

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1210 South 6th Street Blackwell, OK 74631	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure a CMA provided supervision to prevent a resident from falling for 1 (#2) of 3 sampled residents reviewed for falls.</p> <p>The ADON stated 55 residents resided in the facility.</p> <p>Findings:</p> <p>A facility policy titled Falls and Fall Risk, Managing, dated March 2018, read in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>A minimum date set 5-day scheduled assessment, dated 05/01/25, showed in Section C Res #2 had a brief interview for mental status score of 15 (score indicated the resident's cognition was intact). The assessment further showed in Section GG, Res #2 required the assistance of a staff member who would physically support the resident and perform more than half of the physical effort to transfer to and from toileting.</p> <p>A nursing progress note, dated 05/13/25 at 3:30 p.m., showed Res #2 had been found by registered nurse #2 sitting on their bedroom floor. The note showed CMA #2 was in the room as was three family members. The note showed CMA #2 was assisting the resident back from the bathroom when CMA #2 turned around to close the bathroom door Res #2 fell to the floor. The note further showed Res #2 complained of hip pain and was transferred to a local hospital for evaluation.</p> <p>A nursing progress note, dated 05/14/25 at 9:37 p.m., showed Res #2 had received no injuries from the fall on 05/13/25, had been elevated from a one person transfer to a two-person transfer, and had been prescribed the pain medication Tramadol (an opioid) for general pain described by the resident at a level of 7 on a 0 - 10 scale. The note showed the resident had reported their pain level as a 3 at the time of the note.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/19/25 at 10:53 a.m., CMA #2 was asked to describe the incident regarding Res #2 on 05/13/25. CMA #2 stated they were assisting Res #2 back from the bathroom in their room when they turned to close the bathroom door. They stated as the bathroom door latched closed, they heard a family member of Res #2 make a statement to catch the resident. CMA #2 stated when they turned to face the resident they were on the bedroom floor. They stated they contacted the nurse who assessed the resident and the resident was sent to a local hospital for evaluation. CMA #2 stated they believed Res #2 had been a one-person transfer at the time. They stated they should have completed the transfer before closing the bathroom door.</p> <p>On 05/19/25 at 2:40 p.m., anonymous #1 stated they had witnessed Res #2 fall on 05/13/25. They stated CMA #2 had completely let go of the resident to close the bathroom door and that was when the resident fell .</p> <p>On 05/19/25 at 3:47 p.m., CMA #2 was asked again to describe Res #2's fall on 05/13/25. They stated when they had turned to close the bathroom door they had completely let go of the resident and were not touching the resident when they fell .</p> <p>On 05/19/25 at 4:34 p.m., ADON stated CMA #2 should not have let go of the resident or tried to close the bathroom door while they transferred the resident. They stated by doing so they had not been following facility policy or best practice.</p>		