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	07/02/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and policy review the facility failed to protect residents from misappropriation of property when resident medication became missing from the facility for 2 of 2 residents reviewed (Resident #40 and Resident #49). The facility reported a census of 51 residents. Findings include:A Facility Self Report to the Department of Inspections, Appeals and Licensing (DIAL) by the Administrator on 6/21/26 at 3:50 p.m. revealed 54 doses of Hydromorphone (a highly potent, semi-synthetic opioid analgesic (narcotic) used to treat moderate to severe pain) for Resident #40 and on 6/26/26 13 doses of Hydrocodone (a potent, semi-synthetic opioid prescribed to manage severe chronic pain and suppress coughs) for Resident #49 was missing from the narcotic drawer in the medication cart. On June 20th, 2026 at approximately 7:30 p.m. Staff K, Certified Medication Aide (CMA) went to give Resident #40 his Hydromorphone out of the bubble pack per his request. Staff K noted the bubble pack was missing. Staff K notified Staff D, Licensed Practical Nurse (LPN) and Staff K, Staff D, and Staff L, Registered Nurse (RN) immediately began looking for the bubble pack. The Director of Nursing (DON) and Administrator were notified of the missing narcotic. At approximately 8:10 p.m. Staff D found the torn top of the bubble pack for the hydromorphone with Residents Name on it in the shred box. They continued the search and found Resident #40's Lorazepam narcotic count sheet was missing. Resident #40's hydromorphone narcotic sheet was located in the binder. Through the investigation they also found on 6/26/26 Resident #49's Hydrocodone bubble pack and narcotic count sheet was missing. According to the pharmacy, it was filled for 30 doses on 4/13/26 and the last card was empty on 4/17/26. Since 4/17/26, she has only received 17 doses, so there should be 13 doses remaining. 1. Resident #40's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severely impaired cognition. The MDS included diagnoses of heart failure, hypertension, non Alzheimer's disease, anxiety and depression. The MDS also reported Resident #40 was dependent to roll left and right, for sit to lying, for sit to stand, for chair/bed to chair transfer, and toilet transferThe Care Plan initiated on 11/10/24 revealed Resident #40 had chronic pain related to aging and took medication as needed. The Care Plan directed staff to anticipate Resident #40's need for pain relief and respond immediately to any complaint of pain (intervention dated 11/10/24). The Physician Order dated 4/16/26 for Resident #40 revealed, Hydromorphone Hcl Oral Tablet 2 milligrams (MG), with directions to give 0.5 tablet by mouth every 2 hours as needed for shortness of breath(SOB)/pain. The June 2026 Medication Administration Record (MAR) revealed the resident took multiple doses of the medication in June 2026. 2. Resident #49's Minimum Data Set (MDS) assessment dated for 4/17/26 identified a BIMS score of 11 out of 15, indicating moderately impaired cognition. The MDS included diagnoses of non Alzheimer's disease, anxiety and depression. The MDS also reported Resident #49 was dependent for sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfer. Per this assessment, the resident took opioid medication. The resident's pain interview completed as part of the MDS assessment revealed the resident occasionally experienced pain or hurting over the last 5 days which occasionally made it hard to sleep at night, and occasionally limited participation in rehab therapy sessions and day to day activities. The Care Plan revised on 3/18/26 (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #49 had acute pain related to a fracture of right humerus, fracture of T11-T12 vertebra, and dislocation of left humerus. The Care Plan directed staff to administer pain medications per order, if non-medication interventions were ineffective, evaluate effectiveness of pain relieving interventions, evaluate for non-verbal indicators of pain, and evaluate pain (interventions dated 10/24/25). The June 2026 MAR directed hydrocodone-acetaminophen oral tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for pain (ordered 2/17/26). Per the MAR, the last dose shown given was on June 16, 26. The facility was not able to provide the Controlled Drug use Record June 2026, due to it missing. A facility form titled Between Shift Narcotic Count Sign-off Log for [NAME] and Midwest medication carts documented staff who signed the form, acknowledge transfer of responsibility for the narcotic count and have found that the quantity of each medication counted to be in agreement with the quantity stated on the Narcotic Count Sign-off Log. The record required documentation of the Nurse on signature and the Nurse off signature for each shift. Review of the count record for [NAME] and Midwest Narcotic Count Sign-off Log revealed lack of staff signatures, indicating reconciliation of controlled medications for [NAME] and Midwest hall did not occur on the following month of June 2026, dates and shifts:Review of the narcotic count sign off log on 6/30/26 at 12:04 pm for the [NAME] to Midwest medication cart:6/14/26 at 10:00 p.m. only one signature6/17/26 at 6:00 a.m. only one signatureEast medication cart narcotic count sign off log revealed:6/14/26 6:00 p.m. only one signature6/14/26 at 10:00 p.m. only one signature6/15/26 at 2:00 p.m. only one signature6/15/26 at 10:00 p.m. only one signature6/20/26 at 6:00 a.m. only one signature6/20/26 at 2:00 p.m. no signature6/20/26 at 10:00 p.m. only one signature6/24/26 at 2:00 p.m. only one signatureInterview on 6/30/26 at 10:45 a.m. with Staff K confirmed that she worked June 19th, 20th and 21st, 2026 and came into work at 2:00 p.m. on June 20th, 2026. Staff K acknowledged that she didn't count the narcotics with Staff M, Registered Nurse (RN) due to the fact that she had been there since 6:00 a.m. Staff K stated she went to give Resident #40's Hydromorphone around 7:30 p.m. and went to get into the narcotic drawer and the whole medication pack was gone. Staff K stated that she called Staff D and let her know and she came back in and they looked through all the medication carts and the narcotic sheets and that is when they found Resident #40's Lorazepam narcotic sheet was gone. The Hydromorphone narcotic count sheet was still in the binder. Staff K stated they looked through the East medication cart and it wasn't in there either. Staff K stated that Staff D contacted the Administrator, Director of Nursing (DON), and police of the missing narcotics. Interview on 6/30/26 at 12:45 p.m. with Staff D, Licensed Practical Nurse (LPN) revealed she worked June 20th, 2026 at 2:00 p.m. Staff D stated that she was the desk nurse which meant she was responsible for all nursing duties except to pass medication. Staff D stated that she went home early that night and came back in when Staff K called and let her know there were missing narcotics. Interview on 6/30/26 at 2:24 p.m. with Staff J, LPN verified that she worked June 19th and 20th. She stated she wasn't aware of any missing narcotics. Staff J stated that she didn't count narcotics on the morning of the 20th when she left for the day. Staff J stated that she was giving report to the nurses and two nurses came up and grabbed the keys, so she figured they were going to count together. Staff J stated that when she came into work the night of the 20th, they counted narcotics and the only medications missing were the hydromorphone. Interview on 6/30/26 at 4:18 p.m. with Staff N, LPN verified that she worked June 19th, 20th and 21st. Staff N verified that she was not on the medication cart on June 19th. Staff N verified on Saturday that she was on the West/Midwest medication cart training another nurse. She was with her until 2:00 p.m. that day until Staff K came in. She stated that she gave Staff K the keys to the medication cart. Staff N acknowledged that she did not do narcotic count with Staff K. Staff N acknowledged that the staff normally did not do narcotic count and they don't seem to be worried about it either. Interview on 6/30/26 at 8:17 p.m. with Staff P, verified that she worked the weekend of June 19th, 20th and 21st, she stated that she was not on the medication cart that weekend. Staff P stated that she was the skin nurse on the 19th and then on the 20th she was the desk nurse. Staff P stated that on a very rare occasion the nurses would count (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the narcotics. Staff P stated that the nurses would sign at different times that the narcotic count was completed. Staff P stated that when that happened, she would count the narcotics twice in the medication cart she was assigned to. Interview on 7/1/26 at 8:38 a.m. with Staff M, RN, verified that she was in training on June 19th, 20th and 21st. She stated that she didn't have access to the medication cart, but did not see anyone do the narcotic count. Staff M stated that Staff P left and Staff K came in and Staff M didn't see them do narcotic count. Staff M didn't believe her and Staff K did narcotic count together either. Staff M stated that it was Saturday night after [Staff M] left they discovered the medication missing. Staff M stated that when [Staff M] asked the nurses about narcotic count they stated that we don't do narcotic count. Interview on 7/1/26 at 12:52 p.m. with Staff L, RN verified that she worked June 19th and June 20th. Staff L verified that she did not do a narcotic count the morning of June 19th. Staff L stated she was late to work and the nurses gave her the keys and said they did count and everything was okay. Staff L stated that she was assigned to the main and east medication cart. Staff L stated she did a narcotic count herself and everything was accounted for. Staff L stated that when she left for the evening on the 19th that the nurses refused to do narcotic count with her. Staff L stated that when she arrived the morning of the 20th, they again did not do narcotic count. Staff L stated that they generally don't do narcotic count. Staff L stated that at first it bothered her but now she was like whatever. Staff L stated that Staff K came over to her medication cart on June 20th at 8:00 p.m. and went through the medication cart due to the hydromorphone missing. Staff L stated it wasn't in either main or east medication cart. On 7/2/26 at 8:49 a.m., re-interview with Staff K verified that on June 20th at 2:00 p.m. she did not do a narcotic count on west and midwest medication cart. Interview on 7/1/26 at 12:20 p.m. with the DON revealed the expectation was to do the narcotic count anytime the cart changes possession of the staff member. The DON stated that the two staff members sign off at the same time. Review of the facility policy named Nursing Facility Abuse Identification, Prevention, Investigation, Protection and Reporting Policy revealed, in part, all residents have the right to be free from misappropriation of property. The definition of misappropriation of property per the policy revealed the following: the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications. Review of the facility policy named Narcotic Count dated June 2019 revealed the purpose is to ensure an accurate count of each individual's residence narcotics supply, to ensure safe storage of narcotics, and to ensure drugs are disposed of appropriately. The narcotic supply is to be kept under two locks at all times in the medication room.The Procedure Section revealed the following: The licensed nurse going off duty and the licensed nurse going on duty must count and justify accuracy of narcotic supply for each individual resident at the change of each shift. Schedule Two narcotics are required to be counted. Other controlled medications are counted according to facility policy. Narcotic records are reconciled by a physical count of the remaining narcotics supply at the change of each shift by the oncoming and outgoing licensed nurse. Records are retained for at least one year. Emergency kits containing narcotics will be checked at the same time to be sure the seal has not been broken or will be reconciled if kit is not sealed. Narcotic keys will be accounted for at the same time. No more than one prescription for a controlled substance is entered on one individual residence narcotic sheet. After the supply is counted and justified, each nurse must record the number of narcotic records, the date, and their signature verifying that the account is correct. If the account is not accurate the nurse going off duty is to remain on duty until the count is reconciled or the nurse supervisor approves leaving the facility. Discrepancies found at any time, change of shift or other, are to be immediately reported to the Director of Nursing. The Director of Nursing will investigate to determine the cause of inaccuracy and will contact the pharmacist for assistance as needed. To destroy any narcotics always have two nurses present. Use a drug disposal system and follow a manufacturer's instructions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, electronic health record (EHR) review, facility document review, policy review, and resident and staff interviews, the facility failed to consistently respond to activated call lights within a timely manner for 1 of 17 residents reviewed (Residents #47). The facility reported a census of 51 residents.Findings Include:Resident #47's Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS listed Resident #47 required partial/moderate assistance for toileting hygiene and for toilet transfers. The MDS included diagnoses of urinary tract infection, osteoporosis, hyperlipidemia, and renal insufficiency. The Care Plan Focus initiated 5/29/26 identified Resident #47 had impaired mobility. The Interventions included to ensure the call light was available to the resident and to evaluate the resident's ability to activities of daily living (ADLs) (everyday tasks).The Care Plan Focus initiated on 5/29/26 for Resident #47 revealed, Safety. Interventions directed staff to use safety measures including strategies to reduce the risk of infection, fall, or injury. The Care Plan Focus initiated on 5/30/26 identified a functional performance deficit related to increased weakness from transient ischemic attack (a temporary blockage of blood flow to the brain that produces stroke-like symptoms). Interventions directed staff that Resident #47 required limited assist (one-person physical assist) for ambulation, personal hygiene, toilet use, and transfers. The Care Plan Focus initiated on 6/16/26 identified Resident #47 at risk for falls related to increased weakness and history of falls. Interventions directed staff to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. An Incident Report note on 6/24/26 at 9:21 PM, documented the resident had fallen when family had assisted the resident with transfer. A 24-hour Follow-up to Incident Report note dated 6/25/26 at 9:25 PM recommended an intervention of staff to assist resident when transferring. On 6/29/26 at 3:27 PM, Resident #47 was observed sitting in her recliner with her call light in reach. Resident #47 voiced she activated her call light 3 minutes prior but a gal shut it off stating she couldn't help. Resident #47 stated it took 20 minutes for them to respond. Resident #47 revealed it occurred often that the call light was shut off without assistance being provided. Staff F, Call Light Monitor acknowledged she did shut the call light off and was unable to assist the resident to the bathroom. Review of the Excess Response Alarms reports revealed the following for Resident #47:6/21/26 9:26 AM Emergency call cord pressed and cleared at 9:43 AM-response time 17.3 minutes6/23/26 9:47 AM Emergency call cord pressed and cleared at 10:20 AM-response time 33.2 minutes6/27/26 6:28 PM Emergency call cord pressed and cleared at 6:48-response time 20.5 minutes6/27/26 7:53 PM Emergency call cord pressed and cleared at 8:10 PM-response time 16.7 minutes6/28/26 6:30 AM Emergency call cord pressed and cleared at 6:53 AM-response time 23.2 minutes6/28/26 7:59 AM Emergency call cord pressed and cleared at 8:29 AM-response time 29.8 minutes6/29/26 10:26 AM Emergency call cord pressed and cleared at 10:50 AM-response time 43.7 minutes6/29/26 11:23 AM Emergency call cord pressed and cleared at 12:21 PM-response time 57.3 minutesOn 7/2/26 at 8:54 AM, Staff G, Certified Nursing Assistant (CNA) verbalized staff were alerted to activated call light thru the [Brand Name Redacted] server (an end-to-end wireless nurse call and emergency alert system). Staff G reported an appropriate response time for an activated call light was between 1-15 minutes. Staff G acknowledged resident have waited longer than 15 minutes for assistance. Staff G verbalized there wasn't enough staff to respond to call lights. On 7/2/26 at 10:16 AM, Staff D, Licensed Practical Nurse (LPN) reported an appropriate response time to an activated call light was under 15 minutes. Staff D verbalized call lights have exceeded 15 minutes at times. On 7/2/26 at 10:20 AM, the Director of Nursing (DON) verbalized staff were to respond within 15 minutes of an activated call light. The DON acknowledged call lights have exceeded 15 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON revealed the Call Light Monitors were to respond to the call lights and if there was something they cannot do, they were to shut the call light off and turn it back on and alert a CNA. Review of the Call Light facility policy dated 7/20/25, identified an objective that all staff will respond to an engaged call light to rule out emergency situations. The policy directs the following: 1.All Staff will respond to a call light in the on position to rule out an emergency situation.2.Non-Licensed Non-Certified personnel will be able to take care of tasks that would not require the services of a Certified or a Licensed employee. This may include giving the Resident Kleenex, turning off /on TV, etc.3.Resident needs transferred from bed to chair, taken to the bathroom, dressed, etc. will be addressed by Nursing Staff in a timely manner.