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	02/27/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff and family interviews, and policy review the facility failed to make prompt efforts to resolve and investigate a complaint/grievance and actively work toward resolution for 1 of 1 complaint letters reviewed (Resident #2). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 document a Brief Interview for Mental Status (BIMS) of 11 indicating she was moderately cognitively impaired. The MDS also documented she needed supervision or touching assistance with transfers, toileting, and walking. The MDS informed she had diagnoses of diabetes mellitus, heart failure, depression, anxiety, and a prognosis with a life expectancy of less than six (6) months to live. Record review of a letter to the facility dated 1/7/25 from Family Member #1 for Resident #2 informed the facility of the following concerns identified with the care of their loved one: a. Delay in receiving pain medication for Resident #2 when actively dying on 12/22/2024 b. Incompetent nursing knowledge of state regulations regarding Staff C, Licensed Practical Nurse (LPN) c. Lack of sufficient staff in the building on 12/22/24 d. Lack of Hospice and facility integrated nursing care on 12/22/24 Record review of a untitled document from the Administrator dated 1/10/25 documented an investigation completed into Staff C interactions with Resident #2 Family Members and Staff C. Record review of a statement email from Staff C, Licensed Practical Nurse (LPN) dated 2/25/25 documented interactions had with Resident #2 family on 2/22/25. Record review of a statement email from Staff B, Registered Nurse (RN) dated 2/26/25 documented interactions had with Resident #2 family on 2/22/25. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 2/27/25 at 11:45 AM revealed she received a letter dated 1/7/25 by mail from Family Member #1 for Resident #2 regarding care received at the facility on 12/22/2024 and revealed when she read the letter she could not believe the family was upset with the care provided to Resident #2. She informed she spoke with them on 12/23/24 and they were complimentary of the care received at the facility. She revealed Family Member #1 called her roughly three (3) weeks after receiving the letter and questioned what she was able to find out, she revealed she informed her she was not able to disclose specific actions and was taking care of any issues that she found. She then revealed Family Member #1 became upset and asked, Am I just supposed to believe you?. She then informed she never provided Family Member #1 with a formal response to her concerns from her letter dated 1/7/25 about the following key areas of concern for Resident #2. a. Delay in receiving pain medication for Resident #2 when actively dying on 12/22/2024 b. Incompetent nursing knowledge of state regulations regarding Staff C, Licensed Practical Nurse (LPN) c. Lack of sufficient staff in the building on 12/22/24 d. Lack of Hospice and facility integrated nursing care on 12/22/24 Review of the facilities Grievance Policy last revised 12/2/2022 instructed the following: a. The grievance official will be responsible for overseeing the process, receiving, and tracking all grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary considering specific allegations. b. The grievance official will notify the individual who filed the grievance that it has been received and explain the process of the investigation if it was completed verbally or in writing. The investigation will be informal but thorough, affording all interested persons and their representatives an opportunity to submit evidence relevant to the grievance. c. The grievance official will issue a written decision determining the validity of the grievance no later than 30 days after its filing. d. The grievance official will take appropriate corrective action in accordance with the Iowa law if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the state survey agency, quality improvement organization, or local law enforcement agency confirms a violation of any of these resident's rights within its area of responsibility.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff and medical provider interviews, and policy review the facility failed to implement root cause analysis interventions for previous falls resulting in a fall with fracture, and to thoroughly assess a resident for possible injury after a fall for 1 of 3 residents reviewed for falls (Resident #1). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 4 indicating severe cognitive impairment. The MDS documented she was dependent on staff for eating, toileting, transferring, and does not walk. The MDS also informed she had diagnoses of compression fracture of the third (3rd) lumbar vertebra (spine in the lower back), anxiety, and depression. Record review of a Progress Note dated 2/12/2025 at 1:59 PM for Resident #1 documented she had an unwitnessed fall in her room at 1:53 PM and was found sitting in her doorway with her back against the door frame facing into the room and during active range of motion she admitted to having some pain to her left leg and was not able to bear weight to her left leg or able to bend at the hip past 90 degrees, and may have a possible fracture to the left hip/leg. Record review of a Progress Note dated 2/12/2025 at 2:10 PM for Resident #1 documented she had an unplanned/emergent discharge at this time as her medical status was unstable and left the facility by ambulance. Record review of Resident #1 Care Plan on 2/25/25 documented the following falls and interventions implemented since her admission to the facility: a. Fall 12/24/24, high low bed, date initiated: 1/1/25 b. Fall 12/26/24, high low bed, date initiated: 1/1/25 c. Fall 1/2/25, education to Certified Nurse Aide (CNA) who left Resident #1 bed in high position that it need to be in lowest position, date initiated: 1/8/25 d. Fall 1/31/25, do not leave out of sight in retreat room, date initiated: 2/14/25 e. Fall 2/10/25, offer toileting on walking rounds, date initiated: 2/10/25 f. Fall 2/12/25, motion sensor in room and/or personal alarm attached when in bed, wheelchair, recliner, date initiated: 2/12/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of an untitled statement by Staff I, Certified Medication Aide (CMA) dated 2/14/25, documented she found Resident #1 on the floor in her doorway on 2/12/25 and heard and saw Resident #1 yelling my hip, my hip while on the floor then when she came back she saw her sitting in her wheelchair. Record review of a Discharge Summary dated 2/17/25 from a local hospital for Resident #1 documented she was diagnosed with a left hip closed fracture on 2/12/25. During an interview on 2/27/25 at 11:45 AM the Administrator revealed she spoke with Resident #1 after her fall on 2/12/25 and she could not remember if her hip hurt before or after the staff got her up off of the floor, she also informed she would expect staff not to move a resident if complaining of hip pain. During an interview on 2/27/25 at 11:40 PM the Director of Nursing (DON) reveled Resident #1, prior to her fall on 2/12/24, was not able to walk with facility staff, but was able to transfer with one (1) staff member by pivoting to desired locations. She then informed she educated Staff E immediately after Resident #1 fell and informed her residents are not to be moved from the floor if they are complaining of pain or other signs of possible broken bones and to immediately call the ambulance. She then informed the facility is looking at every residents prior falls and current Care Plans to ensure interventions implemented were appropriate and still relevant to meet the residents needs. During an interview with Staff E, Registered Nurse (RN) on 2/27/25 at 12:58 PM revealed she was the nurse that assisted Resident #1 with her fall on 2/12/25 and informed she found her in the doorway of her room on the floor, informed Resident #1 said she was embarrassed and forgot to call for help. Staff E then informed when staff assisted her to stand with three other staff Resident #1 had pain when standing. During an interview on 3/4/25 at 10:05 AM with Resident #1's Primary Care Provider, Staff H, Advanced Registered Nurse Practitioner (ARNP) informed Resident #1 has memory issues at times and at others can be spot on. She informed when Resident #1 fell on [DATE] she would expect staff not to move her especially if there were signs of rotation of the hip joint or shortening of the legs and wait for the ambulance to transfer her safely. She informed she also saw Resident #1 today at the facility and she is doing well and making progress in therapy and rarely complains of pain. Record review of Falls Incident/Accident Prevention dated June 2024 lacked documentation the facility will implement root cause analysis related to each fall.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff and family interviews, and policy review the facility failed to promptly implement a new order for 1 of 3 residents reviewed for pain (Resident #2). The order given was to increase the dosage of as needed (PRN) Morphine (narcotic liquid pain medication) for an actively dying resident. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 document a Brief Interview for Mental Status (BIMS) of 11 indicating she was moderately cognitively impaired. The MDS also documented she needed supervision or touching assistance with transfers, toileting, and walking. The MDS informed she had diagnoses of diabetes mellitus, heart failure, depression, anxiety, and a prognosis with a life expectancy of less than six (6) months to live. Record review of Resident #2 Controlled Drug Record for her morphine dated 12/21/24 documented the last dose of morphine at 0.25 mL was given on 12/22/24 at 1:30 PM. Record review of a document titled, Fax Transmittal from Resident #2 Hospice provider dated 12/21/24 at 1:52 PM revealed a signed order to increase her morphine order at this time to give 0.5 mL every hour as needed. Record review of Resident #2 Controlled Drug Record for her morphine dated 12/21/24 documented the first dose of morphine at 0.5 mL was given on 12/22/24 at 4:45 PM. During an interview on 2/25/2025 at 9:23 AM with Family Member #1 for Resident #2 revealed on 12/22/24 Staff C, Licensed Practical Nurse (LPN) delayed giving Resident #2 pain medication for almost two hours and by then it was two hours too late. She saw her mom in pain and having difficulty getting air. Staff C finally checked the fax machine and saw the order and said maybe she should have checked it earlier. She then informed a family member would have to go and get Staff C to make sure Resident #2 would get pain medication, the facility never would come and check on her by themselves, it was like a skeleton crew working and she ended up passing away that night. During an interview on 2/25/25 at 5:30 PM with Family Member #3 for Resident #2 revealed on 12/22/24 she could tell sometimes that there was distress or discomfort from Resident #2 and the staff would give her pain medication and then it would be better. During an interview on 2/25/25 at 4:26 PM with Hospice Nurse #1, Register Nurse (RN) Clinical Manager revealed a delay in increasing the pain medication for several hours could cause the resident to be in distress depending on if she is having pain or air hunger and could make the resident be uncomfortable. During an interview on 2/27/25 at 11:45 AM the Administrator revealed she would expect orders be implemented as soon as they come in and not be delayed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 11:40 AM the DON revealed she would have expected Resident #2's order to increase pain medication be implemented immediately when it came in. During an interview with Resident #2 Primary Doctor on 3/4/25 at 3:33 PM revealed he would expect an as needed pain medication be given timely if signs of pain or air hunger were being shown.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff, family, and provider interviews, and policy review the facility failed to obtain an order to increase an as need (PRN) morphine (liquid pain medication) order for 1 of 3 residents reviewed who was actively dying (Resident #2). The facility also failed to obtain orders prior to suctioning a resident during end of life cares for 1 of 1 residents (Resident #2). The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #2 document a Brief Interview for Mental Status (BIMS) of 11 indicating she was moderately cognitively impaired. The MDS also documented she needed supervision or touching assistance with transfers, toileting, and walking. The MDS informed she had diagnoses of diabetes mellitus, heart failure, depression, anxiety, and a prognosis with a life expectancy of less than six (6) months to live. Record review of Resident #2 discontinued, current, and completed morphine orders in her Electronic Health Record (EHR) on 2/25/25 at 12:15 PM revealed a new order for morphine 1 mL was received on 12/22/24 at 20:45 PM. Record review of Resident #2 Progress Notes on 2/27/2025 at 3:45 PM lacked documentation of the Doctor who prescribed the increased morphine order from 0.5 mL to 1 mL on 12/22/24 and revealed it was ordered by a Hospice Nurse. During an interview on 2/25/25 at 4:26 PM with Hospice Nurse #1, Registered Nurse (RN) Clinical Manager revealed the Hospice provider only gave orders for Resident #2 pain medication to be increased on 12/22/24 from 0.25 mL to 0.5 mL and does not have record of them increasing it to 1 mL. She then informed she spoke with the Director of Nursing (DON) at the facility today and they are unable to find documentation as well. During an interview on 2/27/25 at 11:45 AM the Administrator revealed she would expect to be able to locate a signed order for the increased dose of morphine to 1 mL for Resident #2 on 12/22/2024. During an interview on 2/27/25 at 11:40 AM the DON revealed if a new order is obtained from a Doctor regardless of what it is she would expect a paper trail like a telephone order or fax to show the Doctor signed and approved the order. During an interview with Resident #2 Primary Doctor on 3/4/25 at 3:33 PM revealed he does not have record of ordering Resident #2 morphine medication from 0.5 mL to 1 mL however if signs at the time of being given revealed her pain was not under control it would have been reasonable to prescribe 1 mL to keep her comfortable. 2. During an interview on 2/25/2025 at 9:23 AM with Family Member #1 for Resident #2 revealed Staff C, Licensed Practical Nurse (LPN) suctioned Resident #2 on 12/22/2024 and informed the family she probably made their mother very mad. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 5:30 PM with Family Member #3 for Resident #2 revealed on 12/22/24 she could tell sometimes that there was distress or discomfort from Resident #2 and the staff would give her pain medication and then it would be better. During an interview on 2/25/25 at 4:26 PM with Hospice Nurse #1, Registered Nurse (RN), Clinical Manger revealed suctioning is something we do not encourage our nurses to do as a Resident can become extremely agitated. We try to avoid that at the end of life. The secretions are not just in their mouth, they are deep down lower in their lungs, and you are unable to get to them with suctioning. During an interview on 2/27/25 at 11:40 PM the Director of Nursing (DON) revealed she does not think Resident #2 had an order for suctioning, and Staff C suctioned Resident #2 on 12/22/24 because her family was asking for them to suction her and she tried to make the family comfortable.