

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Hillcrest Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1108 Clarke Street DE Soto, MO 63020	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31057</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision to ensure the safety of one resident (Resident #1). On 08/01/24 at 3:00 A.M., the facility failed to initiate a search for Resident #1 and implement the facility policy for missing residents when staff noticed the resident's call light on, but the room was empty. On 08/01/24 at 6:45 A.M., during morning medication pass, staff noted Resident #1 was not in his/her room. The staff finished the medication pass and reported to the charge nurse. On 08/01/24 at 8:00 A.M., the staff began searching for the resident and found the resident outside lying on the ground in the courtyard. The resident fell down outside in the late evening on 07/31/24, and lay on the ground until 08/01/24 at 8:15 A.M. The facility census was 84.</p> <p>On 08/08/24 at 4:00 P.M., the Administrator was notified of the past non-compliance immediate jeopardy (IJ) which began on 08/01/24. The facility immediately conducted an investigation and inserviced staff on the Elopement-Missing Resident policy. The IJ was corrected on 08/01/24.</p> <p>Review of the facility's undated policy, Elopement-Missing Resident, directed staff to:</p> <ul style="list-style-type: none"> <li>- Determine when resident was last seen, description of clothing, and where last seen;</li> <li>- Notify all departments and begin a thorough search of the facility and grounds, including bathrooms, closets, storage areas, and crawl spaces;</li> <li>- Search streets and neighborhood adjacent to the facility;</li> <li>- Notify the Director of Nursing and the Administrator;</li> <li>- Notify the physician;</li> <li>- Notify the responsible party and request notification if the resident makes contact with them;</li> <li>- If absence exceeds 30 minutes, notify local law enforcement, give dispatcher the following information, name, age, sex, description of the resident and clothing description, time discovered missing, last seen, physical or mental impairments, if harmful to self and/or others, home address, address of relatives and/or friends, and photograph of resident;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- When located, notify all appropriate people/agencies;</li> <li>- Assess for injuries.</li> </ul> <p>Review of Resident #1's medical record showed admission to the facility on [DATE] with diagnoses of amyotrophic lateral sclerosis (a neurological disorder that affects motor neurons, the nerve cells in the brain and spinal cord that control voluntary muscle movement and breathing), transient ischemic attack (TIA, a mini stroke), depression, chronic kidney disease stage 2 (develops when the kidneys become less effective over time due to damage), high blood pressure, and diabetes mellitus type 2 (a condition that affects the way the body processes blood sugar).</p> <p>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 06/17/2024 showed:</p> <ul style="list-style-type: none"> <li>- Cognition intact;</li> <li>- Minimum difficulty with hearing, no hearing aides;</li> <li>- No speech, absence of spoken words;</li> <li>- Impaired vision, corrected with glasses;</li> <li>- Usually understands and is understood;</li> <li>- Independent with personal hygiene, toileting, feeding self, bed mobility, transfer, ambulation with use of walker;</li> <li>- Continent of bowel and bladder.</li> </ul> <p>Review of the resident's care plan, dated 06/19/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident has difficulty making self understood, no speech. Has electronic communication device for expressing self. Gestures with thumbs up and thumbs down;</li> <li>- At risk for falls;</li> <li>- Independent with dressing, toileting, and personal hygiene;</li> <li>- Assist of one staff for bathing;</li> <li>- Continent of bowel and bladder;</li> <li>- Resident walks with the assistance of a walker with assist one staff member to stand at times.</li> </ul> <p>Review of the resident's progress notes showed;</p> <ul style="list-style-type: none"> <li>- On 08/01/24 at 8:15 A.M., the resident was found in the courtyard laying on his/her back on the sidewalk;</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/08/24 at 11:15 A.M., the DON said he/she last saw Resident #1 at approximately 11:30 P.M., walking towards his/her room, but did not see him/her leave the room after that time. The DON said CMT C questioned him/her if the resident was on LOA around 3:00 A.M., and he/she told CMT C no, the resident had been out on LOA earlier in the day, but had returned. The CMT did not ask where the resident was or report at that time he/she had not seen the resident since arrival to work. The DON said if she had known at that time the resident had not been seen in the facility, she would have immediately taken action and began a search. The DON said at the end of his/her shift, he/she was still not aware the resident had not been seen.</p> <p>During an interview on 08/08/24 at 11:20 A.M., LPN B said he/she had last seen Resident #1 between 11:30-11:45 P.M.</p> <p>During an interview on 08/08/24 at 12:20 P.M., LPN D said he/she arrived to work at approximately 6:45 A.M. to 7:00 A.M. While in another resident's room, CMT C informed LPN D that he/she had not seen Resident #1 since his/her shift started. He/she then left the other resident's room and checked Resident #1's bathroom, checked the log out record for the resident and saw the resident had been signed back in from LOA the previous night at 8:00 P.M. At that time, he/she called the resident's family and asked if the resident was with them. The family said they brought him/her back the previous evening. LPN D immediately alerted other staff the resident had not been seen for several hours. Shortly after, the Medical Records staff found the resident laying out in the courtyard on his/her back. LPN D said the resident was laying in the back of the courtyard on his/her back in the grass with knees bent and barefoot. The resident was alert with scrapes noted on his/her right great toe, right foot, both knees and elbows, and an abrasion to the back of the head. The left side of the resident's shirt and pants were wet. After he/she assessed the resident, staff assisted to a standing position and ambulated the resident to his/her room. LPN D then notified the physician and received orders to send the resident to the hospital for an evaluation. The resident's family was notified and transported the resident to the ER.</p> <p>During an interview on 08/08/24 at 1:55 P.M., the Medical Records staff said he/she came to work on 08/01/24 at 6:45 A.M. LPN D asked if he/she had seen Resident #1. He/She went to the resident's room and saw the light on his/her computer and the bed pulled back. The Medical Records staff went to the courtyard because the resident likes to go out there. The staff found the resident laying on his/her back wearing shorts and a t-shirt. The staff called for the nurse and LPN D assessed the resident and assisted to ambulate back into the facility. The resident's head was red and his/her shirt was wet, not sure if it was urine or sweat.</p> <p>During an interview on 08/08/24 at 11:10 A.M., the Administrator said the facility does not have a policy addressing a specific time each resident should be accounted for, monitoring is based upon need. During the investigation, it was discovered the resident had been on a leave of absence and returned to the facility on [DATE] at 8:00 P.M. The resident was last seen on 07/31/24 at 11:30 P.M. at the nurses station. CMT C told the DON that the resident was not in his/her room and asked if he/she was on LOA. The DON said he/she was not on LOA and had returned the previous evening. No one actually went to look for him/her at that time. She said she would have expected the staff to search for the resident at 3:00 A.M. when the resident was not seen or in his/her room.</p> <p>Complaint #MO239905</p>		