STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165502	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Home	915 West First Street Sumner, IA 50674

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. 25858 Based on clinical record review, policy and procedure review, and staff interviews the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 5 resident reviewed. (Resident #1). The facility identified a census of 47 residents. Findings include: The Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 3/5/24, documented diagnoses which included hypertension, Non-Alzheimer's Dementia, anxiety, and repeated falls. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired decision making abilities, has hallucinations and delusion, and required partial/moderate assistance with shower/bathing. The Plan of Care with an initiated date of 2/27/24, stated the resident had a functional performance self-care deficit related to dementia. Interventions include: Bathing/Showering: Resident is able to have a bath or shower. Bath days per Care Plan. Shower transfer EZ stand times 2 assist. Transfer/Ambulation: is contact guard assist of 1 with walker The Progress Notes dated 4/30/24 at 11:38 a.m., Incident Report: Describe Incident: Staff A, Certified Nursing Assistant (CNA), called this nurses office and asked if Staff B, CNA, came back into the building. Staff A reports that Staff B was to be giving resident a bath in the south tub room. The facility Administrator, immediately went to the tub room to check. The curtain had been pulled so resident wasn't seen until the Administrator pulled back the curtain, and found the resident sitting in her wheelchair in the tub room, without a call light. The Administrator then brought resident out of the tub room and notified floor staff that she had not gotten her bath. Vitals: not done, ROM and Pain: not done, Injuries noted: no injuries as resident was still sitting in her wheelchair. Treatment Provided: CNA's took resident and went to give her a shower. Interventions in place at time of Incident: Resident is to have a call (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	light within reach when left unattended. Interview on 5/29/24, at 12:00 p.m., the facility Administrator and Staff C, Registered Nurse (RN) stated that they seen Staff B, CNA, on the video ring door bell leaving the facility at 8:50 a.m. The administrator stated that over the walkie talkie it was told that Resident #1 was not in the dining room for breakfast and if anyone had seen her. The administrator and Staff A started to look for Resident #1. Resident #1 was found in the shower room, with the lights off, shower curtain pulled around the resident, no call light with in reach, sitting in her wheelchair. Interview on 5/29/24 at 2:00 p.m., Staff D, CNA, stated that around 9:00 a.m. the kitchen staff were asking if anyone had seen Resident #1. Staff D stated that they started to ask if anyone had seen Resident #1 over the walkie talkie with no response from staff. Staff D stated that around 9:10 a.m., a voice came across the walkie talkie that Resident #1 was found in the shower room. Interview on 5/30/24 at 9:00 a.m., the facility Administrator confirmed and verified that the expectation of the staff are to treat all residents with dignity and respect. The Resident Rights policy with no date, given by the Administrator on 5/30/24 at 10:20 a.m., documented, the resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility. The resident has a right to be treated with respect and dignity and to be cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing the resident individuality.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on record review, facility policy and procedure, and staff interviews, the facility failed to follow physicians orders for 2 of 4 residents reviewed for medication administration. (Resident #3 and Resident #4). The facility reported a census of 47 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 for which indicated no cognitive impairments. The MDS indicated the resident had diagnoses which included hypertension, seizure disorder, and cyst of pancreas. The MDS also revealed the resident received a diuretic and an antiplatelet in the last 7 days. Resident #3 Care Plan initiated on 4/12/22 indicated the resident will be prescribed the minimum amount of medications necessary. The interventions with an initiate date of 10/5/22 directed staff to consult pharmacist to review medications, Resident prefers not to be woke up for medications between 10:00 p.m.- 6:00 a.m. and prefers to take medications in her room to promote socialization when going to dining room for meals. Review of the Nurse Progress Notes dated 5/2/24 at 11:18 a.m., revealed Incident Report-Medication Event: This nurse noticed that this nurse gave resident the wrong medications this morning. Immediately this nurse notified the Director of Nursing (DON). Resident received the following medications: Metolazone 2.5 milligrams (mg) Carvedilol 6.25 mg Depakote 100 mg Eliquis 5 mg Januvia 25 mg Lisinopril 2.5 mg Metformin 100 mcg Protonix 20 mg Torsemide 20 mg Vitamin D3 2000 IU Resident was supposed to receive Calcium 120 mg (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plavix 75 mg Depakote 500 mg Colace 100 mg Lasix 40 mg Gabapentin 100 mg Levetiracetam 500 mg Synthroid 75 mcg Lisinopril 30 mg Tylenol 500 mg Vital Signs will be taken every 1 hour for 24 hours. Blood sugars will be checked every 4 hours. A Root Cause Analysis Report dated 5/2/24, described that the event happened where two residents medications where set up at the same time to get medications done in a more timely manner and that staff felt the need to complete medication pass quickly and Resident #3 received the wrong medications. 2. The MDS dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairments. The MDS indicated the resident had diagnoses which included hypertension, seizure disorder, and cyst of pancreas. The MDS also revealed the resident received a diuretic and an antiplatelet in the last 7 days. Resident #4 Care Plan initiated on 6/30/21 indicated resident will be prescribed the minimum amount of medications necessary. The interventions with an initiate date of 8/24/21 directed staff to consult pharmacist to review medications, Resident will be administered medications in her room/hallway/common areas to promote socialization during meals. Resident would prefer not to be woken up between 10:00 p.m., - 6:00 a. m. for medication administration. (per interview). Review of the Progress Notes dated 5/17/24 at 9:37 a.m., documented, Incident Report-Medication event: On 5/10/24, resident had a critically low Potassium, new orders were received from the Doctor to give additional 40 meq for 3 days. The new cards were found in the bottom drawer of the medication cart with no doses popped out. When reviewing the emergency kit, it was noted that 1 dose was taken from the kit. It appears that resident didn't get 2 of the doses. The Potassium was 3.6 on redraw on 5/15/24. A Root Cause Analysis Report dated 5/15/24, described the event happened when medication cards were put in the bottom of the medication cart. The person working the medication cart was busy when the medications arrived and medication doses weren't checked when given, and didn't verify dose, so the resident missed 2 doses of potassium. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/30/24 at 10:40 a.m., the facility Administrator confirmed and verified that the expectation of the staff are to follow the physicians orders as written and to follow the policy for giving oral medications. The Policy/Procedure for giving Oral Medication Administration with no date, documented the purpose: to provide a medication regiment safely and effectively, and to administer medications in a simple routine for the resident. *Seven Rights= right dose, right time, right route, right medication, right resident, right reason, right documentation.