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	06/20/2024

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 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** 42441 Based on observation, clinical record review, staff interview, and policy review, the facility failed to provide services that met professional standards regarding following physician orders with insulin administration for 1 of 5 residents reviewed for medication administration (Resident #16). The facility reported a census of 45 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #16 revealed the resident had a Brief Interview for Mental Status (BIMS) of 10 indicating moderately impaired cognition. The MDS further revealed the resident had a diagnosis of diabetes mellitus (DM) and had received insulin 7 out of the past 7 days. Review of physician orders for Resident #16 revealed an order for blood glucose four times a day related to diabetes mellitus. Physician orders further revealed an order for Humalog (insulin) 30 units subcutaneously (SQ) one time a day to be given at 7:30 AM and to hold the insulin if blood sugar is less than 120 with a start date of 3/14/24. During an observation 6/19/24 at 7:22 AM observed Staff B, Registered Nurse (RN) completed an accu-check on Resident #16 and obtained a reading of 102. During an observation 6/19/24 at 7:38 AM observed Staff B, RN administer 30 units of Humalog SQ to Resident #16. Clinical record review during reconciliation of medications revealed Humalog 30 units was to be held if Resident #16's blood sugar was less than 120. Review of facility policy titled, Administering Medications Policy, revised March 2023 revealed medications must be administered in accordance with the orders. During an interview 6/20/24 at 8:25 AM the Administrator revealed it is an expectation staff follow physician orders.

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 915 West First Street Sumner, IA 50674	

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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 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44972 Based on facility record review, staff interview, and policy review the facility failed to have the minimum required members present at their quarterly Quality Assurance (QA) meetings as directed by Centers for Medicare and Medicaid Services (CMS). The facility reported a census of 45 residents. Findings include: QA meetings were conducted on the following dates: 4/11/23, 7/25/23, 10/10/23, 2/12/24, and 4/8/24. Review of the attendance sheets for the QA meetings revealed the required members attended the meetings on 7/25/23, 10/10/23, and 2/12/24. The attendance sheet for the QA meeting held on 4/11/23 revealed the Director of Nursing (DON) was not in attendance and the attendance sheet for the QA meeting held on 4/8/24 revealed the Infection Preventionist (IP) was not in attendance. In an interview on 6/18/24 at 1:55 PM, the Administrator stated she was not aware who was required to attend the QA meetings. She believed the required attendees were the Administrator, Medical Director and 5 other staff and was not aware the DON and IP were required to be in attendance at the meetings as well. She further stated it was the expectation the required staff be in attendance at the quarterly QA meetings per CMS guidelines. Per the facility provided Quality Assurance Performance Improvement (QAPI) Plan established 10/2013 and last updated on 1/24/22, the QAPI committee meetings were to be held at least quarterly and the QAPI committee members were to include at least the following: Medical Director, Administrator, DON, and direct care worker/caregiver.

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	165502	A. Building B. Wing	06/20/2024

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on personnel record review, staff interview, and policy review, the facility failed to ensure mandatory Dependent Adult Abuse training had been completed within 6 months of employment for 1 of 5 staff reviewed (Staff A). The facility reported a census of 45 residents. Findings include: Personnel record review for Staff A, Certified Nursing Aide (CNA) revealed a hire date of [DATE]. The personnel record revealed Staff A had previously completed Dependent Adult Abuse training [DATE] and it expired [DATE]. Staff A did not complete the mandatory training again until [DATE]. Review of facility policy titled, Abuse Prevention Policy, revised ,d+[DATE] revealed employees will receive training as required by state and federal regulations. Employees and staff members, who are mandatory reporters of dependent adult abuse,shall be required to receive two hours of training related to the identification and reporting of dependent adult abuse within six months of hire, as a part of orientation training, and every three years thereafter. During an interview [DATE] at 11:18 AM, the Administrator acknowledged Staff A should have completed mandatory Dependent Adult Abuse training within 6 months of employment after her previous training expired [DATE].