

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hill Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  808 Northwest M L King Avenue Idabel, OK 74745	

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 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to ensure residents were free from abuse for one (#1) of three sampled residents reviewed for abuse. The deficient practice resulted in skin tears to the resident's wrists.</p> <p>The administrator identified five allegations of abuse in the last six months.</p> <p>Findings:</p> <p>A policy title Abuse, Neglect and Exploitation, dated 08/07/24, read in part, The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or occur .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but not limited to: D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; .The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made.</p> <p>A policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 08/07/24, read in part, When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will:</p> <ol style="list-style-type: none"> <li>a. Respond to the needs of the resident and protect him/her from further incident.</li> <li>b. Remove the accused employee from resident care areas.</li> <li>c. Notify the Administrator or designee.</li> <li>d. Notify the attending physician, resident's family/legal representative, and Medical Director. e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions.</li> </ol> <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:  375234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hill Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  808 Northwest M L King Avenue Idabel, OK 74745	
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>f. Document actions taken in the medical record.</p> <p>A policy titled QAPI Coordination in Situations of Abuse, Neglect and Exploitation, dated 08/07/24, read in part, All reports of abuse, neglect, misappropriation of resident property and exploitation, whether by staff or residents, will be communicated to the QAA committee for tracking and corrective action .The QAA committee will determine through a coordinated effort:</p> <ul style="list-style-type: none"> <li>a. If a thorough investigation is conducted;</li> <li>b. Whether the resident is protected; .</li> <li>e. Whether there is further need for systemic actions such as: .</li> <li>ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about; .</li> <li>iv. Measures to verify the implementation of corrective actions and timeframes, and</li> <li>v. Tracking patterns of similar occurrences.</li> </ul> <p>Resident #1 had diagnoses which included dementia with behavioral disturbances, anxiety disorder, delusional disorders, and major depressive disorder.</p> <p>The care plan, dated 02/13/24, documented the resident had dementia with impaired cognition with frequent verbal and physical behaviors. The care plan documented staff were to leave the resident alone and retry later or get a different caregiver to provide care.</p> <p>A quarterly assessment, dated 07/08/24, documented the resident was severely impaired for daily decision making and required substantial/maximal assistance with most activities of daily living.</p> <p>A witness statement for incident reports, dated 07/28/24 at 12:00 p.m., documented an employee witnessed CMA #1 attempting to give medicine to the resident. The witness statement documented the resident did not want to take the medicine and threw the spoon at CMA #1. The witness statement documented the resident started hitting the CMA and the CMA took the cup of water they were holding and threw the water in the resident's face. The witness statement documented the resident started hitting CMA #1 again and the CMA stated, If your going to hit me then I'm going to make you hit yourself. The witness statement documented CMA #1 grabbed the resident by both wrists and hit them against the resident's face. It was documented the resident became more combative. The witness statement documented the CMA grabbed the resident again and stated, [Verbiage withheld] you better stop playing with me. The witness statement documented the CMA grabbed the resident by the wrists slamming the resident further back in the bed causing the resident to hit their head on the bed rails.</p> <p>An incident report, dated 07/28/24, documented an allegation of abuse for Resident #1 and CMA #1. The report documented the administrator was made aware of the incident on 07/29/24 at 1:00 p.m. by the resident's family. The report documented an investigation revealed Resident #1 became combative with CMA #1 and CMA #1 grabbed Resident #1's wrists causing skin tears. The report documented the primary care physician, family, administrator, and DON were notified and safety precautions maintained.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hill Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  808 Northwest M L King Avenue Idabel, OK 74745	
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A time card report, dated 07/28/24, documented CMA #1 worked from 7:51 a.m. to 12:38 a.m totaling 16.30 hours.</p> <p>A disciplinary report form, dated 07/28/24, documented on 07/29/24 LPN #2 was placed on suspension pending the investigation. The report documented LPN #2 was terminated for failure to notify the administrator, DON, and remove CMA #1 after the incident on 07/28/24.</p> <p>A disciplinary report form, dated 07/28/24, documented on 07/29/24 at 4:00 p.m. CMA #1 was placed on suspension pending an investigation. The report documented on 08/05/24 after the investigation was completed the staff member was terminated.</p> <p>A police department incident report, dated 07/29/24 at 8:50 p.m., documented the police was dispatched to the facility to take an information report.</p> <p>A fax transmission verification report, dated 07/29/24 at 8:51 p.m., documented the allegation of abuse was reported to the Oklahoma State Department of Health.</p> <p>A documented interview with Resident #1's family, dated 07/29/24, documented at 1:15 p.m. the family visited the resident and noticed the resident's right and left hands were bleeding. It was documented the family inquired about the injury and was told by CMA #1 the resident became combative and We weren't going to let [them] hit us.</p> <p>A class attendance record, dated 08/01/24, documented an in-service regarding elderly abuse and neglect was provided to staff.</p> <p>On 11/13/24 at 2:45 p.m., the APRN stated they were notified of the allegation of abuse regarding Resident #1 a few days after the incident occurred.</p> <p>On 11/14/24 at 9:43 a.m., the administrator stated LPN #2 did not report the allegation of abuse regarding Resident #1 to them or protect the resident from the identified staff member. The administrator stated they did not report the allegation of abuse to the Oklahoma State Department of Health within the two hour required time frame. The administrator stated the QAPI committee had not had a meeting since sometime in April 2024. The administrator stated the incident regarding the allegation of abuse had not been presented in a QAPI meeting. The administrator stated their abuse policy was not followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hill Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  808 Northwest M L King Avenue Idabel, OK 74745	
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to implement their written abuse policies and procedures for one (#1) of two sampled residents reviewed for abuse.</p> <p>The administrator identified five allegations of abuse in the last six months.</p> <p>Findings:</p> <p>A policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 08/07/24, read in part, When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will:</p> <ul style="list-style-type: none"> <li>a. Respond to the needs of the resident and protect [them] from further incident.</li> <li>b. Remove the accused employee from resident care areas.</li> <li>c. Notify the Administrator or designee.</li> <li>d. Notify the attending physician, resident's family/legal representative, and Medical Director. e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions.</li> <li>f. Document actions taken in the medical record.</li> </ul> <p>Resident #1 had diagnoses which included dementia with behavioral disturbances, anxiety disorder, delusional disorders, and major depressive disorder.</p> <p>The care plan, dated 02/13/24, documented the resident had dementia with impaired cognition with frequent verbal and physical behaviors. The care plan documented the staff were to leave the resident alone and retry later or get a different caregiver to provide care.</p> <p>A quarterly assessment, dated 07/08/24, documented the resident was severely impaired for daily decision making and required substantial/maximal assistance with most activities of daily living.</p> <p>On 11/14/24 at 9:43 a.m., the administrator stated LPN #2 did not report the allegation of abuse regarding Resident #1 to them or protect the resident from the identified staff member. The administrator stated they did not report the allegation of abuse to the Oklahoma State Department of Health within the two hour required timeframe.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Hill Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  808 Northwest M L King Avenue Idabel, OK 74745	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse within the two hour required timeframe to the Oklahoma State Department of Health for one (#1) of three sampled residents reviewed for abuse.</p> <p>The administrator identified five allegations of abuse in the last six months.</p> <p>Findings:</p> <p>A policy titled Abuse, Neglect and Exploitation, dated 08/07/24, read in part, The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made.</p> <p>Resident #1 had diagnoses which included dementia with behavioral disturbances, anxiety disorder, delusional disorders, and major depressive disorder.</p> <p>The care plan, dated 02/13/24, documented the resident had dementia with impaired cognition with frequent verbal and physical behaviors. The care plan documented the staff were to leave the resident alone and retry later or get a different caregiver to provide care.</p> <p>A quarterly assessment, dated 07/08/24, documented the resident was severely impaired for daily decision making and required substantial/maximal assistance with most activities of daily living.</p> <p>An incident report, dated 07/28/24, documented an allegation of abuse for Resident #1 and CMA #1. The report documented the administrator was made aware of the incident on 07/29/24 at 1:00 p.m. by the resident's family. The report documented an investigation revealed Resident #1 became combative with CMA #1 and CMA #1 grabbed Resident #1's wrists causing skin tears. The report documented the primary care physician, family, administrator, and DON was notified and safety precautions maintained.</p> <p>A fax transmission verification report, dated 07/29/24 at 8:51 p.m., documented the allegation of abuse was reported to the Oklahoma State Department of Health.</p> <p>On 11/14/24 at 9:43 a.m., the administrator stated LPN #2 did not report the allegation of abuse regarding resident #1 to them or protect the resident from the identified staff member. The administrator stated they did not report the allegation of abuse to the Oklahoma State Department of Health within the two hour required timeframe.</p>