STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255278	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Nursing Center	1401 First Avenue Northeast Magee, MS 39111

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41680 Based on observation, interview, facility policy review, and record review, the facility failed to implement the care plan interventions related to oxygen administered for one (1) of 19 care plans reviewed. Resident #79. Findings Included: A record review of the facility's policy, Care Plan Process revised 12/24, revealed, .The overall care plan should be oriented towards .10. Assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs .The Care Plan Format includes .the interventions, the staff responsible to carry out the interventions . A record review of the Comprehensive Care Plan revealed Resident #79 had a care plan Focus The resident has a hx (history) of Asthma .Interventions .Oxygen at 2L/MIN (Liters per minute) per NC (Nasal Cannula) as needed for SOB (Shortness of Breath). On 4/16/25 at 9:15 AM, during an observation of Resident #79 in bed, the oxygen concentrator at the bedside was observed to be running at a flow rate of three (3) liters per minute. A record review of the Order Listing Report revealed Resident #79 had a Physician's Order, revised 4/15/25, for oxygen via nasal cannula at 2 liters per minute for shortness of breath or oxygen saturation of 93% or below every 24 hours as needed. On 4/17/25 at 9:10 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that the physician order and care plan for Resident #79 indicated that the resident should be receiving oxygen at two (2) liters per minute via nasal cannula. LPN #1 confirmed that the oxygen should not have been set at three (3) liters and acknowledged that staff are expected to follow the resident's physician orders and care plan interventions as written. On 4/17/25 at 9:40 AM, during an interview with the Director of Nursing (DON), she confirmed that care plan interventions must be implemented as written. She acknowledged that a discrepancy between the oxygen flow rate provided, and the resident's physician order and care plan represent a failure to follow the individualized plan of care. She stated that if the resident requires an adjustment to the oxygen level, the nurse must obtain a physician's order and update the care plan accordingly. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Admission Record revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired. Further review revealed under Section O that he was receiving oxygen therapy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 52128 Based on observation, staff interview, record review, and facility policy review, the facility failed to revise a comprehensive care plan for a resident with an indwelling catheter for one (1) of 19 care plans reviewed. Resident #79 Findings include: A review of the facility' policy, Care Plan Process dated 12/2024 revealed . The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided . On 04/14/25 at 12:29 PM, during an observation, Resident #79 was sitting in a wheelchair in his room and catheter tubing was observed near his leg. A record review of the Care Plan Report revealed Resident #79 had a care plan focus of The resident has a . Catheter. There was no intervention related to how often catheter care should be performed or the position responsible for providing the care. A record review of the Task List Report, initiated on 3/10/25, revealed Certified Nurse Aides (CNAs) documented the task of Bladder Voiding and Toilet Use, Cath Use every shift for Resident #79. A record review of theFollow Up Question Report for 04/01/25 through 04/16/2025 revealed catheter care was provided by CNAs for Resident #79. On 04/15/2025 at 10:05 AM, in an interview with CNA #1, she explained that the CNAs are responsible for catheter care and documenting in the Electronic Health Record (EHR). She stated that catheter care is displayed on the computer for them to document the task every shift. On 04/16/2025 at 11:16 AM, in an interview with Registered Nurse (RN) #1 she confirmed that the care plan for Resident #79 did not include an intervention for routine catheter care. She stated that a physician's order is not required for catheter care and they had not added it to the care plan. She agreed that routine catheter care should have been included as an intervention and the care plan revised to reflect the frequency and discipline responsible for the care. On 04/17/2025 at 08:59 AM, during an interview with the Director of Nursing (DON), she stated that she was made aware that the care plan related to catheter care for Resident #79 had not been revised to include an intervention for routine catheter care. She reported that the care plan team had already begun to correct this issue. A record review of the Admission Record revealed the facility admitted Resident #79 on 03/10/2025 with diagnoses including Acute Kidney Failure. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated his cognition was moderately impaired. Further review revealed he had an indwelling catheter.

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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. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the oxygen flow rate was consistent with the physician's order for one (1) of one (1) resident reviewed for oxygen administration. (Resident #79) Findings included: A record review of the facility's policy Drug Administration and Documentation, revised 3/25 revealed, .The complete act of administration entails .verifying it with the physician's orders . A record review of the Order Listing Report revealed Resident #79 had a Physician's Order, revised 4/15/25, for oxygen via nasal cannula at two (2) liters per minute for shortness of breath or oxygen saturation of 93% (per cent) or below every 24 hours as needed. During an observation on 4/16/25 at 8:40 AM, Resident #79 was observed receiving oxygen via nasal cannula at a flow rate above three (3) liters per minute. During an observation and interview with Licensed Practical Nurse (LPN) #1 on 4/16/25 at 9:22 AM, Resident #79's oxygen flow was observed at 3.4 liters per minute. LPN #1 stated the resident's oxygen typically runs at three (3) liters per minute. During an observation and follow up interview with LPN #1 on 4/16/25 at 11:08 AM, LPN #1 confirmed the oxygen flow was above 3 liters per minute. She stated she had checked the oxygen flow that morning and she had not changed the setting. She confirmed the physician's order was for 2 liters per minute as needed and acknowledged the oxygen should never be adjusted without a new physician order. She explained that receiving oxygen at a higher rate than ordered could lead to adverse effects and make it harder for the resident to breathe. During an interview on 4/17/25 at 10:37 AM, the Director of Nursing (DON) stated when a resident receives more oxygen than ordered, their lungs may have to work harder to exhale. She stated the nurse should check the order and ensure it is followed every shift. A record review of the Admission Record revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired. Further review revealed he was receiving oxygen therapy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were not left unattended at the bedside or on the medication cart for two (2) of four (4) residents observed during medication administration. Residents #19 and #79. Findings Included: A review of the facility's policy, Drug Administration and Documentation, revised 3/25, revealed, .Under no circumstance is medication to be left at the bedside or given to the resident without him/her swallowing it in your presence . Do not leave any medication on top of the medication cart unattended . Resident #19 A record review of the Order Listing Report revealed Resident #19 had a Physician's Order, revised 9/3/2024, for Polyethylene Glycol 3350 Oral Powder 17 gram/scoop, one (1) scoop orally two (2) times daily, mix in juice or water. On 4/16/25 at 8:00 AM, during an observation of medication administration, Licensed Practical Nurse (LPN) #2 administered Polyethylene Glycol 3350 Oral Powder 17 gram/scoop in water to Resident #19. She left the medication at the bedside and informed the resident she was going to leave it for her to finish drinking. On 4/16/25 at 10:46 AM, during an interview with LPN #2, she stated that some days she leaves Polyethylene Glycol 3350 at the bedside and that the amount left varies. She stated the resident takes a while to drink it and she does not want to rush her. She confirmed that Polyethylene Glycol 3350 is a medication and should not be left at the bedside. She acknowledged that if the medication is left unattended, there is no way to confirm whether the resident consumed the full dose, and that physician orders required a full dose to be taken. A record review of the Admission Record revealed the facility admitted Resident #19 on 9/6/19 with diagnoses including Constipation. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/14/25 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of ten (10), which indicated her cognition was moderately impaired. Resident #79 On 4/16/25 at 9:22 AM, during an observation of medication preparation for Resident #79, LPN #1 was observed placing a vial of Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligrams)/3ML (milliliters) on top of the medication cart and leaving the medication unattended while she left to retrieve supplies. The medication cart was unattended for two (2) to three (3) minutes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 10:15 AM, during an interview with LPN #1, she acknowledged that she should not have left Resident #79 medication on the cart and stated she was not thinking. She admitted that she knew better and that leaving medication unattended on the cart could result in another resident taking it. On 4/17/25 at 10:33 AM, during an interview with the Director of Nursing (DON), she confirmed that no medications should be left unattended on the cart or in residents' rooms. She stated that leaving medications unattended could result in uncertainty about whether the resident took, discarded, or pocketed the medication. She stated that staff are expected to always follow medication administration policy. A record review of the Order Listing Report revealed Resident #79 had a Physician's Order, revised 4/15/25, for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (a type of nebulizer medication) every 12 hours as needed for wheezing and cough. A record review of the Admission Record revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired.