STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255278	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING CENTER	1401 FIRST AVENUE NORTHEAST MAGEE, MS 39111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 4/14/25 through 4/17/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F657, F695 and F761. The facility held a license for 100 beds, with a census of 86.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		5/19/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/01/2025

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and record review, the facility failed to implement the care plan interventions related to oxygen administered for one (1) of 19 care plans reviewed. Resident #79. Findings Included: A record review of the facility's policy, "Care Plan Process" revised 12/24, revealed, " ...The overall care plan should be oriented towards ...10. Assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs ...The Care Plan Format includes ...the interventions, the staff responsible to carry out the interventions ..." A record review of the "Comprehensive Care	F 656	On 4/17/25, the Facility Nurse Practitioner (FNP) assessed resident #79 with no concerns noted. Resdient #79 discharged from the facility on 4/19/25. Any resident who uses oxygen has the potential to be affected. On 4/17/25, the Director of Nursing (DON) in serviced the nursing department related to following the care plans on residents receiving oxygen. On 4/30/25, the QA Committee reviewed the policy 'care plan process' with no recommended changes to the policy. Beginning 4/28/25, the RN Supervisor will audit care plans related to oxygen use	

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F 656	Continued From page 2 Plan" revealed Resident #79 had a care plan "Focus The resident has a hx (history) of Asthma ...Interventions...Oxygen at 2L/MIN (Liters per minute) per NC (Nasal Cannula) as needed for SOB (Shortness of Breath). On 4/16/25 at 9:15 AM, during an observation of Resident #79 in bed, the oxygen concentrator at the bedside was observed to be running at a flow rate of three (3) liters per minute. A record review of the "Order Listing Report" revealed Resident #79 had a Physician's Order, revised 4/15/25, for oxygen via nasal cannula at 2 liters per minute for shortness of breath or oxygen saturation of 93% or below every 24 hours as needed. On 4/17/25 at 9:10 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that the physician order and care plan for Resident #79 indicated that the resident should be receiving oxygen at two (2) liters per minute via nasal cannula. LPN #1 confirmed that the oxygen should not have been set at three (3) liters and acknowledged that staff are expected to follow the resident's physician orders and care plan interventions as written. On 4/17/25 at 9:40 AM, during an interview with the Director of Nursing (DON), she confirmed that care plan interventions must be implemented as written. She acknowledged that a discrepancy between the oxygen flow rate provided, and the resident's physician order and care plan represent a failure to follow the individualized plan of care. She stated that if the resident requires an adjustment to the oxygen level, the nurse must obtain a physician's order and update the care	F 656	weekly for 4 weeks and then monthly times 2 months. The QA Committee will review the audits on a monthly basis for 3 months to ensure ongoing compliance with F tag 656 beginning on May 19, 2025.	

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F 656	Continued From page 3 plan accordingly. A record review of the "Admission Record" revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired. Further review revealed under Section O that he was receiving oxygen therapy.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		5/19/25

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F 657	Continued From page 4 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to revise a comprehensive care plan for a resident with an indwelling catheter for one (1) of 19 care plans reviewed. Resident #79 Findings include: A review of the facility' policy, "Care Plan Process" dated 12/2024 revealed... "The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided..." On 04/14/25 at 12:29 PM, during an observation, Resident #79 was sitting in a wheelchair in his room and catheter tubing was observed near his leg. A record review of the "Care Plan Report" revealed Resident #79 had a care plan focus of "The resident has a...Catheter." There was no intervention related to how often catheter care should be performed or the position responsible for providing the care. A record review of the "Task List Report", initiated on 3/10/25, revealed Certified Nurse Aides (CNAs) documented the task of "Bladder Voiding and Toilet Use, Cath Use" every shift for Resident	F 657	Resident #79 care plan was revised on 4/17/25, by Registered Nurse (RN) Case Manager. Residents who require catheter care have the potential to be affected. On 4/17/25, the Director of Nursing (DON) in serviced the Minimum Data Set (MDS) department related to the care plan process. On 4/30/25, the Quality Assurance (QA) Committee reviewed the policy 'care plan process' with no recommended changes to the policy. Beginning 4/28/25, the facility (RN) Case Manager will audit care plans related to catheter care weekly for 4 weeks and then monthly times 2 months. The (QA) Committee will review the audits on a monthly basis for 3 months to ensure ongoing compliance with F tag 657 beginning on May 19, 2025.	

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F 657	Continued From page 5	F 657		

#79.

A record review of the"Follow Up Question Report" for 04/01/25 through 04/16/2025 revealed catheter care was provided by CNAs for Resident #79.

On 04/15/2025 at 10:05 AM, in an interview with CNA #1, she explained that the CNAs are responsible for catheter care and documenting in the Electronic Health Record (EHR). She stated that catheter care is displayed on the computer for them to document the task every shift.

On 04/16/2025 at 11:16 AM, in an interview with Registered Nurse (RN) #1 she confirmed that the care plan for Resident #79 did not include an intervention for routine catheter care. She stated that a physician's order is not required for catheter care and they had not added it to the care plan. She agreed that routine catheter care should have been included as an intervention and the care plan revised to reflect the frequency and discipline responsible for the care.

On 04/17/2025 at 08:59 AM, during an interview with the Director of Nursing (DON), she stated that she was made aware that the care plan related to catheter care for Resident #79 had not been revised to include an intervention for routine catheter care. She reported that the care plan team had already begun to correct this issue.

A record review of the "Admission Record" revealed the facility admitted Resident #79 on 03/10/2025 with diagnoses including Acute Kidney Failure.

A record review of the Comprehensive Minimum

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F 657	Continued From page 6 Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated his cognition was moderately impaired. Further review revealed he had an indwelling catheter.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the oxygen flow rate was consistent with the physician's order for one (1) of one (1) resident reviewed for oxygen administration. (Resident #79) Findings included: A record review of the facility's policy "Drug Administration and Documentation," revised 3/25 revealed, " ...The complete act of administration entails ...verifying it with the physician's orders ..." A record review of the "Order Listing Report" revealed Resident #79 had a Physician's Order, revised 4/15/25, for oxygen via nasal cannula at two (2) liters per minute for shortness of breath or	F 695	On 4/17/25, the Family Nurse Practitioner (FNP) assessed resident #79 with no concerns noted. Resident #79 discharged form the facility on 4/19/25. Registered Nurse (RN) Supervisor performed an audit on 4/17/25, to ensure residents concentrators settings matched their physician orders. Residents who have orders for oxygen have the potential to be affected. On 4/17/25, the Director of Nursing (DON) in serviced the nursing department related to ensuring residents are receiving oxygen per physician orders. The Quality Assurance (QA) Committee met on 4/30/25, to discuss findings from survey	5/19/25

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F 695	Continued From page 7 oxygen saturation of 93% (per cent) or below every 24 hours as needed. During an observation on 4/16/25 at 8:40 AM, Resident #79 was observed receiving oxygen via nasal cannula at a flow rate above three (3) liters per minute. During an observation and interview with Licensed Practical Nurse (LPN) #1 on 4/16/25 at 9:22 AM, Resident #79's oxygen flow was observed at 3.4 liters per minute. LPN #1 stated the resident's oxygen typically runs at three (3) liters per minute. During an observation and follow up interview with LPN #1 on 4/16/25 at 11:08 AM, LPN #1 confirmed the oxygen flow was above 3 liters per minute. She stated she had checked the oxygen flow that morning and she had not changed the setting. She confirmed the physician's order was for 2 liters per minute as needed and acknowledged the oxygen should never be adjusted without a new physician order. She explained that receiving oxygen at a higher rate than ordered could lead to adverse effects and make it harder for the resident to breathe. During an interview on 4/17/25 at 10:37 AM, the Director of Nursing (DON) stated when a resident receives more oxygen than ordered, their lungs may have to work harder to exhale. She stated the nurse should check the order and ensure it is followed every shift. A record review of the "Admission Record" revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing.	F 695	exit and systemic changes needed to ensure this deficient practice does not re occur. Beginning 4/28/25, the (RN) Supervisor will audit residents receiving oxygen to ensure concentration level on oxygen concentrator is the same as physician orders weekly for 4 weeks, then monthly times 2 months. The (QA) Committee will review the audits on a monthly basis for 3 months to ensure ongoing compliance with F tag 695 beginning on May 19, 2025.	

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F 695	Continued From page 8 A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired. Further review revealed he was receiving oxygen therapy.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/19/25

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F 761	Continued From page 9 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were not left unattended at the bedside or on the medication cart for two (2) of four (4) residents observed during medication administration. Residents #19 and #79. Findings Included: A review of the facility's policy, "Drug Administration and Documentation," revised 3/25, revealed, " ...Under no circumstance is medication to be left at the bedside or given to the resident without him/her swallowing it in your presence... Do not leave any medication on top of the medication cart unattended ..." Resident #19 A record review of the "Order Listing Report" revealed Resident #19 had a Physician's Order, revised 9/3/2024, for Polyethylene Glycol 3350 Oral Powder 17 gram/scoop, one (1) scoop orally two (2) times daily, mix in juice or water. On 4/16/25 at 8:00 AM, during an observation of medication administration, Licensed Practical Nurse (LPN) #2 administered Polyethylene Glycol 3350 Oral Powder 17 gram/scoop in water to Resident #19. She left the medication at the bedside and informed the resident she was going to leave it for her to finish drinking. On 4/16/25 at 10:46 AM, during an interview with LPN #2, she stated that some days she leaves Polyethylene Glycol 3350 at the bedside and that the amount left varies. She stated the resident takes a while to drink it and she does not want to rush her. She confirmed that Polyethylene Glycol	F 761	* On 4/21/25, the Registered Nurse (RN) Supervisor assessed resident #19 with no adverse finding noted. On 4/17/25, Family Nurse Practitioner (FNP) assessed resident #79 with no concerns noted. Resident #79 discharged form the facility on 4/19/25. On 4/17/25, Licensed Practical Nurse (LPN) #1 and (LPN) #2 were in serviced on Drug Administration and documentation by Director of Nursing (DON). * All residents who receive medications from the facility staff have the potential to be affected. * On 4/16/25, the Staff Development Coordinator (SDC) in serviced the (LPNs) and (RNs) related to leaving medication unattended. On 4/30/25, the Quality Assurance (QA) Committee reviewed the policy 'Drug Administration' with no recommended changes to the policy. * Beginning April 28, 2025, the (RN) Supervisor will observe 5-10 med passes weekly for 4 weeks and then monthly times 2 months to ensure medications are not being left unattended. The (QA) Committee will review the audits on a monthly basis for 3 months to ensure ongoing compliance with F tag 761 beginning on May 19, 2025.	

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F 761	Continued From page 10	F 761		

3350 is a medication and should not be left at the bedside. She acknowledged that if the medication is left unattended, there is no way to confirm whether the resident consumed the full dose, and that physician orders required a full dose to be taken.

A record review of the "Admission Record" revealed the facility admitted Resident #19 on 9/6/19 with diagnoses including Constipation.

A record review of the "Minimum Data Set (MDS) with an Assessment Reference Date (ARD)" of 4/14/25 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of ten (10), which indicated her cognition was moderately impaired.

Resident #79

On 4/16/25 at 9:22 AM, during an observation of medication preparation for Resident #79, LPN #1 was observed placing a vial of Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligrams)/3ML (milliliters) on top of the medication cart and leaving the medication unattended while she left to retrieve supplies. The medication cart was unattended for two (2) to three (3) minutes.

On 4/17/25 at 10:15 AM, during an interview with LPN #1, she acknowledged that she should not have left Resident #79 medication on the cart and stated she was not thinking. She admitted that she knew better and that leaving medication unattended on the cart could result in another resident taking it.

On 4/17/25 at 10:33 AM, during an interview with

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F 761	Continued From page 11	F 761		

the Director of Nursing (DON), she confirmed that no medications should be left unattended on the cart or in residents' rooms. She stated that leaving medications unattended could result in uncertainty about whether the resident took, discarded, or pocketed the medication. She stated that staff are expected to always follow medication administration policy.

A record review of the "Order Listing Report" revealed Resident #79 had a Physician's Order, revised 4/15/25, for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (a type of nebulizer medication) every 12 hours as needed for wheezing and cough.

A record review of the "Admission Record" revealed the facility admitted Resident #79 on 3/10/2025 with current diagnoses including Cough and Wheezing.

A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated his cognition was moderately impaired.