

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Hill View Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 28th Street Portsmouth, OH 45662	

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)
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Hill View Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 28th Street Portsmouth, OH 45662	
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)		
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the facility's fall investigation, review of the hospital notes, review of the Medscape guidance, and review of the facility's pain management policy, the facility failed to provide adequate pain management for one resident. This result in Actual Harm for Resident #64 who screamed out in pain at multiple staff, receiving a delay and appropriate treatment of pain beginning 10/30/25 at 6:30 P.M. to 10/31/25 at 12:40 A.M. This resulted in an emergency room visit for acute pain and reporting a severe pain level of nine (pain scale from zero indicating no pain to ten being worst pain). This affected one (Resident #64) of three residents reviewed for pain control. The facility census was 72. Findings include: Review of the closed medical record revealed Resident #64 was re-admitted to the facility on [DATE] and discharged to another facility on 11/10/25. Diagnoses included osteoporosis, osteopenia, atherosclerosis, and a history of bone demineralization. The quarterly Minimum data Set (MDS) assessment dated [DATE] revealed Resident #64 had moderate cognitive impairment and required extensive assistance of two persons with bed mobility and transfers. Review of the care plan dated 02/22/24 revealed Resident #64 was at risk for pain related to osteoarthritis, recent fractures, and to be able to voice a level of comfort. Interventions included pain medications half hour before treatments, turning and repositioning, evaluating effectiveness every shift, notify the physician of any significant change in comfort, and offering non-pharmacological interventions first. Review of the late entry nursing note dated 10/30/25 at 7:45 P.M. revealed Resident #64 was complaining of pain to her left arm. No redness or edema noted. Acetaminophen (Tylenol, treats mild to moderate pain) provided per resident request. Resident repositioned in bed, and call light in place. The Medication Administration Record (MAR) for 10/30/25 revealed Acetaminophen 325 milligrams (mg) two tablets by mouth every eight hours as needed for pain. This resident was administered this medication as documented at approximately 7:45 P.M. for a pain level of nine (pain scale from zero indicating no pain to ten being worse pain ever.) The post administration assessment pain level was seven out of 10. There was no time documented as to when the post assessment pain was assessed. There were no documented interventions attempted to relieve Resident #64's pain after 7:45 P.M. on 10/30/25. The late entry nursing note dated 10/30/25 at 10:30 P.M. revealed the nurse was summoned to resident's room still complaining of pain in left arm. Physician made aware. The nursing note dated 10/30/25 at 11:00 P.M. revealed Resident #64 complained of pain in her left arm and elbow. The evening shift nurse messaged physician about the pain. No redness or swelling currently. The nursing note dated 10/31/25 at 12:00 A.M. revealed the physician responded to a text and provided an order to send Resident #64 to the emergency room (ER) for evaluation. The nursing note dated 10/31/25 at 12:42 A.M. revealed emergency medical services (EMS) arrived at the facility at approximately 12:40 A.M. to transport Resident #64 to the hospital. Family members were waiting at the hospital for the resident's arrival. Review of the hospital encounter report dated 10/30/25 revealed Resident #64 resided in a long-term-care facility. Resident #64 was brought in complaining of left elbow pain and was brought to the ER by EMS. Resident #64 was assessed to have a pain level of nine out of 10 upon her arrival at the hospital. Work-up in the ER revealed a previous shoulder fracture and a new acute displaced transcondylar humerus fracture (serious break at the lower end of the upper arm near the elbow joint, where bone fragments have significantly shifted out of alignment) to her left elbow. Resident #64 was treated with nonsurgical interventions with a sling/immobilizer to her left arm. Resident #64 was discharged back to the facility on [DATE], with orthopedic follow up on 11/06/25 and a medication order for Norco 5-325 (narcotic pain medication to treat severe pain) mg by mouth every four hours as needed for pain control. The nursing note dated 10/31/25 at 3:30 A.M. revealed Resident #64 returned from the ER and records sent with no new orders for the right shoulder, with the right elbow showing the appearance of an acute displaced transcondylar humerus fracture and joint effusion. Recommend orthopedic consult. Review of the facility's fall investigation report dated 10/31/25 completed by the Director of Nursing (DON) revealed Resident #64 began complaining of pain to the left arm on 10/30/25 at approximately 7:30 P.M. The report revealed Resident #64 sustained an acute left displaced transcondylar humerus fracture to her left elbow and complained of left elbow pain after being sent to the hospital and returning on 10/31/25 around 4:00 A.M. Review of the e-mail statement provided by Certified Nursing Assistant (CNA) #590 dated 10/31/25 revealed CNA #590 had entered the resident's room to feed her dinner around 5:45 P.M. with the resident reporting no complaints of pain at that time. She stated she had returned</p>		