STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265620	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center Inc	1108 Clarke Street DE Soto, MO 63020

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the dumpster was maintained to keep pest out and/or to keep garbage contained in the dumpster. This deficient practice had the potential to affect all residents in the facility. The facility was 81. The facility did not provide a policy for maintaining the dumpster. Observations on 01/19/26 at 10:05 A.M., and 1:00 P.M., of the outside trash dumpster showed;- Each dumpster lid was open with visible garbage bags, boxes, and other miscellaneous debris inside. Observations on 01/20/26 at 11:24 A.M., and 2:02 P.M., 1/21/26 at 8:22 A.M., 11:44 A.M., and on 01/22/26 at 8:14 A.M., and 10:11 A.M., of the outside trash dumpster showed:- The left-side dumpster lid was open with visible garbage bags, boxes, and other miscellaneous debris inside. Observation on 01/21/26 at 9:38 A.M., of the outside trash dumpster showed:- Housekeeper A discarded a bag of trash into the dumpster and did not close the lid. During an interview on 01/21/26 at 9:42 A.M., Housekeeper A said he/she never closed the dumpster lids after throwing away trash and had not been told to do so. During an interview on 01/21/26 at 11:48 A.M., Housekeeper B said trash lids should be closed each time a staff member threw away trash or anything else in the dumpster. During an interview on 01/22/26 at 11:07 A.M., the Dietary Manager (DM) said staff should close the dumpster lids after discarding trash and debris into it. During an interview on 01/22/26 at 11:11 A.M., the Maintenance Supervisor (MS) said staff should close the dumpster lids after discarding trash and debris into it. During an interview on 01/22/26 at 12:21 P.M., the Administrator said staff should close the dumpster lids after discarding trash and debris into it.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to treat residents with dignity and respect when staff stood over three residents (Residents #21, #33, and #36) and fed the residents during meals and left one resident (Resident #80) with no privacy and exposed during his/her wound care, out of 18 sampled residents. The facility census was 81.Review of the facility's policy titled, Resident Rights, undated, showed:- Each resident shall be treated with consideration, respect a full recognition of his/her dignity and individuality, including privacy in treatment and care of his/her personal needs. 1. Observation on 01/20/26 at 12:07 P.M., of the main dining room showed:- Certified Nursing Assistant (CNA) N stood over and fed Resident #36 during the noon meal. Observation on 01/20/26 at 5:03 P.M., of the cafe dining room showed:- CNA M stood over and fed Resident #21 during the evening meal. Observation on 01/20/26 at 5:20 P.M., showed:- CNA M stood over and fed Resident #33 during the evening meal. 2. Observation of Resident #80's wound care on 01/21/26 at 10:51 A.M., showed:- CNA K and Registered Nurse (RN) J entered the room to perform the resident's wound care; - CNA K and RN J did not close the curtains to the window and the sidewalk was visible through the window;- CNA K and RN J did not close the privacy curtain around the resident;- CNA K and RN J removed the resident's brief;- RN J opened the resident's door and exited the room to obtain additional supplies while the resident lay with his/her front peri area uncovered and exposed;- RN J did not pull the privacy curtain prior to opening the door to exit the room;- CNA K did not close the privacy curtain around the resident;- RN J opened the resident's door, entered the room while the resident lay with his/her front peri area uncovered and exposed, and performed wound care. During an interview on 01/21/26, at 1:45 P.M., RN J said he/she should pull the window curtain closed before care, as well as the privacy curtain before leaving the room to obtain more supplies. During an interview on 01/22/26, at 11:40 A.M., the Director of Nursing (DON) said she would expect staff to close the window curtain, as well as the privacy curtain before providing care to any resident. Staff should be seated at eye level to feed residents during meals, not standing. During an interview on 01/22/26, at 11:48 A.M., the Administrator said she would expect staff to close window shades, as well as privacy curtains during care. Staff should be sitting at eye level when helping feed residents in the dining room. During an interview on 01/27/2026 at 7:01 A.M., CNA M said he/she always stood when feeding the residents in the dining room.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to the resident and/or the resident's representative in writing at least two calendar days before discharge from skilled services. This notice informs the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting the financial liability for those services. This practice affected two residents (Residents #43 and #100) out of three sampled residents. The facility census was 81.The facility did not provide a policy regarding SNF ABN forms. 1. Review of Resident #43's medical record showed:- The resident discharged from skilled Medicare services on 01/16/26, and remained in the facility;- No documentation the resident and/or the representative received a SNF ABN;- The facility failed to provide the SNF ABN form to the resident and/or the representative at least two calendar days before the skilled Medicare services ended. 2. Review of Resident #100's medical record showed:- The resident discharged from skilled Medicare services on 11/11/25, and remained in the facility;- No documentation the resident and/or the representative received a SNF ABN;- The facility failed to provide the SNF ABN form to the resident and/or the representative at least two calendar days before the skilled Medicare services ended. During an interview on 01/21/26 at 2:49 P.M., the Social Services Designee (SSD) said he/she was unaware that the SNF ABN form needed to be filled out for residents that elected to stay in the facility. During an interview on 01/22/26 at 12:00 P.M., the Administrator said if a resident discharged from skilled Medicare services and remained in the facility, the resident and/or the resident representative should receive a SNF ABN.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 81. The facility did not provide a homelike environment policy. Observations on 01/19/2026 at 10:34 A.M., 01/20/2026 at 6:00 P.M., 01/21/2026 at 11:35 A.M., and 01/22/26 at 11:21 A.M., of the nurse's station area, showed: - One ceiling fan over the cafe area with a buildup of dirt and debris; - Two ceiling fans over the bird cage area with a buildup of dirt and debris and missing fan blades; - Two skylight (roof installed window) outer edges over the cafe area with a buildup of dust and debris; - Two skylight outer edges over the nurses' station with a buildup of dust and debris. Observation on 01/19/2026 at 12:34 A.M. and 01/20/2026 at 6:05 P.M., of the main dining room, showed: - An approximate one foot (ft.) by two ft. area near the double doors on the left-side with peeled areas of paint. - A four ft. linear (straight line) piece of corner molding on the left-side held together with two strips of medical tape against the wall. - An approximate one ft. by two ft. area near the double doors on the right-side with peeled areas of paint; - A nickel size hole in the wall above the handrail near the double doors on the right side. Observations on 01/19/2026 at 1:34 P.M., 01/20/2026 at 3:34 P.M., 01/21/2026 at 11:12 A.M., and 01/22/26 at 10:21 A.M., of the 200 hall, showed: - Several one-to-two inch (in.) long areas of exposed sheetrock and peeled paint on the wall behind the headboard of bed 2 by the window in room [ROOM NUMBER]; - A missing corner piece of base board with exposed sheetrock and peeled paint by bed 1 near the door in room [ROOM NUMBER]; - Three areas of peeled wallpaper on the left-side wall near room [ROOM NUMBER]; - Three ft. of peeled wallpaper by a large canvas painting between room [ROOM NUMBER] and room [ROOM NUMBER]; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two ft. of peeled wallpaper by a brown-framed wooden picture near room [ROOM NUMBER]. Observations on 01/19/2026 at 1:38 P.M., 01/20/2026 at 3:39 P.M., 01/21/2026 at 11:22 A.M., and 01/22/26 at 10:16 A.M., showed: - An approximate four in. by six in. area of exposed sheetrock and peeled paint on the hallway wall below a cork-like bulletin board located by the laundry room door entrance. Review of the Maintenance Repair Log, dated 11/01/25 through 01/21/26, showed: - No documentation of areas of concern addressed. During an interview on 01/21/2026 at 9:42 A.M., Housekeeper A said any repairs should be written down on the maintenance log located at the nurse's station. He/She had not seen anything to write down that needed repaired. During an interview on 01/21/2026 at 11:48 A.M., Housekeeper B said any repairs should be written down on the maintenance log located at the nurse's station. He/She had not seen anything to write down that needed repaired During an interview on 01/22/26 at 10:00 A.M., Certified Nurse Aide (CNA) F said he/she filled out a request on the maintenance logbook. If it was something that maybe was a danger to the residents, he/she would verbally tell the nursing department or the maintenance staff. During an interview on 01/22/26 at 10:05 A.M., CNA G said he/she would go to the nurse's station and fill out a request on the maintenance logbook. If it was an emergency, then he/she would go straight to the maintenance staff to make it a priority. During an interview on 01/22/26 at 10:15 A.M., Licensed Practical Nurse (LPN) I said the areas of concern near the nurse's station were probably the housekeeping and maintenance departments combined. He/She did not know how the areas were cleaned. He/She said staff should put anything related to repairs in the maintenance book located at the nurse's station. During an interview on 01/22/26 at 11:35 A.M., the Assistant Director of Nursing (ADON) said he/she would expect the staff to fill out a maintenance request on the logbook. If it was detrimental (bad) or dangerous he/she would expect the staff come and get the ADON and/or Director of Nursing (DON) and let them know so the concern could be addressed immediately. During an interview on 01/22/26 at 12:25 P.M., the Housekeeping Supervisor (HS) said the housekeeping department was responsible for cleaning the commons area and should assist the maintenance department when needed. During an interview on 01/22/26 at 12:30 P.M., the Maintenance Supervisor (MS) said he/she is responsible for cleaning the commons area and has shut down the ceiling fans totally, due to the fan blades being broke. He/She reviewed the logbook every other day. MS said sometimes staff just tell him/her in passing what needs repaired. However, he/she would rather there be an entry in the logbook due to having a record of needed and completed repairs. During an interview on 01/22/26 at 12:41 P.M., the Administrator said she would expect staff to write (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down any needed repairs on the maintenance log and for documentation purposes. By doing so allows the MS to prioritize the repairs needed to be completed in a timely manner.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document, obtain a signature, and/or send notification in writing to the resident and/or the resident's representative of a transfer or discharge to a hospital, including the statement of appeal rights or the name, address, or the telephone number of the Office of the State Long Term Care Ombudsman (advocate for the resident in nursing facilities) within the transfer and discharge notices and bed-hold policy (the holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) for four residents (Residents #3, #5, #19 and #34) out of five sampled residents. The facility census was 81. The facility did not provide a transfer/discharge policy. Review of the facility's policy titled, Bed Hold Guidelines, undated, showed:- The facility will notify all residents and/or their representative of the bed hold guidelines;- This notification shall be given on admission to the facility, at the time of transfer to the hospital, and at the time of non-covered therapeutic leave;- If the resident or resident representative wants to hold the bed, a signed authorization must be obtained with each discharge;- If the resident or resident representative does not choose to hold the bed, the bed will be released and any personal belongings must be picked up within three days;- Bed holds are strictly voluntary:- If the bed is not held and is not available when the resident wants to be re-admitted , the resident's name will be placed on a waiting list for the next available bed. 1. Review of Resident #3's medical record showed:- admitted 0n 08/26/25;- The resident transferred to the hospital on [DATE], and returned on 09/17/25;- The resident transferred to the hospital on [DATE], and returned on 09/30/25. Review of the resident's Transfer/Discharge and Bed Hold Guidelines forms, dated 09/09/25 and 09/24/25, showed:- No selected bed-hold preference;- No daily bed-hold rate;- No signature from the resident and/or the resident's representative;- No documentation the information was provided in writing to the resident and/or the resident's representative. 2. Review of Resident #5's medical record showed:- admitted on [DATE];- The resident transferred to the hospital on [DATE], and returned on 09/28/25. Review of the resident's Transfer/Discharge and Bed Hold Guidelines forms, dated 09/24/25, showed:- No selected bed-hold preference;- No daily bed-hold rate;- No signature from the resident and/or the resident's representative;- No documentation the information was provided in writing to the resident and/or the resident's representative. 3. Review of Resident #19's medical record showed:- admitted on [DATE];- The resident transferred to the hospital on [DATE], and returned on 11/10/25. Review of the resident's Transfer/Discharge and Bed Hold Guidelines forms, dated 11/06/25, showed:- No selected bed-hold preference;- No daily bed-hold rate;- No signature from the resident and/or resident's representative;- No documentation the information was provided in writing to the resident and/or the resident's representative. 4. Review of Resident #34's medical record showed:- admitted on [DATE];- The resident transferred to the hospital on [DATE], and returned on 11/18/25. Review of the resident's Transfer/Discharge and Bed Hold Guidelines forms, dated 11/06/25, showed:- No selected bed-hold preference;- No daily bed-hold rate;- No signature from the resident and/or resident's representative;- No documentation the information was provided in writing to the resident and/or the resident's representative. During an interview on 01/21/26 at 10:00 A.M., the Assistant Director of Nursing (ADON) said the charge nurse should fill out the paperwork and give it to the resident or the responsible party upon discharge to for a signature. If the responsible party was not present, a phone call should be made informing him/her of the transfer and a letter should be mailed for a signature. There should be documentation the resident or the representative received the bed hold and the transfer/discharge information. During an interview on 01/22/26 at 10:20 A.M., Licensed Practical Nurse (LPN) I said when a resident was sent to the hospital, the nursing staff filled out the bed hold form and sent it with the resident. A copy was made and the Social Service Director (SSD) would get the copy. The SSD would get in contact with the resident's representative. I (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident could sign, then he/she signed it at that time. However, if the resident couldn't sign it, two nurses would sign the form. During an interview on 01/22/26 at 10:28 A.M, the SSD said he/she did not send a notification letter to the responsible representative to be signed or filled out. He/She did keep a copy of the transfer/discharge and bed-hold paperwork. During an interview on 01/22/26 at 12:10 P.M., the Administrator said the charge nurse on duty should fill out the transfer/discharge and bed-hold paperwork. If the resident could sign, a copy was made and given to the SSD. If the resident was unable to sign, the SSD should notify and send the paperwork to the responsible representative. The paperwork should also have documentation showing it was mailed to the responsible representative for his/her signature. There should be a bed-hold choice selected and a daily room rate on the forms.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used acceptable infection control procedures and practices for wound care for four residents (Residents #1, #19, #51 and #80) out of five sampled residents. The facility also failed to ensure ice chest carts were monitored to prevent access to residents and visitors without staff assistance for two residents (Residents #14 and #77) outside the sample. These deficient practices could potentially affect all residents. The facility census was 81.Review of the facility's policy titled, Enhanced Barrier Precautions (EBP) to Infection Control Guidance, dated March 2024, showed:- To prevent broader transmission of multidrug resistance organisms (MDRO) and to help protect residents with chronic wound and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed;- Residents with indwelling medical devices including urinary catheter or with a wound, regardless of their MDRO status require EBP;- Use EBP when providing high-contact resident care activities such as: transferring residents from one position to another; providing hygiene; changing briefs or assisting with toileting; caring for or using an indwelling medical device; or performing wound care;- Gloves and putting on and taking off gowns are required when conducting high-contact resident care activities. Gloves and gown should be removed and discarded after each resident care encounter. Review of the facility's policy titled, Glove Use, dated, May 2015, showed:- To ensure safe and proper food handling during food preparation and service. The food code states that food items should not be handled with bare hands;- Gloves should be removed when changing or walking away from specific tasks and hands should be washed;- Hands should be washed after handling dirty dishes, after disposing of trash or food, and when changing tasks. The facility did not provide an ice chest policy. 1. Observation of Resident #19's wound care on 01/20/26 at 1:55 P.M., showed:- EBP signage on the resident's door;- Personal protective equipment (PPE) stored just inside the resident's room on the bathroom door;- Licensed Practical Nurse (LPN) I and Certified Nurse Assistant (CNA) F performed hand hygiene, put on gloves, did not put on gowns, and entered the resident's room;- LPN I provided the wound treatment to the resident. Observation of Resident #51's wound care on 01/21/26 at 8:54 A.M., showed:- No EBP signage on the resident's door;- PPE stored just inside the resident's room on the bathroom door;- Registered Nurse (RN) J and CNA L performed hand hygiene, put on gloves, did not put on gowns, and entered the resident's room;- RN J cleaned the wound;- RN J removed the gloves, did not perform hand hygiene, and left the room to obtain additional supplies;- RN J did not perform hand hygiene, put on gloves, did not put on a gown, and entered the resident's room;- RN J provided wound treatment to the resident. Observation of Resident #1's wound care on 01/21/26 at 10:30 A.M., showed:- EBP signage on the resident's door;- PPE stored just inside the resident's room on the bathroom door;- RN P performed hand hygiene, put on gloves, a mask, and a gown;- RN P performed the resident's wound care, removed the gloves, performed hand hygiene, did not remove the gown, exited the room, walked into the hallway to the treatment cart and obtained supplies, re-entered the resident's room, performed hand hygiene, put on clean gloves, did not put on a clean gown, and continued the wound treatment;- RN P removed the gloves, performed hand hygiene, did not remove the gown, exited the resident's room, walked to the linen cart to retrieve hygiene wipes, performed hand hygiene, put on clean gloves, did not put on a clean gown, and continued to provide incontinent care to the resident. Observation of Resident's #80's wound care on 01/21/26 at 10:51 A.M., showed:- No EBP signage on the resident's door;- PPE stored just inside the resident's room on the bathroom door;- RN J and CNA K performed hand hygiene, put on gloves, and did not put on a gown;- CNA K rolled the resident and RN J cleaned the wound;- RN J removed gloves, did not perform hand hygiene, and left the room to obtain additional supplies;- RN J entered the resident's room, did not perform hand hygiene, put on gloves, and did not put on a gown;- RN J provided the wound treatment to the resident. During an interview on 01/22/26 at 10:05 A.M., CNA F said residents with wounds should have EBP signage to let staff know the resident had a (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound, catheter, a feeding tube or something like that. CNA F said he/she should have worn a gown when assisting with wound care but just forgot today. During an interview on 01/22/26 at 10:20 A.M., LPN I said staff only wear the gowns in the resident's room that had an infection. Staff did not wear a gown to provide a wound treatment for residents. During an interview on 01/22/26 a 11:20 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said staff should perform hand hygiene prior to entering a resident room and after exiting a resident room. During an interview on 01/22/26 at 11:30 A.M., the DON and ADON said staff that were providing care for residents on EBP should remove the gown before exiting the resident's room. 2. Observation on 01/19/26 at 3:32 P.M., of Resident #77 showed:- The ice chest cart sat unmonitored on the 200 Hall;- Resident #77 opened the lid on the ice chest cart;- He/She picked up the ice scoop and reached inside the ice chest with his/her bare hand;- He/She scooped ice into his/her beverage container three times;- He/She held the beverage container over the ice;- Pieces of ice fell back into the ice chest after it touched his/her beverage container;- He/She left the ice chest lid opened and returned to his/her room;- He/She returned to the ice-chest and closed the lid;- No staff present. Observations on 01/20/26 at 12:41 P.M., of Resident #14 showed:- The ice chest cart sat in the cafe area;- Resident #14 sat in the cafe area with a visitor near the nurses' station;- The visitor took the resident's beverage container off the table, walked to the ice chest cart, and opened the lid;- The visitor picked up the ice scoop and reached inside the ice-chest with his/her bare hand;- The visitor scooped ice in the resident's beverage container;- The visitor closed the ice-chest lid;- The visitor returned to the cafe area and placed the resident's beverage container on the table;- Two charge nurses sat behind the nurses' station, two nurse assistants picked up meal trays, and a housekeeper swept the floor in view of the ice-chest and observed the visitor put ice in the resident's beverage container;- Staff did not intervene. During an interview on 01/22/26 at 11:44 A.M., the DON and ADON said they would expect the ice chest to be removed, ice discarded and refilled with fresh ice if a resident and/or visitor was witnessed using it other than staff. During an interview on 01/22/26 at 12:05 P.M., the Administrator said she would expect staff to sanitize their hands before entering and after exiting a resident's room. She would expect staff providing care to residents on EBP to remove the gown before exiting a resident's room.