

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  |                                                                                                       |                                                                                                                          |                                                                    |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255278</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                  |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/31/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HILLCREST NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 FIRST AVENUE NORTHEAST</b><br><b>MAGEE, MS 39111</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                               | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted two (2) Complaint Investigations (CI MS#24706 and CI MS# 25156), at the facility from 7/30/24 through 7/31/24. CI MS #24706 was investigated regarding Infection Control with the kitchen staff not having Styrofoam plates, cups, bowls, and lids for COVID residents and not having items in the kitchen the residents need. CI MS #25156 was investigated regarding call lights not in reach and Quality of Care. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and there were no deficiencies cited.</p> <p>The facility had a census of 87 and a licensed for 100.</p> |                                                                            |  | F 000                                                                                                 |                                                                                                                          |                                                                    |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/08/2024

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.