessments for Resident #1 and Resident #2 failed to include measurements. She added they hired a wound nurse that started on 4/29/2026 and will come to the facility every Wednesday to complete all wound/skin assessments.On 5/1/2026 at 8:59 AM Staff G Registered Nurse (RN) stated skin assessments are to be completed weekly by the nurses with measurements completed if needed. When asked what completed if needed meant, she stated if the area is new or if the area is open measurements will be obtained. Staff G stated if an order on the TAR is not signed out it means the treatment was not completed.On 5/6/2026 at 12:40 PM the Wound Nurse stated she started at the facility last week and today was her first day completing skin assessments in the building. She will come on Wednesdays to complete skin assessments. She stated skin assessments should be completed every 7 days and should include measurements and wound characteristics to include any changes in the wound.On 5/6/2026 at 1:33 PM the Director of Nursing (DON) stated skin checks are to be completed weekly on the resident's bath day. They hired a Wound Nurse that will come in every Wednesday to complete skin assessments, obtain measurements, notify providers if treatments need to be adjusted and complete documentation. The DON stated wound measurements should be obtained and documented weekly along with the wound appearance. When asked what it meant when an order is not signed out on the TAR, she assumed or would say the order was not completed. If there is no documentation, it was not done. She added if something is done, document it.The facility provided a document titled Medication Administration with a reviewed date of 5/2022. It is the policy of this facility that medications shall be administered as prescribed by the attending physician. The seven rights of medication administration are as follows to ensure safety and accuracy of administration:6. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns.The facility provided a document titled Skin/Wound Management with a revision date of 5/2007. It is the policy of this facility to have a routine skin/wound assessment completed by a nurse. A skin alteration is identified as an Arterial Ulcer, Diabetic Neuropathic Ulcer, Pressure Ulcer, Venous Insufficiency Ulcer, Surgical Wound, and Lacerations.PROCEDURES:1. A skin review will be completed on all residents routinely and documented in the Electronic Health Record (EHR) by a nurse.2. Any identified wounds will be assessed routinely.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, observations, resident interviews, staff interviews, and policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 2 of 2 residents (Resident #12, #13) reviewed, requiring the use of oxygen. The facility failed to provide oxygen as documented in the physician orders. The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 indicating moderate cognitive impairment. The MDS recorded diagnoses of hypertension, diabetes mellitus, Non-Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease (COPD). The MDS revealed the resident utilized oxygen while a resident and during the last 14 days of the assessment period. The Care Plan revised on 5/1//26 identified Resident #12 has an altered cardiovascular status related to hypertension with interventions of giving oxygen as ordered by the physician initiated on 1/22/26. The document included use of oxygen therapy related to ineffective gas exchange due to the history of COPD initiated 5/1/26 with interventions of oxygen per physician orders, oxygen via nasal prongs at 2-4 liters per minutes (lpm) continuously initiated 5/1/26. The document revealed the need for assistance to and from the activity area and wear oxygen at all times with interventions including wearing oxygen at all times, having a portable unit and use of portable concentrator initiated 1/15/26. The clinical record's Physician Orders revealed oxygen 2-4 lpm via nasal cannula or mask every shift for COPD ordered 1/11/26. Review of the Medication Administrator Record (MAR)/Treatment Administration Record (TAR) for 4/26 found lack of documentation on 4/16/26 day. Observed on 4/28/26 at 12:00 PM Resident #12 seated in the dining room with oxygen via nasal cannula and use of a concentrator set at 3 lpm. Observed on 5/4/26/at 12:46 PM Resident #12 seated at the dining room table with head down towards table. Observed the nasal cannula in place, the concentrator plugged in but not turned on. The resident presented with a congested cough.Continuous observation with interviews on 5/4/26 at 12:49 PM provided Staff A, Certified Nurse Assistant (CNA) and Staff B, CNA/Certified Medication Aide (CMA)/Housekeeping Supervisor approached Resident #12 with Staff A pushing button to turn the concentrator off only to turn the concentrator on. Observed Staff A and Staff B look at each other with Staff A stating the concentrator was not on. Observed Staff B proceed to remove the nasal cannula from Resident #12 and prompted the resident to walk to her room. Observed Staff B and Resident #12 using a 4 wheeled walker to walk to the resident's room. Requested Staff C, Registered Nurse (RN), to obtain an oxygen saturation from the resident. With Resident #12 seated on the edge of her bed, Staff C obtained an oxygen saturation from the resident of 76%. Staff C stated CNAs can move concentrators within the facility. Staff C stated Resident #12 had an order for continuous oxygen at 2-4 lpm. When asked if an oxygen saturation of 76% could be the result of not having her oxygen on, Staff C confirmed with Staff A that the resident did not have her oxygen on prior to the assessment and Staff A confirmed the resident did not have oxygen on. With the confirmation of Resident #12 not having her concentrator turned on, Staff C stated the low saturation could be the result of that. Resident #12 stated she was short of breath prior to the oxygen being turned on in the room. Staff C stated she would be coming back to check on the resident and in the future she would be double checking to ensure the resident's concentrator was turned on. Observed on 5/4/26 at 12:58 PM Staff C return to Resident #12's room and reported the resident's oxygen saturation was 94% with 3 lpm. Observed on 5/4/26 at 1:56 PM Resident #12 walk into the dining room with the nasal cannula in place and the remaining oxygen tubing dragging on the floor behind her. Observed Staff E, Agency CNA, intervene, remove the oxygen tubing, carry it back to the resident's room, connect it to the resident's concentrator and move the concentrator to the dining room for the resident to attend an activity.On 5/4/26 at 2:00 PM Staff E confirmed she had picked the resident's oxygen tubing up off the floor to prevent the resident from tripping on it, connected it to the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator and moved the concentrator to the activity for resident's use. The staff stated CNAs were allowed to move concentrators within the facility.On 5/4/26 at 2:05 PM Staff B confirmed Resident #12's oxygen concentrator was not on following the noon meal. The staff stated when finding oxygen not on when it is supposed to be she would immediately turn the oxygen on. The staff stated she did not know who had brought the concentrator out for the noon meal. When asked what she would do if found, she stated she would turn it on and ask whoever brought the resident out why they had not turned the oxygen on. The staff confirmed that CNAs could move oxygen tanks within the facility. 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 revealed a BIMS score of 11/15 indicating moderate cognitive impairment. The MDS recorded diagnoses of hypertension, depression, and COPD. The MDS revealed the resident utilized oxygen while a resident and during the last 14 days of the assessment period. The Care Plan revised on 5/4/26 revealed an alteration in respiratory related to COPD with interventions of giving oxygen therapy as ordered by the physician, checking oxygen tank frequently when in use to ensure it was not empty initiated 9/17/22. The document included use of oxygen therapy related to hypoxia secondary to COPD with an intervention of oxygen settings as ordered revised on 1/11/23. An additional area on the document revealed the need for oxygen when coming out to activities if the level was too low with interventions of ensuring the resident has oxygen when needed and assistance to turn on the portable oxygen tank on the wheelchair.The clinical record's Physician Orders disclosed an order to apply oxygen at 2 lpm via nasal cannula to keep oxygen levels above 90%, check oxygen saturations every shift for hypoxia ordered 3/19/26. The 4/26 MAR-TAR revealed no documentation on 4/27/26 day. The 5/26 MAR -TAR revealed the resident had oxygen saturation of 73%. The Physician's Orders revealed staff were to check the oxygen tank to ensure it was not empty every shift with an order date of 12/30/25. The 4/26 MAR-TAR lacked documentation on 4/14/26 day and 4/28/26 night. Observed on 4/28/26 at 12:00 PM Resident #13 seated at the dining room table with oxygen via a nasal cannula using a portable oxygen tank (E-tank) set at 2 lpm. Observed on 5/4/26 at 12:40 PM Resident #13 without nasal cannula, the E-tank set at 2 lpm and the tank reading empty. Continuous observation on 5/4/26 beginning at 1:11 PM revealed Staff H, Nurse Consultant, stop and look at Resident #13's oxygen tank. The staff applied the nasal cannula, obtained a tank key from the nurses station and turned the lock on the tank. The staff left the resident, and returned carrying a new E-tank. Following return and request of resident's oxygen saturation, Staff H stated the resident's initial oxygen saturation was 81% then moved to 85%. The staff proceeded to change the oxygen tanks and turn the tank on. On 5/4/26 at 1:19 PM Resident #13 stated she used oxygen most of the time. The resident stated she was short of breath prior to the staff applying the oxygen.On 5/4/26 at 1:22 PM Staff H stated she had observed Resident #13 did not have her oxygen on when she normally had it. The staff stated she went and obtained a key to make sure the oxygen was on and it was, but the tank read empty therefore she obtained a new tank. The staff stated with resident's saturations in 80 percentiles the resident required the oxygen to be applied.On 5/5/26 at 3:00 PM the DON stated she expected a concentrator to be turned on when it was plugged in and the nasal cannula in place. The Administrator present during the conversation concurred. On 5/6/26 at 1:52 PM The DON stated CNAs can walk residents with oxygen. The DON stated if a tubing end was on the floor it should be disposed of and new tubing obtained. The DON stated the expectation was oxygen to be used as per physician orders with tanks and concentrators to be turned on. The facility's undated Oxygen Administration Policy revealed oxygen therapy was administered as ordered by the physician. The document included that the unit should be turned on to the desired flow rate, assess for proper functioning, apply to the resident and reassess the oxygen flowmeter for correct liter flow.