

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

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to immediately notify the resident's representative when there was a need to alter treatment for 1 of 3 residents (Resident #1) reviewed for notification of change. The facility failed to notify Resident #1's representative when the medication, Pramipexole (Mirapex), was added to her drug regimen on 01/01/25 to treat restless leg syndrome. This failure could place residents at risk for a delay in treatment and not receiving proper care due to failure to notify resident representative. Findings included: Record review of Resident #1's admission MDS assessment dated [DATE] reflected the resident was [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked), high blood pressure, hemiplegia (a condition that causes weakness or paralysis to one side of the body), anxiety disorder, depression, and pain. Resident #1 had a BIMS of 10, meaning her cognition was moderately impaired. Record review of Resident #1 care plan initiated on 12/13/24 reflected the resident had the potential for uncontrolled pain disease process related to neuropathy. Interventions included to notify the physician if intervention were unsuccessful or if current complaint was a significant change from resident's past experience of pain. Review of Resident #1's Facesheet printed on 02/19/25 reflected the resident's Family Member was the resident's Responsible Party/Emergency Contact #1/Resident Representative. Record review of Resident #1's progress notes dated 12/31/24 documented by the Nurse Practitioner reflected the following: .Patient seen and examined at bedside today. She complains of bilateral leg pain/restlessness . Treatment (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restless leg syndrome Clinical notes: on Baclofen, Duloxetine, Gabapentin and Tramadol. Will add Pramipexole 0.5mg at bedtime . Record review of Resident #1's monthly physician orders for January 2025 reflected the resident was on Pramipexole 0.5 mg; give one tablet by mouth one time a day for restless leg syndrome. The physician's orders further reflected the order had been put into the electronic health record by LVN B on 01/01/25 at 1:00 AM. Record review of Resident #1's January 2025 MAR reflected LVN C administered the first dose of the medication Pramipexole on 01/01/25. Record review of Resident #1's clinical record reflected there was no documented evidence reflecting Resident #1's responsible party had been notified that Pramipexole had been added to Resident #1's drug regimen. Record review of Resident #1's facesheet printed on 02/19/25 reflected the resident was discharged to the hospital on 01/14/25 and did not return to the facility. Interview on 02/18/25 at 4:44 PM with Resident #1's Family Member revealed they were not made aware Resident #1 had been started on the medication Pramipexole. The Family Member stated they had noticed a decline in the resident and when they were asking about Resident #1's medication list, they were told the resident had began taken Pramipexole. The Family Member further stated they were never contacted about the resident's new medication. Interview on 02/19/25 at 2:35 PM with LVN A revealed she recalled the Resident #1 being up one night complaining of her legs and feet bothering her. LVN A stated Resident #1 reported she could not get comfortable due to her restless leg syndrome. Interview on 02/19/25 at 3:34 PM with LVN B revealed she did not recall Resident #1 or the circumstances under which the resident was prescribed the medication Pramipexole. LVN B said if the order was put in at 1:00 AM, she would not have called the family at that time. She stated she would have passed it on to the morning shift nurse to contact the family. Interview on 02/19/25 at 3:55 PM with LVN C revealed she did not recall giving Resident #1 her first dose of the medication Pramipexole. LVN C said if the night nurse would have told her to contact Resident #1's family about the added medication, she would have documented in the nurse's notes in Resident #1's record. LVN C further stated if it was not documented in the notes, she probably did not contact the family. Interview on 02/19/25 at 4:02 PM with the ADON revealed when a new medication was ordered for a resident, the nurse that took the order would be responsible for contacting the resident's responsible party. He was not aware Resident #1's responsible party had not been contacted about the resident's new medication Pramipexole. He stated since the order was put in at 1:00 AM, he would understand the nurse being polite and waiting until the morning to make the call. The ADON said any time a resident's responsible party was contacted about a medication order or change, it should be documented in the system because it was part of their compliance. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Family Notification policy dated 2003 reflected the following: Objectives: 1. To keep families informed Procedure: 1. The family will be notified of any resident change .3. Notification will occur in a timely manner .		