

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 07/03/2024
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure a resident received proper pain management for one (#31) of one sampled resident who was reviewed for an injury of unknown origin.</p> <p>The administrator identified 40 residents who resided in the facility.</p> <p>Findings:</p> <p>A Pain - Clinical Protocol policy, revised on March 2018, read in part, The physician and staff will identify individuals who have pain or who are at risk for having pain. The nursing staff will assess each individual for pain .when there is onset of new pain .The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, .repositioning.</p> <p>Res #31 had diagnoses which included cerebral infarction, aphasia, right sided flaccid hemiplegia and osteoporosis.</p> <p>A physician's order, dated 03/10/23, documented Tylenol 325mg 1-2 every six hours as needed for pain.</p> <p>A progress note on 02/22/24 at 6:36 p.m., documented Res #31 had seizure like activity and was transferred to the local hospital emergency room . The resident returned the same day and staff noted Res #31 was unable to bear weight or tolerate range of motion and was holding their right hip hollering in pain. An order to obtain a right hip xray was obtained STAT.</p> <p>A progress note on 02/24/24 at 3:51 p.m. documented the right hip xray was obtained and at 6:08 p.m., the resident was transferred to the local hospital emergency room for a left hip fracture.</p> <p>A hospital xray report on 02/24/24 documented the resident had a comminuted fracture (fracture causing multiple bone splinters) of the left acetabulum (hip socket) with extension into the ischium (pelvis area). The report also documents a fracture of the right sacrum (lower part of the spine).</p> <p>The February medication administration record, documented Res #31 was not medicated for pain on 02/22/24, was given 650mg of Tylenol on 02/23/24 at 10:11 a.m., and 650mg of Tylenol on 02/24/24 at 2:35 p.m.</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
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07/03/24 at 11:25 p.m., CMA #1 reported they did not feel the resident's Tylenol was effective for pain and stated, sometimes the Tylenol didn't touch their pain. CMA #1 reported they didn't know why they only gave the resident one dose of Tylenol.</p> <p>On 07/03/24 at 12:45 p.m., LPN #1 reported Res #31 was in pain with positioning and could not tolerate sitting up in a chair. LPN #1 reported calling the xray company to ask why the xray hadn't been done, but reports not calling the physician with an update. LPN #1 reported Tylenol helped some but the resident still had pain. LPN #1 reported they were sure the resident received more Tylenol than what was documented. LPN #1 reported not documenting the resident's pain and limitations with mobility in the nursing notes and stated, I probably didn't document about their pain because the resident wasn't in pain if they weren't being moved.</p> <p>On 07/03/24 at 1:05 p.m, the APRN reported there was no communication from the facility between giving the order for a STAT xray and getting the xray results. APRN reported they would have given an order to send the resident to the hospital had the facility called and reported no xray had been obtained and the resident's level of pain.</p> <p>On 07/03/24 at 2:00 p.m., the DON reported the physician should have been notified of the resident's continued pain and being unable to obtain the xray as ordered. The DON reported the nurses should have documented the resident's pain with mobility.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to ensure menus were:</p> <ul style="list-style-type: none"> a. prepared in advance, b. followed, and c. reviewed by the facility's dietitian or other qualified nutrition professional for the residents. <p>The administrator identified 38 residents who ate meals prepared by the kitchen and two resident who received nutrition via feeding tube.</p> <p>Findings:</p> <p>The Facility Assessment Tool HNHINC, last updated 06/26/24, read in parts .OUR FACILITY IS CURRENTLY TRANSITIONING TO LIBERAL DIETS WITH DIET MODIFICATIONS AS REQUIRED TO MEET RESIDENTS' NEEDS. MENUS WILL BE CREATED BY OUR DSM AND STAFF AND APPROVED BY OUR REGISTERED DIETITIAN WITH CONSIDERATION OF SPECIALIZED DIETS AS ORDERED BY THE PCP. OUR CONSULTANT DIETITIAN VISITS THE FACILITY MONTHLY AND SUBMITS RECOMMENDATIONS TO THE FACILITY TO PRVIDE [sic] TO THE PCP'S FOR APPROVAL. QUARTERY IN-SERVICE TRAINING CLASSES ARE CONDUCTED BY THE RD .</p> <p>The facility menu provided did not document therapeutic diets or portions sizes.</p> <p>On 07/01/24 at 7:32 a.m. the DM was asked for a copy of the therapeutic menus. The DM pointed to a hand written menu with no portion sizes or therapeutic diets documented. The DM stated this was the menu provided for meals.</p> <p>On 07/02/24 at 11:57 a.m., the assistant administrator stated currently a part time cook, who was the previous dietary manager, made the facility menus and has for over a year. The assistant administrator stated the previous dietary manager was not certified and the dietitian does not sign off for the menus.</p> <p>On 07/02/24 at 12:15 p.m., the part time cook/ previous dietary manager stated they watched the residents eat and based on their likes and dislikes determined the menus. The cook stated the staff just know what portion sizes to give for the meals. The cook stated the kitchen staff should know portion sizes based on the education given at weekly meeting.</p> <p>On 07/02/24 at 1:43 p.m., the dietary aide stated they would know what to prepare and serve for the day when they arrive that morning. Stated the dinner meal was oven baked hot dogs with chili, tator tots, salad, and desert. The dietary aide did not know what the desert was for the dinner meal. The dietary aide stated they prepare what the DM tells them to prepare.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/02/24 at 2:05 p.m., the facility dietitian was contacted by phone. The dietitian stated they had not documented or signed off on menus in a year. The dietitian stated menus were prepared and signed off by the facility's food provider to their knowledge.</p> <p>On 07/03/24 at 10:05 a.m., the assistant administrator provided menus for a month. The assistant administrator stated the dietary did not follow the menus provided, but followed the menus prepared by the part time cook/previous dietary manager.</p> <p>On 07/03/24 at 12:10 p.m., the DM prepared the pureed diet for the residents. The DM stated the facility has beans every Wednesday and fish every Friday. The DM stated beans was not on the menu for every Wednesday, but that was what the kitchen served.</p> <p>On 07/03/24 at 5:38 p.m., the assistant administrator stated the kitchen had stopped serving beans every Wednesday, but guess they stated back. The assistant administrator stated the DM decided what the meal would be each day just like you would if you were home.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33097</p> <p>Based on observation and interview, the facility failed to ensure food was stored, prepared, and served in a safe and sanitary manner for the residents.</p> <p>The administrator identified 38 residents who ate meals prepared by the kitchen and two resident who received nutrition via feeding tube.</p> <p>Findings:</p> <p>On 07/01/24 at 7:28 a.m., the refrigerator contained dozens of unpasteurized eggs. No pasteurized eggs were observed. The dietary aide was serving scrambled eggs for breakfast. The dietary aide stated the unpasteurized eggs were served and prepared as scrambled eggs, hard eggs, and sometimes over medium eggs.</p> <p>On 07/01/24 at 7:32 a.m., the DM stated they had not had pasteurized eggs for two weeks. The DM stated there were some residents who request hard eggs and one resident who requests over medium eggs. The DM stated they should be using pasteurized eggs.</p> <p>On 07/01/24 at 7:34 a.m., the refrigerator in the kitchen contained a bag of shredded cheese open to air and three containers containing a liquid cheese, gravy, and some type of meat not dated.</p> <p>On 07/01/24 at 7:35 a.m., the DM stated meat was from yesterdays meal and should be thrown out. The DM did not respond regarding the other undated items in the refrigerator.</p> <p>On 07/01/24 at 7:38 a.m., the refrigerator in the storage room contained thawed meat in a container with bloody juice and was uncovered.</p> <p>On 07/01/24 at 7:39 a.m., the DM stated the meat was thawed last Friday and was used for the alternate menu. The DM stated the meat should not be served if thawed more than two days.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45913</p> <p>Based on record review and interview, the facility failed to ensure the medical record was accurate for one (#31) of one sampled resident who was reviewed for an injury of unknown origin.</p> <p>The administrator identified 40 residents who resided in the facility.</p> <p>Findings:</p> <p>Res #31 had diagnoses which included cerebral infarction, aphasia, right sided flaccid hemiplegia and osteoporosis.</p> <p>A physician's order, dated 03/10/23, documented Tylenol 325mg 1-2 every six hours as needed for pain.</p> <p>A progress note on 02/22/24 at 6:36 p.m., documented Res #31 had seizure like activity and was transferred to the local hospital emergency room . The resident returned the same day and staff noted Res #31 was unable to bear weight or tolerate range of motion and was holding their right hip hollering in pain. An order to obtain a right hip xray was obtained STAT.</p> <p>A progress note on 02/24/24 at 3:51 p.m. documented the right hip xray was obtained and at 6:08 p.m., the resident was transferred to the local hospital emergency room for a left hip fracture.</p> <p>A hospital xray report on 02/24/24 documented the resident had a comminuted fracture (fracture causing multiple bone splinters) of the left acetabulum (hip socket) with extension into the ischium (pelvis area). The report also documents a fracture of the right sacrum (lower part of the spine).</p> <p>The February medication administration record, documented Res #31 was not medicated for pain on 02/22/24, was given 650mg of Tylenol on 02/23/24 at 10:11 a.m., and 650mg of Tylenol on 02/24/24 at 2:35 p.m.</p> <p>On 07/03/24 at 12:45 p.m., LPN #1 reported Res #31 was in pain with positioning and could not tolerate sitting up in a chair. LPN #1 reported Tylenol helped some but the resident still had pain. LPN #1 reported not documenting the resident's pain and limitations with mobility in the nursing notes and stated, I probably didn't document about their pain because the resident wasn't in pain if they weren't being moved.</p> <p>On 07/03/24 at 1:15 p.m., RN #1 reported the resident had pain with movement and positioning but felt the resident's pain wasn't excruciating and probably didn't document about the pain because the resident had no pain when they weren't being repositioned.</p> <p>The progress notes between 02/22/24 at 6:36 p.m. and 02/24/24 at 6:08 p.m., did not document the resident being in pain.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/03/24 at 2:00 p.m., the DON reported the nurses should have documented the resident's pain with mobility in the progress notes.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>33097</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on record review and interview, the facility failed to impliment their policy regarding monitoring and measures to prevent the growth of Legionella bacteria for the facility.</p> <p>The administrator identified 40 residents who resided in the facility.</p> <p>Findings:</p> <p>A policy titled Legionella Water Management Program documented .our facility has a water management program, which is overseen by the water management team .The water management team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance .The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, .d. The identification of situations that can lead to Legionella growth, .h. A system to monitor control limits and effectiveness of control measures; .j. Documentation of the program .</p> <p>On 07/03/24 at 9:00 a.m., the maintenance director stated they were not familiar with a Legionella program. The staff stated no monitoring documentation has been completed regarding Legionella.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097</p> <p>Based on record review and interview, the facility failed to provide documentation regarding offering or given the pneumococcal vaccine for three (#5, 8, and #24) of five residents reviewed for immunizations.</p> <p>The administrator identified 40 residents who resided in the facility.</p> <p>Findings:</p> <p>A policy titled Pneumococcal Vaccine documented .Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility .</p> <ol style="list-style-type: none"> 1. Resident #5 was admitted to the facility on [DATE]. The immunization record for the resident did not document the pneumococcal vaccine was offered or given. 2. Resident #8 was admitted to the facility on [DATE]. The immunization record for the resident did not document the pneumococcal vaccine was offered or given. 3. Resident #24 was admitted to the facility on [DATE]. The immunization record for the resident did not document the pneumococcal vaccine was offered or given. <p>On 07/03/24 at 10:16 a.m., the facility IP stated two of five residents reviewed for immunizations had received the pneumococcal vaccine. The IP stated they could not find documentation regarding the pneumococcal vaccine given or offered for the remaining three residents. The IP stated the facility pharmacy had not filled the prescription for the pneumococcal vaccine since 2019.</p>