STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445316	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Healthcare Center	111 E Pemberton Street Ashland City, TN 37015

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on policy review, employee list review, and interview, the facility failed to offer COVID-19 vaccinations to employees after February 2025, which had the potential to affect 76 of 76 residents that were residing in the facility. The findings include: Review of the facility policy titled, Employee Immunization and Vaccination Status, dated January 2024, revealed .Employees are offered or provided with immunization/vaccinations per state or local agency policies/regulations. Review of the employee list dated 1/14/2026 revealed 45 employees were hired from 2/2025 to 1/14/2026. The facility was unable to provide documentation that employees hired from 2/2025 to 1/14/2026 were offered the COVID vaccine. During an interview on 1/14/2026 at 8:30 AM, the Infection Control Preventionist (ICP) was asked if the COVID vaccine was offered to staff. The ICP stated, We do not offer the COVID vaccine to employees. We only educate them if a new vaccine is available .the vaccine was no longer offered to staff beginning in February 2025 .

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to provide Advance Beneficiary Notice of Medicare Non-Coverage for 3 of 3 (Resident #20, #82, and #83) sampled residents reviewed for Advanced Beneficiary Notice. The findings include: 1. Review of the facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, dated 9/2024, revealed .A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change in coverage is likely.Written notices of the likelihood of Medicare payment denial are provided to the resident/beneficiary.as soon as the facility makes the assessment that Medicare payment certainly or probably will not be made and before the item of service is furnished.far enough in advance of an event.so that the beneficiary can make a rational, informed decision without undue pressure. 2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, and Diabetes. Review of the facility's Notice of Medicare Non-Coverage, form revealed that Resident #20's last covered day was 12/23/2025. The form was signed on 12/23/2025. The facility failed to provide Resident #20 advanced notification of Medicare coverage ending far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. 3. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE], with diagnoses including Amputation of Lower Limb, Abscess of Lower Limb, Gout, and Hypertension. Review of the facility's Notice of Medicare Non-Coverage, form revealed that Resident #82's last covered day was 11/5/2025. The from was signed on 11/5/2025. The facility failed to provide Resident #82's representative advanced notification of Medicare coverage ending far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. 4. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Hypertension, and COPD. Review of the facility's Notice of Medicare Non-Coverage, form revealed that Resident #83's last covered day was 9/6/2025. The form was signed on 9/5/2026. The facility failed to provide Resident #83's representative with notification of Medicare coverage ending far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice. During an interview on 1/14/2026 at 9:16 AM, the Social Services Director (SSD) was asked when notices at end of Medicare services should be given. The SSD stated, We usually give them 72-hour notice. The SSD was asked if the notice of end of Medicare services was given 72 hours before coverage ended. SSD stated, No.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure 2 of 4 (Licensed Practical Nurse (LPN) B and LPN C) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 2 errors were observed out of 25 opportunities, resulting in a medication error rate of 8%. The findings include: 1. Review of facility policy titled, Medication Administration, .Residents shall receive medications according to safe standards of practice.Medications are prepared and administered according to the following: right medication, right dose, right time, right person, right route, right position, right texture and right documentation.Prior to administration, the medication and dosage schedule on the resident's MAR (medication administration record) is compared with the medication label. If the label and MAR are different, stop and compare to physician's orders. Seek further clarification as needed. 2. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Heart Failure and Enterococcus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the MDS had not been exported. Review of the Physician's Orders dated 1/2/2026, revealed .cefTRIAXone Sodium [an antibiotic used to treat bacterial infections] Intravenous [by way of a vein] Solution Reconstituted 2 GM [Gram].Use 2 gram intravenously two times a day for ENTEROCOCCUS AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE (until 2/5/2026). Review of the medication label dated 1/8/2026, revealed .[Resident #26].CEFTRIAXONE INJ [injection] 2GM.INFUSE 1 BAG (2GM/100ML [milliliter]) INTRAVENOUSLY OVER 30 MINUTES TWICE A DAY UNTIL 2/5/2026. ˆObservation in Resident #26 room on 1/13/2026 at 1:50 PM, revealed Licensed Practical Nurse (LPN) C prepared ceftriaxone sodium intravenous solution in 100ml sodium chloride [salt based additive solution used with IV medications] 0.9% (percent), set infusion pump to infuse at 100ml/hr (hour) for a total volume to infuse of 100 ml. LPN C administered the medication to Resident #26 resulting in the medication to be infused over 1 hour. During an interview on 1/13/2026 at 2:48 PM, LPN C was asked what the order or directions were for the ceftriaxone sodium intravenous solution to infuse at. LPN C stated .He only gets Rocephin (Ceftriaxone) once a day, the ampicillin [antibiotic medication used for infections] has a rate of 100ml/hr so we are running them both at 100ml/hr.ˆLPN C was asked if the Physician Order should have a rate to infuse the medication. LPN C stated, Rocephin don't.ˆLPN C then went to clarify with the Assistant Director of Nursing (ADON). LPN C returned with the medication label for Resident #26's ceftriaxone sodium intravenous solution and stated it should have been infused over 30 minutes per the medication label. Review of the Progress Note dated 1/13/2026 at 15:33 PM, revealed pt [patient] have 2 different antibiotic (cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM and Ampicillin Sodium Intravenous Solution Reconstituted 2 GM). Ampicillin is to be run over an hour according to the MAR and ceftriaxone did not have the rate on the MAR but it was on the bag to be run over 30 min. Both meds [medications] were run at the rate of an hour; med error was reported to NP [Nurse Practitioner] and was told there is nothing to monitor. Supervisor made aware. No adverse effect noted or reported. 3. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Diabetes, and Peripheral Vascular Disease. Review of the quarterly MDS assessment dated [DATE], revealed Resident #59 scored a 13 on the BIMS assessment, which indicated she was cognitively intact. Resident #59 was assessed for the use of an antiplatelet [medication used to prevent blood clots or prevent heart attaches]. Review of the Physician's Orders dated 10/31/2025, revealed .Aspirin [medication used to thin the blood to prevent clots or heart attach] Tablet Chewable 81 MG [milligram] Give 1 tablet by mouth one time a day. Observation in Resident #59's room on 1/13/2025 at 8:34 AM, LPN B administered Aspirin 81 mg EC (Enteric Coated). During an interview on 1/14/2026 at 11:41 AM, the Director of Nursing (DON) was asked if staff shouldˆadminister medications at the prescribed rate and in the correct form prescribed by the physician. The DON stated, Yes.

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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. Based on facility policy review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 3 (Licensed Practical Nurse (LPN) B left a medication cart unsecured and unattended. The findings include: Review of the facility policy titled, Storage of Medications, dated 11/2020, revealed .The facility stores all drugs and biologicals in a safe, secure, and orderly manner.Drugs and biologicals used in the facility are stored in locked compartments.Only persons authorized to prepare and administer medications have access to locked medications.Compartment (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. Review of the facility policy titled, Medication Administration, dated 7/1/2025, revealed .The medication cart should always be locked when not attended by nurse. During an observation and interview on the 600 Hall on 1/13/2026 at 1:18 PM, LPN B walked away from the 600 Hall F/Bottom Medication Cart and walked into a resident's room out of sight of the surveyor and unsecured medication cart while the Surveyor was performing a medication cart inspection. LPN B was asked if they should have left the Surveyor alone with the medication cart unsecured and unsupervised. LPN B stated No, I should not have, but you are State. During an interview on 1/14/2026 at 11:41 AM, the Director of Nursing (DON) was askedˆif medication carts should be locked and secured at all times when unattended. The DON stated Yes. The DON was asked if a nurse should leave a medication cart unsecure and unattended while a Surveyor performed a medication cart inspection. The DON stated No, not if they were out of sight of the cart.ˆ