STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515117	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Healthcare Center	462 Kenmore Drive Danville, WV 25053

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on resident interviews, record review, and staff interview, the facility failed to include residents in their care plan meetings and ensure care plans were reviewed at least quarterly. Furthermore, the facility failed to revise the care plan for Resident #71's dentures. This was true for three (3) of five (5) residents sampled for care planning during the Long-Term Care Survey process. Census: 89 Resident identifier: #88, #71, #9a) Resident #71 During an interview on 06/22/26 at 12:16 PM, Resident #71 stated she had not been invited to attend care plan meetings. Review of Resident #71's medical records showed a care plan meeting had been held on 03/13/25 and the resident had attended. However, no further care plan meetings were documented since then. On 06/23/26 at 2:45 PM, the facility's Social Worker confirmed 03/13/25 was the last care plan conference that had been held regarding Resident #71. She stated she was behind on holding resident care plan meetings. During an interview on 06/22/26 at 12:16 PM, Resident #71 stated she had been fitted for an upper denture but had not received it yet. Review of the resident's medical records showed the resident had been fitted for an upper denture on 04/09/26. The expected delivery date for the denture was 07/09/26. Review of Resident #71's comprehensive care plan showed the following focus initiated on 12/04/24, The resident is at risk for oral/dental problems r/t [related to] being edentulous. She chooses to not wear dentures. On 06/25/2026 at 10:14 AM, the Director of Nursing confirmed Resident #71's care plan had not been revised to reflect the resident had been fitted for an upper denture and was awaiting arrival of the upper denture. No further information was provided through the completion of the survey process. b) Resident #9 A policy titled, Plan of Care Overview reads, Resident/representative will have the right to participate in the development and implementation of his/her own plan of care. The policy also stated that the facility will review care plans quarterly and/or with significant changes in care. (continued on next page)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During initial interview on 06/22/26 at 11:45 AM, Resident #9 stated that she had not been invited to care plan meetings. A review of the health record shows no documented invitations or attendance of care plan meetings since admission. In an interview with Director of Social Services (DoSS) #88 on 06/23/26 at 2:40 PM, she stated she was the only social worker for 90 residents and was behind on care plan meetings. The DoSS said, If it isn't in the documentation, then it probably wasn't done. This was in response to the question of whether state surveyor could find documentation of invitation or attendance of the care plan meetings. c) Resident #88 In an initial interview with Resident #88 on 06/22/26 at 12:10 PM, he stated he had not been invited to, nor participated in his quarterly care plan meetings. A review of the electronic medical record reveals that Resident #88 has participated in his care plan on 03/27/25 and 03/05/26. In an interview with DoSS #88 on 06/23/26 at 2:40 PM, DoSS stated she was the only social worker for 90 residents. DoSS said she was behind on care plan meetings. DoSS said, If it isn't in the documentation, then it probably wasn't done. This was in response to the question of whether state surveyor could find documentation of invitation or attendance of the care plan meetings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to obtain consent from the resident's representative on the POST form, instead it was signed by a resident who did not have capacity at the time of consent. This was found to be true for one (1) of three (3) residents reviewed for Advanced Directives during the long term care survey process. Resident identifier: #11. Facility census: 89. Findings included: Findings included: a) Resident #11 Medical Record Review (MRR) revealed Resident #11 had the following mental health diagnoses:-Vascular Dementia-Major Depressive Disorder-Hallucinations-Unspecified Mood Disorder-Anxiety A [NAME] Virginia Post Form was completed for the resident on [DATE]. The resident signed the POST Form on [DATE], selecting Cardiopulmonary Resuscitation (CPR) with full treatment. On the same date ([DATE]), a physician deemed the resident to not have capacity to make medical decisions and that a medical power of attorney representative or surrogate decision-maker may be making medical decisions regarding life-prolonging intervention or mental health treatment for him/her. On [DATE], the surveyor asked the Nursing Home Administrator who in the facility oversaw the residents' POST forms. He responded, The Director of Admissions (DoA). The surveyor then reviewed with the Director of Admissions on [DATE] at 3:05 PM, the resident's POST form and the physician's determination of capacity for Resident #11. The Director of Admissions (DoA) acknowledged this error, and stated she would update this form.

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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 record review and staff interview, the facility failed to provide documentation that the Notice of Medicare Non-Coverage (NOMNC) was delivered to resident representative. This was true for one (1) of two (2) residents sampled for Beneficiary notification during the Long-Term Care Survey process. Census: 89 Resident identifier: #101a) Resident #101 The Medicare Claims Processing Manual section 260.3.8 titled NOMNC Delivery to Representatives reads as follows: The NOMNC must be annotated with the following information on the day that the provider makes telephone contact: Reflect that all of the information indicated above was communicated to the representative; Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file. The NOMNC dated 11/26/25 shows that Social Services called the resident representative on 11/24/25 but was signed by only one facility representative. In an interview with Director of Social Services #88 on 06/24/26 at 12:55 PM, she confirmed that the NOMNC for Resident #101 was done verbally over the phone with only one (1) person signing as the facility representative and best practice is to have two (2) signatures. In an interview with Director of Social Services #88 on 06/25/26 at 10:30 AM, she stated she could not provide documentation that the NOMNC was mailed to the resident representative because they do not use certified mail and there is no documentation in the medical record stating this was done.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the Pre-admission Screening Resident Record (PASRR) was not updated when the resident had new mental health diagnoses of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder, and the PASARR was not coordinated with the Minimum Data Set (MDS). Failure to coordinate the PASARR and the MDS can lead to duplication of effort and testing. This was found to be true for one (1) of two (2) residents reviiewed during the long term care survey process. Resident identifier: #89. Facility census: 89. Findings included: a) Resident #89 Resident #89 was admitted to the facility on [DATE]. A physician determined the resident did not have decision-making capability for health care decisions. Upon admission to the facility, the resident had the following diagnoses relating to mental health: -AUDITORY HALLUCINATIONSN/A, not an acceptable Primary Diagnosis 11/25/2025-ANXIETY DISORDER, UNSPECIFIED 08/07/2025 Present on admission The resident obtained new mental health diagnoses during the stay at the facility. These included: -POST-TRAUMATIC STRESS DISORDER, CHRONIC 05/07/26-MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED 05/07/26 The Pre-admission Screening and Resident Record (PASARR) was most recently completed on 01/29/26 by the facility. On this PASARR, Section 30 Current Diagnosis the person completing the PASARR is to check all the diagnoses that apply. Checked was Other Related Conditions, and typed in below was anxiety, depression and auditory hallucinations. The resident subsequently acquired new diagnoses for Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder on 05/07/26, during the stay at the facility, and the PASARR was not updated and submitted for Level II review. The NHA was asked who normally completes the PASARR at the facility, and the NHA responded it was usually either the Director of Admissions or the Director of Social Services. During an interview with the Director of Admissions and the Director of Social Services on 06/23/26 at 3:00 PM, the PASARR was reviewed and the resident's diagnoses. It was confirmed the PASARR needed to be updated for Major Depressive Disorder and PTSD, which were diagnosed on [DATE].

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on resident interview, record review, and staff interviews, the facility failed to ensure a dependent resident received services to maintain gained level of independence with activities of daily living (ADLs) after finishing therapy services. This was true for one (1) of four (4) resident sampled for ADLs during the Long-Term Care Survey process. Census: 89 Resident identifier: #9a) Resident #9 During an interview with Resident #9 on 06/22/26 at 11:49 AM, she stated she was supposed to walk daily with nursing staff since being discharged from therapy but has only walked once. A record review of the walking tasks for April, May, and June 2026 revealed Resident #9 walked with nursing staff once in the last three (3) months. The Physical Therapy discharge note dated 04/24/26 reads, discharge recommendations: transfers to wheelchair daily with assist of nursing staff. Ambulation with rolling walker with assistance from nursing staff with wheelchair follow as tolerated. The discharge also shows that Resident #9 was able to ambulate 65 feet with rolling walker with contact guard assist (CGA) with fair balance as of 04/24/26. In an interview with Physical Therapy Assistant (PTA) #110 at 9:15AM on 06/24/26, he stated he would expect a resident discharged from therapy with recommendations to ambulate with a rolling walker and nursing assistance to walk daily unless the resident refused. He stated he would also expect for Resident #9 to be able to maintain the assistance levels from discharge at least through the next quarter, when she would automatically be screened again for therapy. In an interview with Nursing Assistant (NA) #52 and NA #70 on 06/24/26 at 10:15 AM, they reported that they do not assist Resident #9 regularly. However, when they assisted her over the last 3 months, she only required minimal assistance for bed-to-wheelchair transfers, but they had never seen her walk. In an interview with CNA #76 at 10:30AM on 06/24/26, she stated Resident #9 is able to walk with touching assistance about 20 feet. CNA #76 states Resident #9 gets up daily and rarely, if ever refuses. In an interview with the DON at 10:50 AM on 06/24/26, she stated she would expect nursing staff to walk residents daily if that was the recommendation from therapy at discharge. She confirmed that according to documentation, Resident #9 has only walked once with nursing staff since discharge from 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. Based on observation, record review, and staff interview, the facility failed to store and label medications within accepted standards of practice. A Humalog Insulin Kwikpen located in the medication cart was past its expiration date based on when the medication was opened. Additionally, a multi-use vial of tuberculin purified protein derivative (PPD) located in the medication refrigerator had not been dated when first accessed. These were random opportunities for discovery during the facility task of medication storage. Resident Identifier: #9. Facility Census: 89. Findings included:a) Policy review The facility's policy titled, Vials and Ampules of Injectable Medications, with an effective date of September 2025, stated that when a vial is opened, the nurse should record the opened date on the vial. Nurses may also record the expiration date on the vial. b) Resident #9 - Humalog Kwikpen On 06/24/26 at 8:05 AM, the west wing medication cart was inspected with Licensed Practical Nurse (LPN) #22 in attendance. In the cart was a Humalog Insulin Kwikpen for Resident #9. Written on the pen label was an opening date of 05/10/26 and a use by date of 06/10/26. LPN #22 confirmed the Humalog Insulin Kwikpen should have been discarded. Review of Resident #9's physician's orders showed the resident's Humalog insulin sliding scale coverage had been discontinued on 05/22/26. However, the resident was having fingerstick blood glucose levels checked twice a day and could have required insulin coverage for an extremely high reading. According to the Humalog Kwikpen prescribing insert, available on-line on the Food and Drug Administration (FDA) Website, Do not use your pen past the expiration date printed on the label or for more than 28 days after you first start using the pen. c) Tuberculin PPD On 06/24/2026 at 8:37 AM, the east wing medication refrigerator was inspected with Licensed Practical Nurse (LPN) #1 in attendance. The refrigerator contained a multi-use vial of tuberculin purified protein derivative (PPD) that had not been labeled when first opened. The vial's labeling showed it had been delivered by the pharmacy on 06/01/26. Tuberculin PPD is used to aid in the diagnosis of tuberculosis infection. According to the Tuberculin PPD prescribing insert, available on-line on the Food and Drug Administration (FDA) Website, a vial that has been entered and in use for 30 days should be discarded. LPN #1 confirmed the vial had not been dated when first opened but should have been dated. No further information was provided through the completion of the survey process