

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  04/04/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>34270</p> <p>Based on observation, records review, and interview, the facility failed to ensure a resident who self-administered their medication had been assessed for the ability to safely administer to do so for 1 (#13) of 9 sampled residents observed during medication administration observations.</p> <p>The DON stated one resident had self-administered medication at the facility.</p> <p>Findings:</p> <p>On 04/03/25 at 12:49 p.m., RN #1 was observed pre-setting an injector of insulin for Res #13. RN #1 was observed entering the resident's room and handing the insulin injector to the resident who raised their blouse, pushed the injector against their abdomen and pushed the button to release the insulin. The resident did not look to check the dose set on the injector prior to administering. The resident then handed the injector back to RN #1 and the RN departed the room.</p> <p>A policy titled Self-Administration of Medications, dated December 2016, read in part, As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate and safe for the resident.</p> <p>Res #13's medication administration records (MAR) from March 2024 through March 2025 were reviewed. Each month showed the resident had a physician's order for Novolog insulin ( a medication used in the mangement of diabetes mellitus and hyperglycemia) to be administered simultaneously with each meal. The records showed the resident had received 1,113 doses of the Novolog insulin during the reviewed months.</p> <p>An annual assessment, dated 02/02/25, showed Res #13 had a BIMS score of 15 which is considered normal cognitive functioning.</p> <p>Res #13's medical record was reviewed for an assessment to determine if Res #13 could safely self-administer medications. None were observed.</p> <p>On 04/03/25 at 1:03 p.m., Res #13 stated they had begun self-administering their insulin about one year ago. They stated they started doing it because they did not believe the staff kept the injector in long enough and not all the insulin was being injected. They stated their blood sugars were controlled better now that they injected the medication themselves.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/03/25 at 1:08 p.m., RN #1 stated they allowed Res #13 to administer their insulin the first time they attempted to administer it to them. They stated on that occasion the resident had told them they injected themselves so they allowed the resident to give the injection.</p> <p>On 04/03/25 at 1:11 p.m., LPN #1 was asked about Res #13 self-administering their insulin. LPN #1 stated the resident had been self-administering their insulin for about two years. LPN #1 stated they would set up the injector and hand it to the resident for administration. They stated they had been told the resident's doctor had written an order for the self-administration but could not recall by whom. They stated they were not sure if there was an order for the resident to self-administer their insulin.</p> <p>On 04/03/25 at 1:15 p.m., the DON was asked if they were aware of any residents that self-administered medications. The DON stated they were not aware of any. They were informed of the observation of Res #13 self-administering their insulin. The DON stated they were aware of that situation. They stated they did not know if the resident had been assessed for safety prior to them self-administering the insulin.</p> <p>On 04/03/25 at 1:19 p.m., the ADON stated they did not know if there was an order or assessment for Res #13 to self-administer but would look for them. The ADON stated they did have a policy on self-administering medications by residents.</p> <p>On 04/03/25 at 2:54 p.m., the ADON stated they had not found an order or assessment for the resident to self-administer insulin. They stated they were starting the process for getting Res #13 assessed to self-administer. The ADON stated they have alerted the nurses to wait for the process to be completed prior to allowing the resident to self-administer again.</p> <p>On 04/03/25 at 2:57 p.m., the DON stated the nurses would not allow the resident to administer until the process is complete.</p> <p>On 04/03/25 at 2:59 p.m., Corp VP #1 stated the facility had not been following their policy regarding resident self-administration but had now started the process for Res #13.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34270</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive assessment contained accurate health care information for 1 (#4) of 24 sampled residents reviewed for comprehensive assessments.</p> <p>The DON stated 54 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled Certifying Accuracy of the Resident Assessment, dated November 2019, showed that each assessment must be accurate.</p> <p>An MDS annual assessment for Res #4, dated 01/08/25, showed in Section N0415 the resident was taking antipsychotic medications. Section N0450 of the same assessment showed the resident had not received antipsychotic medications.</p> <p>Res #4's medication administration record (MAR) for the month of January 2025, showed the resident had been administered the antipsychotic medication Latuda each of the seven days prior to the date of the MDS annual assessment, dated 01/08/25.</p> <p>On 04/03/25 at 8:07 a.m., Corp. VP #1 stated they had reviewed Res. #4's annual MDS assessment dated [DATE] and the resident's January 2025 MAR. They stated section N of the assessment showed the resident was both on and not on antipsychotic medication. They stated the resident's chart showed they were taking the antipsychotic medication Latuda now and at the time of the assessment. They stated they and the DON did spot checks of the MDS coordinator work, but do not review each assessment.</p> <p>On 04/03/25 at 8:46 a.m., the DON reviewed Res #4's annual MDS dated [DATE] and stated section N stated the resident was both taking and not taking antipsychotic medications. They stated the resident was taking an antipsychotic at that time. They stated the Corp. VP #1 checked the work of the MDS coordinator, but they did not. They stated the MDS was inaccurate.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure resident assessments were completed and submitted to Centers for Medicare and Medicaid Services for 1 (#21) of 19 sampled residents who were reviewed for resident assessments.</p> <p>The DON identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>A discharge summary, dated 10/25/24 at 2:18 p.m., showed Resident #21 was discharged from the facility on 10/25/24.</p> <p>The electronic health record showed the last assessment completed was a quarterly assessment, dated 10/25/24. The electronic health record did not show a discharge assessment had been completed on 10/25/24.</p> <p>04/02/25 at 1:31 p.m., Corporate Vice-President of Operations #1 stated a quarterly assessment had been completed instead of a discharge assessment by mistake.</p>

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure a resident's care plan was updated to include an intervention to prevent an identified pattern of falls for 1 (#39) of 2 sampled residents reviewed for accidents.</p> <p>The DON stated 54 residents at the facility had care plans.</p> <p>Findings:</p> <p>A facility policy titled Care Plans, Comprehensive Person-Centered, dated December 2016, read in part, The Interdisciplinary Team (IDT), in conjunction with the resident and/or their family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>A progress note, dated 08/12/24 at 2:30 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 09/25/24 at 11:34 p.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 11/06/24 at 3:26 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 12/20/24 at 3:35 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 12/25/24 at 3:55 a.m., showed Res #39 had fallen while attempting to go to their bathroom. The note further showed the resident suffered a laceration to their head from the fall.</p> <p>A progress note, dated 01/14/25 at 6:14 p.m., showed Res #39 had fallen on 01/14/25 but did not describe the incident.</p> <p>A progress note, dated 01/14/25 at 9:34 p.m., showed the resident had been uninjured during the fall on 01/14/25.</p> <p>A progress note, dated 01/17/25 at 1:10 a.m., showed Res #39 had fallen in the bathroom of their room. The note further showed the resident suffered a skin tear and abrasion on their left arm from the fall.</p> <p>An annual MDS assessment for Res #39, dated 01/31/25, showed in Section C they had a BIMS score of 13 which indicated normal cognition. The assessment also showed in Section GG the resident was able to use the toilet independently without any assistance.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, revised date 02/06/25, showed Res #30 had fallen on 08/12/24, 09/24/24, 11/06/24, 12/20/24, 12/25/24, 01/14/25, 01/17/25, and 02/22/25. The care plan further showed the fall on 12/25/24 resulted in the resident suffering a laceration, the fall on 01/17/25 resulted in the resident suffering a skin tear and abrasion, and the fall on 02/22/25 resulted in the resident suffering a fracture. The care plan further showed the last care plan revision was on 02/22/25 which was for the resident to have therapy following surgery and for the resident's wheelchair to be kept out of the resident's walking path. There were no interventions to check on the resident for the need to toilet between 3:00 a.m. and 5:00 a.m.</p> <p>A progress note, dated 02/22/25 at 3:30 a.m., showed Res #39 had fallen in their room after tripping over their wheelchair. The note further showed when the staff stood Res #39 up, they cried out in pain and could not bear weight on their left side.</p> <p>An acute care hospital physician's note, dated 02/22/25, documented the resident had been seen for a hip fracture following a fall. The note further showed the resident had reported they had fallen while attempting to go to the bathroom.</p> <p>An acute care hospital physician's examination note, dated 02/23/25, showed the resident had undergone a left hip arthroplasty (a hip replacement surgery using artificial hardware) at the hospital.</p> <p>An acute care hospital discharge summary, dated 02/25/25, showed the resident had been treated for a fracture of the left femoral neck (left hip) and had undergone hip replacement surgery.</p> <p>On 04/04/25 at 9:09 a.m., LPN #3 stated they had provided care to Res #39 during the resident's stay at the facility. When asked about falls LPN #3 stated the resident had time between 3:00 a.m., and 5:00 a.m. when they wanted to go to the bathroom and had some falls during that time.</p> <p>On 04/04/25 at 9:59 a.m., the resident's POA stated on three occasions in 2024 and 2025 they had been called by the facility between 3:00 a.m. and 5:00 a.m. about Res #39 having fell while going to the bathroom. They stated during each of those calls they had asked the staff to check on the resident between those times each day to see if the resident needed to go to the bathroom. The POA stated it was not difficult to figure out the resident was falling about the same time while trying to go to the bathroom. They stated they told the staff if they checked on the resident around those times it might prevent the falls.</p> <p>On 04/04/25 at 10:10 a.m., LPN #3 was asked if they had spoken to the resident's POA about the resident's falls sometime last year. They stated they had and the POA had asked them to check on the resident in the morning around the times the resident had been falling. They stated they had that conversation sometime in the Fall of 2024, but they were not sure exactly when. LPN #3 stated they had not told the night shift about what the POA had told her but believed they knew. They stated they could not recall who they may have talked to about the conversations with the POA.</p> <p>(continued on next page)</p>		

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F 0657  Level of Harm - Actual harm  Residents Affected - Few	On 04/04/25 at 10:20 a.m., the DON was asked about the care plan process at the facility. They stated they received information for the care plan from morning meetings. They stated they kept a book which included all the care plans so they could keep up with residents who were falling and add interventions. They stated they looked for patterns of the falls and possible interventions. They were asked about Res #39's falls and the POA's suggestion to LPN #3 about checking on the resident at a particular time. The DON stated in that situation the nurse should have informed management of the conversation with the POA as well as their own understanding the resident needed to be checked on between 3:00 a.m., and 5:00 a.m. They stated the information could have been acted on and placed in the care plan. They stated they used agency staff at the facility and such information needed to be passed on to them through the care plan. They stated the intervention should have been put into place once it was identified.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42171</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record review and interview, the facility failed to ensure residents were bathed as scheduled for 1 (#1) of 3 residents reviewed for assistance with ADL's.</p> <p>The DON identified 54 residents who resided in the facility.</p> <p>Findings:</p> <p>An undated policy titled Activities of Daily Living (ADLs), Supporting, read in part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>A quarterly assessment, dated 01/29/25, showed resident #1 had a BIMS score of 15 which is indicative of independence for daily decision making and they required moderate assistance with bathing.</p> <p>Shower sheets from 02/01/25 through 04/03/25 showed out of 18 opportunities, Resident #1 did not have a shower documented on 02/08/25, 02/18/25, 02/22/24, 02/25/25, 03/04/25, 03/08/25, or 04/01/25.</p> <p>On 04/03/25 at 10:18 a.m., Resident #1 stated they were supposed to receive a bath twice a week on Tuesday and Saturday, but sometimes they do not get a bath. Resident #1 also stated when they asked staff about getting a shower, they say they will do it later, but they do not always follow-up.</p> <p>On 04/04/25 at 8:10 a.m., CNA #1 stated the CNA working on hall was responsible for giving the showers to the residents on that hall. They stated shower sheets were filled out for every shower they completed, and the shower sheets were kept in a book at the nurse's desk. They also stated if a resident refused a shower it should be documented on a shower sheet. CNA #1 stated if they did not have a shower sheet, they could not say for sure if the resident had a shower or not.</p>		

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<p>F 0689</p> <p>Level of Harm - 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 interviews, the facility failed to ensure staff provided supervision to prevent falls which resulted in a fracture for 1 (#39) of 2 sampled residents who were reviewed for accidents.</p> <p>The DON stated 54 residents resided at the facility.</p> <p>Findings:</p> <p>A facility policy titled, Fall 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 and minimize complications from falling.</p> <p>A progress note, dated 08/12/24 at 2:30 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 11/06/24 at 3:26 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 12/20/24 at 3:35 a.m., showed Res #39 had fallen while attempting to go to their bathroom.</p> <p>A progress note, dated 12/25/24 at 3:55 a.m., showed Res #39 had fallen while attempting to go to their bathroom. The note further showed the resident suffered a laceration to their head from the fall.</p> <p>A progress note, dated 02/22/25 at 3:30 a.m., showed Res #39 had fallen in their room after tripping over their wheelchair. The note further showed when the staff stood Res #39 up, they cried out in pain and could not bear weight on their left side.</p> <p>An acute care hospital physician's note, dated 02/22/25, showed the resident had been seen for a hip fracture following a fall. The note further showed the resident had reported they had fallen while attempting to go to the bathroom.</p> <p>An acute care hospital physician's examination note, dated 02/23/25, showed the resident had undergone a left hip arthroplasty (a hip replacement surgery using artificial hardware) at the hospital.</p> <p>An acute care hospital discharge summary, dated 02/25/25, showed the resident had been treated for a fracture of the left femoral neck (left hip) and had undergone hip replacement surgery.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/04/25 at 9:09 a.m., LPN #3 stated they had provided care to Res #39 during the resident's stay at the facility. LPN#3 was asked about falls. LPN #3 stated the resident had a period of time between 3:00 a.m. and 5:00 a.m. when they wanted to go to the bathroom and had some falls during that time.</p> <p>On 04/04/25 at 9:59 a.m., the resident's POA (power of attorney) stated on three occasions in 2024 and 2025 they had been called by the facility between 3:00 a.m. and 5:00 a.m. about Res #39 having fell while going to the bathroom. They stated during each of those calls they had asked the staff to check on the resident between those times each day to see if the resident needed to go to the bathroom. The POA stated it was not difficult to figure out the resident was falling about the same time while trying to go to the bathroom. They stated they told the staff if they checked on the resident around those times it might prevent the falls.</p> <p>On 04/04/25 at 10:10 a.m., LPN #3 was asked if they had spoken to the resident's POA about the resident's falls. They stated they had and the POA had asked them to check on the resident in the morning around the times the resident had been falling. LPN #3 stated they thought that conversation took place in the Fall of 2024 but could not be certain. LPN #3 stated they had not told the night shift about what they had spoke about with the POA but believed they knew. They stated they could not recall who they may have talked to about the conversations with the POA.</p> <p>On 04/04/25 at 10:20 a.m., the DON was asked about Res #39's falls and the POA's suggestion to LPN #3 about checking on the resident at a particular time. The DON stated in that situation, the nurse should have informed management of the conversation with the POA as well as their own understanding the resident needed to be checked on between 3:00 a.m. and 5:00 a.m. The DON stated the information could have been acted on and placed in the care plan. They stated they used agency staff at the facility and such information needs to be passed on to them through the care plan. The DON stated the intervention should have been put into place once it was identified.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure labs were completed as ordered by the physician for 1 (#24) of 6 sampled residents whose labs were reviewed.</p> <p>The DON reported 54 residents resided in the facility.</p> <p>Findings:</p> <p>A care plan, initiated 06/06/24 showed Resident #24 had diagnoses which included heart failure and hypertension.</p> <p>A quarterly assessment, dated 03/20/25, showed Resident #24 had a BIMS score of 13, which was indicative of no impairment for daily decision making.</p> <p>A health status note, dated 03/19/25 at 5:42 p.m., showed the physician was notified Resident #24 was complaining of a cough and congestion. The note also showed the physician ordered guaifenesin (an expectorant) 15 mg every four hours as needed and a test for RSV.</p> <p>A review of Resident #24's health record did not show a physician order for an RSV test on 03/19/25 or results of an RSV test collected on 03/19/25.</p> <p>On 04/03/25 at 4:02 p.m., LPN #1 stated when a nurse received an order for lab work they should collect the sample and put an order in the computer. They also stated if the lab was routine the lab company would come pick it up on Monday or Thursday. LPN #1 stated when the results were ready they would automatically go into the resident's electronic health record.</p> <p>On 04/04/25 at 8:28 a.m., the ADON stated the order for the RSV test was not put into the computer. They also stated they were out of swabs and the lab company was bringing more and the facility did not follow up to ensure the sample was collected.</p>		

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  04/04/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42171</p> <p>Based on observation, recored review, and interview, the facility failed to ensure enhanced barrier precautions were implemented for 1 (#7) of 3 sampled residents reviewed for enhanced barrier precautions.</p> <p>The DON reported 14 residents were on enhanced barrier precautions.</p> <p>Findings:</p> <p>On 04/02/25 at 2:19 p.m., RN #1 and CNA #2 were observed providing wound care to Resident #7. RN #1 was observed wearing a gown and CNA #2 was not observed wearing a gown.</p> <p>On 04/02/25 at 2:30 p.m., CNA #2 was observed providing incontinent care to resident #7. They were not wearing a gown.</p> <p>A medication administration record, dated 04/25, showed Resident #7 had diagnoses which included neuromuscular dysfunction of the bladder and stage IV pressure ulcer to the left heel.</p> <p>A quarterly assessment, dated 1/17/25, showed a staff assessment of Resident #7 was conducted. The staff assessment showed Resident #7 was severely impaired for daily decision making and was totally dependent on staff for care.</p> <p>On 04/02/25 at 2:39 p.m., CNA #2 stated they should have been wearing a gown.</p> <p>On 04/02/25 at 2:44 p.m., RN # 1 stated the facility used enhanced barrier precautions and CNA #2 should have been wearing a gown while providing direct care.</p> <p>On 04/04/25 at 8:30 a.m., the ADON stated gowns should be worn when providing care to residents on enhanced barrier precautions.</p>