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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 26 residents out of 27 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26) were free of misappropriation of their property when Bookkeeper A utilized resident trust accounts and resident cash for his/her own personal use totaling $20,110. The facility census was 84. The administration was notified on 03/28/25 of the Past Non-Compliance which occurred between 02/06/25 through 02/10/25. On 02/06/25, upon notification, the facility administrator started an investigation, notified the police department and the Department of Health and Senior Services of the misappropriation. The non-compliance was corrected on 02/10/25, as the facility completed disciplinary action for Bookkeeper A, in-serviced staff on the facility's policy and procedure on misappropriation and refunded residents' the amounts misappropriated. Review of the facility's policy entitled, "Abuse Prohibition Protocol Manual", dated November 2016, showed:	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/17/2025

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.

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 1 -Misappropriation of resident property defined as deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money with the resident's consent; -Employees are educated on Abuse Protocol upon hire and annually. Review of facility policy entitled, "Instructions for Daily Cash Box Duties and Reconciliation", undated, showed: -Cash box is for residents' personal use and facility shopping for residents only and cash is not to be used to pay bills or reimburse family members; -Cash box reconciliations must be turned in by 4:00 P.M. each day; -Each cash withdrawal must be listed on the reconciliation report; -Three signatures are required on the reconciliation report (Business Office Manager, Administrator or designee and a witness); -A completed and signed disbursement log with a reason for the cash request must be listed; -A yes or no must be entered if the facility shopped for the resident or not. If cash was used by the facility to shop for the resident, the resident or legal representative must sign the disbursement logt to give consent to shop for the resident. Signed receipts must be attached; -If cash is given directly to the resident, the resident must sign the disbursement log. If the resident makes a mark or the signature is not legible, two witness signatures are required; -Do not enter "personal spending" as the reason for cash disbursement. Must have more detail like shopping at Walmart, vending machine cash or snacks, etcetera; -Cash tickets must be entered in the computer	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 2 system for each cash withdrawal before sending in the reconciliation form. Review of the facility's investigation summary dated, 02/25/25, showed: -On 02/06/25, Social Services Assistant (SSA) B notified Resident #1's family of the resident's trust account (RTA) getting low on money. Resident #1's family said there was no way this was possible as Bookkeeper A said in January 2024 the RTA had thousands of dollars in it. Resident #1's family said the resident had no concept of money and he/she always takes the resident to the store to buy what the resident needs and the resident's craft items. SSA B said he/she would inform the Administrator so the account could be looked into; -On 02/06/25, Administrator contacted the facility's Financial Consultant (FC) regarding the concern and an audit was started. In-Service was also started regarding Abuse/Neglect Protocol. Bookkeeper A had been out of the facility on leave since 01/17/25. All staff informed Bookkeeper A was not to be in the building pending the investigation. Locks on the bookkeeping office and front office doors were changed; -On 02/10/25, the audit by FC identified seven possible RTAs for misappropriation. Reports were made to Department of Health and Senior Services (DHSS), law enforcement, the local ombudsman and family representatives regarding the possible misappropriation; -On 02/11/25, RTA audits completed and identified five resident RTAs affected (Residents #1, #2, #3, #4 and #5), who had no previous cash withdrawals until after Bookkeeper A took over. Bookkeeper A took the position in 05/2023. Bookkeeper A failed to respond to multiple facility	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 3 attempts for a statement and termination process was started; -On 02/12/25, Bookkeeper A notified by voicemail employment had been terminated. The five affected residents' family representatives were notified funds were reimbursed; -On 02/13/25, Resident #6 was reimbursed due to facility being unable to determine if there resident requested money, as the request was not signed off per facility policy; -On 02/18/25, facility informed by Resident #8's family to move his/her funds into Resident #7's RTA as Resident #8 had passed. Investigation revealed Resident #7 and Resident #8 did not have RTAs set up. Family member informed facility he/she had given $100 to Bookkeeper A to put $50 in Resident #7's RTA and $50 in Resident #8 RTA. Receipt was found for the $100 but funds were not deposited into the petty cash account in order for a check to be written to the RTA. A second family member of Resident #7 and Resident #8 said he/she had also given $100 to Bookkeeper A and was not given a receipt as he/she met Bookkeeper A in the hallway. 1: Review of Resident #1's face sheet showed: -Admitted 01/18/22; -Diagnoses of intellectual disabilities, dementia, depression and insomnia; -Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by the staff), dated 01/20/25, showed moderate cognitive impairment. Review of Resident #1's RTA statement from 01/01/23 through 02/10/25 in conjunction with facility cash box disbursement logs showed: - Resident #1 had multiple cash withdrawals	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 4 labeled "personal spending" starting 12/13/23 and ending 11/11/24 totaling $1346; -Cash box disbursement log signed by resident and Bookkeeper A; - No witness signature as per the facility policy. 2: Review of Resident #2's face sheet showed: -Admitted 05/15/10; -Diagnoses of cerebral infarction (stroke), major depressive disorder, epilepsy (seizure disorder), dementia and anxiety. -Significant change MDS, dated 02/17/25, showed moderate cognitive impairment. Review of Resident #2's RTA account statement from 01/01/23 through 02/10/25 in conjunction with facility cash box disbursement logs showed: - Resident #2 had multiple cash withdraws labeled personal spending starting 01/24/24 and ending 01/15/25 totaling $1254; -Cash box disbursement log signed by resident and Bookkeeper A; - No witness signature as per the facility policy. 3: Review of Resident #3's face sheet showed: -Admitted 01/22/22; -Diagnoses of paranoid schizophrenia (disorder characterized by persistent delusions of persecution, distrust and hallucinations), depression and dementia; -Quarterly MDS, dated 02/26/25, showed moderate cognitive impairment. Review of Resident #3's RTA account statement from 01/01/23 through 02/10/25 in conjunction with facility cash box disbursement logs showed: - Resident #3 had multiple cash withdraws labeled personal spending starting 01/23/24 and ending 01/10/25 totaling $899;	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 5 -Cash box disbursement log signed by resident and Bookkeeper A; - No witness signature as per the facility policy. 4: Review of Resident #4's face sheet showed: -Admitted 01/25/21; -Diagnoses of chronic obstructive pulmonary disease (COPD-lung disease that blocks air flow making it difficult to breath), dementia, personality disorder, depressive episodes, hallucinations and paranoid schizophrenia; -Quarterly MDS, dated 01/13/25, showed moderate cognitive impairment. Review of Resident #4's RTA account statement from 01/01/23 through 02/10/25 in conjunction with facility cash box disbursement logs showed: - Resident #4 had multiple cash withdraws labeled personal spending starting 10/19/23 and ending 01/09/25 totaling $1436; -Cash box disbursement log signed by resident and Bookkeeper A; - No witness signature as per the facility policy. 5: Review of Resident #5's face sheet showed: -Admitted 10/20/18; -Diagnoses of hypertension (high blood pressure), major depressive disorder, and dementia; -Quarterly MDS, dated 03/10/25, showed severe cognitive impairment. Review of Resident #5's RTA account statement from 01/01/23 through 02/10/25 in conjunction with facility cash box disbursement logs showed: - Resident #5 had multiple cash withdraws labeled personal spending starting 12/11/23 and ending 01/15/25 totaling $430; -Cash box disbursement log signed by resident	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 6 and Bookkeeper A; - No witness signature as per the facility policy. 6: Review of Resident #6's face sheet showed; -Admitted 08/26/14; -Diagnoses of schizophrenia, Parkinsonism (condition causing slowed movements, rigidity and stiffness), depressive episodes, dementia, and anxiety' -Significant change MDS, dated 02/03/25, showed moderate cognitive impairment. Review of Resident #6's RTA account statement from 01/01/23 through 02/28/25 in conjunction with facility cash box disbursement logs showed: - Resident #6 had multiple cash withdraws labeled personal spending starting 01/08/24 and ending 01/10/25 totaling $420; -Cash box disbursement log signed by resident and Bookkeeper A; - No witness signature as per the facility policy. 7: Review of Resident #7's face sheet showed: -Admitted 10/23/24; -Diagnoses of hypertension, dementia, anxiety disorder, restlessness and agitation; -Significant change MDS, dated 01/07/25, showed severe cognitive impairment. Review of Resident #7's RTA showed account created on 02/20/25 after the discovery of the misappropriation. 8: Review of Resident #8's face sheet showed: -Admitted 10/23/24; -Date of Death 02/05/25; -Diagnoses of atrial fibrillation (irregular, rapid heart rate), femur fracture, hearing loss, major depressive disorder and anxiety disorder.	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 7 Review of Resident #8's RTA showed account created on 02/20/25 after the discovery of the misappropriation. Review of facility cash receipt book audits, dated 03/03/25 through 03/07/25, where Bookkeeper A signed the receipts, showed: -On 03/03/25, Resident #9's room and board paid by the resident's representative with funds not deposited for the receipts given and no receipts for deposits from September 2024 through January 2025 with a total of $12885; - A receipt for Resident #10 of $50 but no RTA account, no petty cash deposit and no RTA deposit record; - A receipt for Resident #11 of $30 but no RTA account, no petty cash deposit and no RTA deposit record; -Receipts for Resident #12 totaling $160 but no RTA account, no petty cash deposit and no RTA deposit record; -Receipts for Resident #13 totaling $260 with no petty cash deposit and no RTA deposit; -Receipts for Resident #14 totaling $200 with no RTA account, no petty cash deposit and no RTA deposit record; -Receipts for Resident #15 totaling $100 with no petty cash deposit and no RTA deposit; -Receipt for Resident #16 of $20 but no RTA account, no petty cash deposit and no RTA deposit record; -Receipt for Resident #17 of $50 with no petty cash deposit and no RTA deposit and resident; -Receipt for Resident #18 of $100 with no RTA account, no petty cash deposit and no RTA deposit record; -Receipts for Resident #19 totaling $60 with no RTA account, no petty cash deposit and no RTA	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 8	F 602		

deposit record;
-Receipt for Resident #20 of $20 with no RTA account, no petty cash deposit and no RTA deposit record:
-Receipt for Resident #21 of $60 with no RTA account, no petty cash deposit and no RTA deposit record;
-Receipt for Resident #22 of $40 with no RTA account, no petty cash deposit and no RTA deposit record;
-Receipt for Resident #23 of $20 with no RTA account, no petty cash deposit and no RTA deposit record;
-Receipt for Resident #24 of $20 with no RTA account, no petty cash deposit and no RTA deposit record;
-Receipt for Resident #25 of $50 with no RTA account, no petty cash deposit and no RTA deposit record;
-Receipt for Resident #26 of $30 with no RTA account, no petty cash deposit and no RTA deposit record.

9: Review of Resident #9's face sheet showed:
-Admitted 02/01/24;
-Diagnoses of intellectual disabilities, schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), parkinsonism, and depression;
-Significant change MDS, dated 01/27/25, showed severe cognitive impairment.

10: Review of Resident #10's face sheet showed:
-Admitted 05/11/23;
-Date of Death 06/25/23;
-Diagnoses of vascular dementia (decline in thinking due to decreased blood flow to areas of the brain), malignant neoplasm of the liver (liver

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 9 cancer), pain and type 2 diabetes mellitus (high blood sugars). 11: Review of Resident #11's face sheet showed: -Admitted 05/12/23; -Date of Death 06/16/23; -Diagnoses of lung cancer, liver cancer and bone cancer. 12: Review of Resident #12's face sheet showed: -Admitted 10/05/22; -Date of Death 03/06/25; -Diagnoses of hypertension, chronic kidney disease requiring dialysis, hypertension, diabetes and atrial fibrillation; -Significant change MDS, dated 01/27/25 showed moderate cognitive impairment. 13: Review of Resident #13's face sheet showed: -Admitted 10/13/22; -Diagnoses of Brown-Sequard syndrome (lesion in one (lateral) half of the spinal cord resulting in a specific pattern of symptoms on one side of the body), hypertension, congestive heart failure (heart doesn't pump blood as well as it should) and major depressive disorder; -Significant change MDS, dated 01/10/25, showed cognitively intact. 14: Review of Resident #14's face sheet showed: -Admitted 11/06/23; -Date of Death 05/11/24; -Diagnoses of schizophrenia, vision loss, anxiety disorder, COPD and depression. 15: Review of Resident #15's face sheet showed: -Admitted 07/18/22; -Date of Death 10/13/24; -Diagnoses of hypertension, dementia, chronic	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 10	F 602		

kidney disease and major depressive disorder;
-Significant change MDS, dated 07/22/24, showed moderate cognitive impairment.

16: Review of Resident #16's face sheet showed:
-Admitted 03/01/25;
-Diagnoses of heart failure, posterior displaced type II dens fracture (a break through a specific part of C2, the second bone in the neck), restlessness and agitation, chronic kidney disease and Parkinson's.

17: Review of Resident #17's face sheet showed:
-Admitted 05/21/24;
-Date of Death 08/15/24;
-Diagnoses of cerebral infarction (stroke), anxiety disorder, fracture of part of the neck of the femur (break in neck of femur bone, the long bone of the leg), depression, hypertension, atrial fibrillation and chronic kidney disease.

18: Review of Resident #18's face sheet showed:
-Admitted 11/17/22;
-Discharged 08/16/24;
-Diagnoses of intellectual disabilities, chronic kidney disease, depression, schizoaffective disorder and anxiety.

19: Review of Resident #19's face sheet showed:
-Admitted 03/15/24;
-Diagnoses of chronic lymphocytic leukemia of B-cell type (blood cancer affecting white blood cells), anxiety disorder, insomnia and pain;
-Quarterly MDS, dated 12/30/24, showed severe cognitive impairment.

20: Review of Resident #20's face sheet showed:
-Admitted 12/15/23;
-Diagnoses of Alzheimer's dementia, depression,

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 11 anxiety disorder and hypertension; -Quarterly MDS, dated 03/14/25, showed severe cognitive impairment. 21: Review of Resident #21's face sheet showed: -Admitted 05/07/24; -Diagnoses of Parkinson's, dementia, schizoaffective disorder, major depressive disorder and anxiety disorder; -Significant change MDS, dated 02/11/25, showed severe cognitive impairment. 22: Review of Resident #22's face sheet showed: -Admitted 06/10/24; -Date of Death 11/03/24; -Diagnoses of stroke, amyotrophic lateral sclerosis(Lou Gehrig's disease, weaknes muscles and impacts physical function), chronic kidney disease, diabetes and depression. 23: Review of Resident #23's face sheet showed: -Admitted 03/18/24; -Date of Death 07/10/24; -Diagnoses of COPD, depression, supraventricular tachycardia (rapid heart rate), dependence on oxygen and hypertension. 24: Review of Resident #24's face sheet showed: -Admitted 07/02/24; -Discharged 07/25/24; -Diagnoses of hypertension, history of breast cancer and overactive bladder. 25: Review of Resident #25's face sheet showed: -Admitted 03/10/24; -Date of Death 02/09/25' -Diagnoses of COPD, atrial fibrillation, difficulty swallowing, anxiety, hypertension with heart failure and stroke;	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 12 -Significant change MDS, dated 12/11/24, showed moderate cognitive impairment. 26: Review of Resident #26's face sheet showed: -Admitted 11/26/24; -Diagnoses of Parkinson's, dementia, anxiety and schizoaffective disorder; -Significant change MDS, dated 03/03/25, showed moderate cognitive impairment. During an interview on 02/25/25 at 11:00 A.M., Resident #1 said he/she never gets money from the facility. The resident said his/her family takes him/her shopping or they buy and bring him/her what she needs. Resident said Bookkeeper A has had him/her sign forms before but he/she was not sure what they were for. Resident said he/she did not receive any money from Bookkeeper A. During an interview on 02/25/25 at 11:10 A.M., Resident #2 said he/she has not gotten any cash from the facility and mainly stays in bed in his/her room. Resident #2 said Bookkeeper A has come to his/her room and had him/her sign forms at different times but never received any cash. The resident said he/she was not sure what the forms were for. During an interview on 02/25/25 at 11:19 A.M., Resident #3 said he/she has never asked for or received any money from the facility since he/she has been there. Bookkeeper A comes in at times and has him/her sign a form but he/she was not sure what it was for and did not receive money. During an interview on 02/25/25 at 11:27 A.M., Resident #4 said the facility does shop for him/her. The resident said he/she never asks for	F 602		

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 13	F 602		

money other than for a few dollars occasionally to get a soda or candy bar. Resident #4 said Bookkeeper A has come to his/her room to have him/her sign a form but has not received any money after signing the form.

During an interview on 02/25/25 at 11:38 A.M., Resident #5 said he/she never requests money out of his/her account and has never received any money from Bookkeeper A. Resident said Bookkeeper A has come to his/her room and had him/her sign a form, but he/she was not sure what it was and received no money after signing it.

During an interview on 02/25/25 at 11:49 A.M., Resident #6 said he/she is able to go to the office to get money if he/she needs it. Resident #6 said Bookkeeper A has come to his/her room before and had him/her sign a form but did not receive any money after signing the form.

During an interview 02/25/25 at 1:45 P.M., SSA said he/she had not seen Resident #1, Resident #2, Resident #3, Resident #4 or Resident #5 in the business office requesting money and is not sure they would even know how. SSA said he/she had not seen these residents ever having money on them.

During and interview on 02/25/25, FA said Bookkeeper A received the appropriate training in regards to how RTAs are to be handled. Facility policy requires two witness signatures any time cash is given out of the cash box. When cash is received in the office for a resident account, a receipt should be given and the money should be deposited and the residents' RTA updated with the deposited amount.

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 _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER INC	1108 CLARKE STREET DE SOTO, MO 63020

(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 602	Continued From page 14 During an interview on 02/25/25 the Administrator said when a resident receives cash, the resident is to sign the log, as well as the person handing out the money, as well as a witness. The Administrator said it is never okay for an employee to take funds from a resident. Review of Bookkeeper A's employee filed showed he/she completed the facility bookkeeping training on 05/31/23. During an interview on 03/25/25 at 2:00 P.M., the Police Department said multiple attempts have been made to get an interview with Bookkeeper A before presenting the evidence to the prosecuting attorney. Bookkeeper A has not cooperated in speaking with the police department and has hired an attorney. Complaint# MO00249344	F 602		