Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675388	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillview Nursing & Rehabilitation	1110 Rice St Goldthwaite, TX 76844

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for 2 (Resident #1 and #2) of 4 residents reviewed for quality of care. 1. The facility failed to ensure staff conducted neurological assessments on Resident #1 after his unwitnessed fall on 12/05/24. 2. The facility failed to ensure staff conducted neurological assessments on Resident #2 after her unwitnessed fall on 01/31/25. These deficient practices could place residents at risk of head injuries, brain bleed and developing undiagnosed conditions. Findings include: Resident #1 Review of Resident #1's Admission Record, dated 02/28/25, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. Resident #1 had diagnoses including cellulitis of right lower limb, neurocognitive disorder with Lewy bodies, dementia, and delusional disorders. Review of Resident #1's Significant Change MDS Assessment, dated 11/11/24, reflected he had a BIMS score of 3, which indicated he had severe cognitive impairment. Resident #1 also had 0 falls since admission. Review of Resident #1's care plan, initiated 07/05/22, reflected he was at risk for falls and staff were required to follow facility fall protocol and evaluate and treat him as ordered or PRN. Review of Resident #1's Progress Notes reflected LVN A documented the following note on 12/05/24 at 10:24 a.m., Resident rolled out of low bed onto floor mat. He was observed laying on left side and comfortable .Resident alert and not in distress. He was laying on the floor on left side. Bed in lowest position. Resident is confused at baseline. He was resistant to us getting him up with Hoyer lift and was hollering which is his normal .No other injuries noted. Resident legal guardian notified of above. (continued on next page)

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: 675388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Hillview Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1110 Rice St Goldthwaite, TX 76844	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Fall Nurse's Note, documented by LVN A on 12/05/24 at 10:29 a.m., reflected he had an unwitnessed fall in his room and was found by staff sitting on the floor next to his bed. Review of Resident #1's Assessments, dated 02/28/25, reflected there were no neurological assessments initiated and completed after Resident #1's fall on 12/05/24. Resident #2 Review of Resident #2's Admission Record, dated 02/28/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses including Alzheimer's disease. Review of Resident #2's Quarterly MDS Assessment, dated 12/20/24, reflected she had a BIMS score of 4, which indicated she had severe cognitive impairment. Resident #2 had 0 falls since admission. Review of Resident #2's Care Plan, dated 12/24/24, reflected she was at moderate risk for falls and staff were required to follow facility fall protocol and evaluate and treat her as ordered or PRN. Review of Resident #2's Progress Notes reflected RN B documented the following note on 01/31/25 at 2:35 a.m., Resident rolled out of bed onto fall mat. No injuries, redness, edema, complaint of pain, bruising noted. Resident assessed and assisted back to bed. (Family Member) notified and stated thanks for letting her know. Hospice notified .Physician notified. No new orders. Resident stated she was getting up to do the laundry. Review of Resident #2's Fall Nurse's note, documented by RN B on 01/31/25 at 2:35 a.m., reflected she had a fall from her low bed to mat or floor and stated she was getting up to do the laundry. Review of Resident #2's Assessments, dated 02/28/25, reflected there were no neurological assessments initiated and completed after Resident #2's fall on 01/31/25. During an interview on 02/28/25 at 11:18 a.m., the ADM stated she did not know and would find out if neurological assessments were initiated and completed on Resident #1 after his unwitnessed fall on 12/05/24 and on Resident #2 after her unwitnessed fall on 01/31/25. During an interview on 02/28/25 at 11:23 a.m., the ADM stated she did not see Resident #1's and #2's neurological assessments for their unwitnessed falls and determined there were no neurological assessments initiated and completed. The ADM stated she just learned by the surveyor that Resident #1's and #2's neurological assessments were not initiated and completed after their unwitnessed falls. The ADM stated charge nurses initiated and completed neurological assessments on residents. The ADM stated she was unsure when she most recently in-serviced staff on neurological assessments. The ADM stated she knew it was important to initiate and complete neurological assessments on residents and said, Because they could have a head injury or brain bleed. It could cause an adverse event if neurological assessments were not initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Hillview Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1110 Rice St Goldthwaite, TX 76844	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/25 at 11:33 a.m., the DON stated she was unsure if she in-serviced staff on neurological assessments and falls. The DON stated charge nurses were responsible for performing neurological assessments on residents. The DON stated she expected neurological assessments to be initiated and completed whenever staff did not know if a resident hit their head and had an unwitnessed fall. The DON stated charge nurses documented neurological assessments on physical sheets that were scanned into residents' electronic health records. The DON stated she did not know why neurological assessments were not performed on Resident #1 and #2 after their unwitnessed falls. The DON stated she did not review Resident #1's and #2's electronic health records to ensure their neurological assessments were initiated, completed, and uploaded and did not follow-up with staff. The DON stated she knew it was important to initiate and complete neurological assessments on residents and said, To make sure there was no declining change in condition due to a head injury. During an interview on 02/28/25 at 11:54 a.m., LVN A stated he was working as the charge nurse on the day and shift Resident #1 had his unwitnessed fall. LVN A stated he was notified by one of the CNAs on duty that Resident #1 rolled out of bed. LVN A stated he went into Resident #1's room and observed the bottom half of his body on the bed and the top half of his body hanging off the bed and towards the floor. LVN A stated he assessed Resident #1 for injuries, changes in condition, vitals, and pain. LVN A stated he was unsure if he needed to initiate neurological assessments on Resident #1 because Resident #1 was still in the bed, there was a fall mat next to the bed, Resident #1 was leaning towards the fall mat, Resident #1's head was hanging on the floor, and he used his nursing judgement. LVN A stated charge nurses were expected to initiate neurological assessments on residents for unwitnessed falls. LVN A stated the DON oversaw and ensured neurological assessments were initiated and completed on residents. LVN A stated he was unsure if he was in-serviced on neurological assessments after Resident #1's unwitnessed fall incident. LVN A stated he knew it was important to initiate and complete neurological assessments on residents and said, Because residents could have hit their head and it could have caused a brain bleed or concussion. An attempt to contact RN B was made on 02/28/25 at 1:51 p.m. The customer called was unavailable. Review of the facility's In-Services, from 12/01/24 through 02/28/25, reflected there were no trainings and in-services related to falls and neurological assessments completed. Review of the facility's Neurological Assessments policy and procedure, revised October 2010, reflected, Purpose: The purpose of this procedure is to provide guidelines for a neurological assessment: .2) when following an unwitnessed fall . General Guidelines: 1. Neurological assessments are indicated: b. Following an unwitnessed fall; Steps in the Procedure: .3. Perform neurological checks with the frequency as ordered or per falls protocol. Documentation: The following information should be recorded in the resident's medical record: .3. All assessment data obtained during the procedure. Review of the facility's Assessing Falls and Their Causes policy and procedure, revised March 2018, reflected, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Hillview Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1110 Rice St Goldthwaite, TX 76844	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. General Guidelines: .4. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Equipment and Supplies: .2. Tools to assess resident's level of consciousness and neurological status, if necessary; Steps in the Procedure: After a Fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. .6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. Defining Details of Falls: .2. For each individual, distinguish falls in the following categories: a. Rolling, sliding, or dropping from an object (e.g., from bed or chair to floor); b. Falling while attempting to stand up from a sitting or lying position; or c. Falling while already standing and trying to ambulate. Documentation: When a resident falls, the following information should be recorded in the resident's medical record: .2. Assessment data .