

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  04/30/2025
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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43791</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 3 residents (Residents #1 and #2) reviewed for accidents.</p> <p>1. Driver A failed to secure Resident#1's wheelchair properly in the van, resulting in the resident hitting her head when the wheelchair tipped backwards during transport on 03/18/25. The resident was sent to the hospital but did not have any injuries.</p> <p>2. Driver B failed to secure the safety strap on the lift when Resident #2 was being lowered. Driver B fell on to Resident #2 causing him to tip backwards in his wheelchair and hitting his head on the ground on 04/07/25. The resident was sent to the hospital where he was found to have an abrasion on his scalp but no serious injury.</p> <p>The noncompliance was identified as past noncompliance. The IJ began on 03/18/25 and ended on 04/07/25. The facility had corrected the noncompliance before the survey began.</p> <p>The failures placed residents who used the facility's transportation at risk for injury.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's undated Admission Record, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The Admission Record reflected Resident #1 was her own RP and had diagnoses which included diabetes, heart failure, and vision loss.</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14 indicating she was cognitively intact. Her Functional Status assessment indicated she was independent in her ADLs.</p> <p>Record review of Resident #1's care plan, dated 02/26/25, reflected she had a history of headaches, and making false allegations.</p> <p>Record review of the facility's Provider Investigation Report, completed by the Administrator on 03/25/25, reflected the following incident occurred on 03/18/25 at 3:15 PM in the facility's van:</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>.Description of Allegation:</p> <p>[Resident #1] stated [her] wheelchair was not secure in transport van, and that it tipped back a few inches and she hit her head on ramp behind her. Transport Driver [Driver A] stated that she secured [the] wheelchair, but discovered it was loose when she started to drive. Immediately pulled over and re-secured it.</p> <p>.Name and title of person who completed assessment: [RN D]</p> <p>Description of assessment including extent of injuries No sign of bump, bruising, or redness on head where resident states she hit it. Sent to ED for additional evaluation due to c/o head injury.</p> <p>.Provider Response .Driver [Driver A] suspended pending investigation. Resident [Resident #1] assessed by DON and sent to ED for CT scan due to hitting head - no bruising, laceration, or raised a red noted. CT at ED negative. Physician, ombudsman notified. Resident is RP.</p> <p>Investigation Summary .DON was notified by COTA (Therapy) that [Resident #1] refused therapy due to headache pain resulting from hitting head during transport the previous day. COTA .immediately report this incident to DON (was in office next to therapy gym) and provided written statement and report to Admin. Driver provided statement to Administrator that she did fail to completely secure [Resident #1's] wheelchair prior to driving. She noticed the wheelchair tip back 3-5 inches and immediately pulled off the road and properly secured [Resident #1's] wheelchair. [Resident #1] stated that she hit her head on the ramp in the van when she tipped back. Driver was talking about this incident at the nurse[s] station upon return to the facility, and Administrator was at the nurse[s] station at the same time. Driver assumed Admin was aware. Admin was conducting in-service/monitoring with another staff member at the time and did not hear the report of an incident in the van. Admin provided to [sic] coaching to driver regarding reporting any and all incidents or potential for incident or injury directly to him, not just when it could be heard. Investigation revealed driver [Driver A] had reported complaint of pain by resident [Resident #1] - upon return to facility - to resident's nurse. Nurse stated that she was unable to provide prn pain medication at that time due to caring for another resident and then forgot to get back to it. Nurse did assess resident for pain a few hours later and there was no c/o of pain or signs of distress. Resident does receive routine pain medications and has order for PRN, which she used most days. PRN order was changed to routine in AM with additional PRN available later in the day as needed. Admin identified all residents who had been on transport in last 30 days (from appointment calendar) and Social Worker completed safe survey assessments with each of them as well as safe survey pain assessments with several residents. No additional transport or pain issues were reported in surveys.</p> <p>Investigation showed that driver [Driver A] had been properly and completely trained on all policies and procedures for properly securing residents in transport van and properly transporting them. Driver [Driver A] failed to follow proper procedures. Driver [Driver A] failed to report complaint of injury during transport and failed to report failure to properly secure resident and wheelchair prior to transport. Driver [Driver A] resigned her position and employment.</p> <p>.Provider Action Taken Post-Investigation:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>All staff in-serviced on recognizing, preventing, and immediately reporting abuse and neglect directly to Abuse Coordinator. Nursing staff in-serviced on pain management policies and procedures. All drivers of van retrained on pre and post trip inspections as well as safety attestations to be completed prior to each trip.</p> <p>Record review of Driver A's written statement, dated 03/19/25, reflected: On Tuesday March 18, 2025 at approximately 1515 [3:15 PM] hrs. I, [Driver A], was transporting [Resident #1] from a doctor apt. She had complained about having a headache. I loaded [Resident #1] into [the] back of transport van and secured the chair using the straps and seat belt. I started driving and her chair tipped backwards about 4 inches. I immediately pulled over and re-secured the straps to her chair. She claimed she hit her head, but I am not positive she did. We got back to [the] facility where she asked the nurse for tylenol. It was mentioned in front of [the Administrator] about her hitting her head.</p> <p>Interview on 04/30/25 at 9:50 AM with Resident #1 revealed she was in the van on 03/19/25 in her wheelchair when her wheelchair tipped backwards 4-5 inches. Resident #1 stated when Driver A accelerated it caused her to hit her head on the lift of the van. The resident stated she had a headache, but she had a headache prior to the incident, so she did not have any injury. Resident #1 stated she was more startled than anything. Resident #1 stated she had not been in the van since, but she was not afraid to be transported again.</p> <p>Record review of Resident #1's nursing notes reflected the resident was sent to the ER via ambulance since she stated she had hit her head on a piece of metal. Nursing assessment revealed no obvious injury. The resident returned from the ER with no abnormal findings after examination and CT scan of her head.</p> <p>Record review of text communications, undated but timed 1:55 PM, with Driver A reflected:</p> <p>Can you please clarify for me exactly what process you did to secure [Resident #1]?</p> <p>I attached the ratchet straps to the frame of her chair in the back and front.</p> <p>When I re-secured the chair, I adjusted the positions of the straps to better secure the chair in place, ensuring it did not move again.</p> <p>I secured the seat belt across her lap to ensure she did not slip from the chair in case of an incident.</p> <p>The seat belt was placed prior to initially moving the van the first time. This belt was not needed to be adjusted after the incident.</p> <p>Record review of an Employee Disciplinary Report Action Request, dated 03/19/25, reflected Driver A had a written counseling and investigatory suspension due to an infraction that occurred involving Resident #1. This was signed by the Administrator on 03/19/25.</p> <p>Record review of a Coaching Form, dated 03/19/25, signed by both Driver A and the Administrator reflected:</p> <p>Situation:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 04/30/25 at 3:45 PM with the Administrator revealed Driver A had been the primary driver and Driver B was the back up driver who covered when Driver A was off. Driver B took over the primary driving responsibilities after Driver A had been terminated. The Administrator stated Driver A had also failed to call him or the DON from the scene, instead she waited until she returned from the transport. Driver A stated in her interview she had told the nurse and himself when she returned, she had assumed he heard her tell the nurse, but he stated he was speaking with another employee and did not hear Driver A report to the nurse. The Administrator stated Driver B had participated in the in-service and training on 03/20/25 and she did not follow procedures on 4/07/25, so she was terminated as well. The Administrator stated they now have two drivers on the van when transporting to improve safety and reduce the risk of procedure violation. He stated the facility did not have a policy covering transporting the residents, they relied on the company's driver training manual.</p> <p>Record review of Resident #1's hospital record reflected she was treated for abrasions after a fall.</p> <p>An attempt was made to interview Driver A via telephone on 04/30/25 at 1:15 PM. A voicemail message was left for Driver A; however, she did not return the call.</p> <p>Record review of Drivers A's driver training revealed Driver A had been initially trained for driving the van on 04/13/23 and her last re-training had been completed on 01/30/25.</p> <p>2. Record review of Resident #2's undated Admission Record, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney failure, diabetes, heart failure, and Parkinson's disease.</p> <p>Record review of Resident #2's quarterly MDS, dated [DATE], revealed he had a BIMS score of 15, indicating he was cognitively intact. His Functional Ability assessment reflected he required minimal assistance with his ADLs.</p> <p>Record review of Resident #2's care plan, dated 03/12/25, reflected he required the use of a wheelchair for mobility, he was on blood thinning medication, and he required assistance with transfers to and from his wheelchair.</p> <p>Record review of the facility's Provider Investigation Report, completed by the Administrator on 04/14/25, reflected the following incident occurred on 04/07/25 at 11:00 AM involving Resident #2 and Driver B:</p> <p>.Description of the Allegation:</p> <p>Driver [Driver B] was walking to take resident off of van, driver tripped and fell on resident causing the resident to flip backwards in wheelchair. Back ramp strap was not done. Resident complained of pain and was sent to ER [sic]. CT was negative and resident returned to facility. Driver suspended.</p> <p>.Description of assessment including extent of injuries</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident returning from doctors [sic] appt on facility van, Per the staff driver [Driver B] of the day, patient fell back while on the wheelchair. Resident [Resident #2] complained of head and neck pain. This LVN [LVN E] sent resident out EMS for eval.</p> <p>.Provider Response .Driver [Driver B] reported incident immediately, resident was assessed by nurse. All resident transports will require 2 staff members to be present to ensure resident safety.</p> <p>Investigation Summary .Driver [Driver B] immediately reported incident to DON (Admin Offsite) .per facility protocol. Resident was assessed by a nurse prior to being moved. Resident did not have any injuries but did complain of pain. Resident was transferred to ED for additional evaluation and treatment. CT negative for head and neck, resident returned to facility in stable condition. Driver was suspended pending investigation. It was determined that driver did fail to properly secure seatbelt on lift, and that driver stood on ramp with resident, both being failure to follow company policy and procedure. Driver [Driver B] had been fully trained and given additional training and in-services on van/transport protocols. Driver [Driver B] was terminated for failure to follow company policies. All drivers were re-trained on protocols and procedures prior to resuming transports. Facility has instructed all drivers that 2 staff members must be present for each transport to ensure safety.</p> <p>.Provider Action Taken Post-Investigation:</p> <p>Abuse and neglect in-service Van retraining completed for all drivers before van returns to driving.</p> <p>Record review of Resident #2's hospital records reflected he was treated on 04/07/25 for a fall and scalp abrasion. The hospital record reflected the resident did not sustain any serious injuries.</p> <p>Interview on 04/30/25 at 10:55 AM with Resident #2 revealed on 04/07/25 he was being unloaded from the facility's van. After he had been lowered to the ground on the lift, the driver fell on to him causing his wheelchair to roll backwards, and he tipped backwards. He stated he hit his head on the ground and had back pain. He denied losing consciousness. He was sent to the hospital via ambulance. He has been on the van three times a week since the incident for dialysis without incident.</p> <p>Interview on 04/30/25 at 11:05 AM with the Administrator revealed their investigation revealed Driver B failed to secure the safety strap at the back of the lift that is designed to prevent the resident from rolling off the back of the ramp. He stated Driver B had unlocked the wheelchair's locks, lost her balance, and fell on to the resident. The resident rolled backwards off the lift, at ground level, and tipped over backwards. Resident #2 was assessed by the nurse before being moved, he was found to have a minor abrasion to the back of his head and was sent to the hospital via ambulance. The Administrator stated Driver B was in-serviced on 03/20/25 on van transport procedures, after the incident with Resident #1, but still did not follow procedures with Resident #2. As a result she was terminated. The Administrator stated all six people authorized to drive the facility van were in-serviced again on 04/07/25, and all six were given the company's driving test again. The procedure had also been changed to have two drivers on the van for all transports in the future. Driver B was suspended on 04/07/25 and terminated on 04/08/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's in-services and training documents from 03/20/25 and 04/07/25 reflected six staff had been in-serviced by the regional trainer on transport procedures including loading and unloading the resident, and proper securement of the wheelchair in the van. All six staff had passed the company driving test administered by the regional trainer.</p> <p>Observation on 04/30/25 at 11:45 AM of van transport procedures, performed by Driver C, with Resident #3, revealed the resident was secured in his wheelchair with two straps to the front frame of the wheelchair, and two straps to the back frame of the wheelchair. A lap belt was placed and secured to the floor behind the wheelchair, and a chest strap was secured across the left shoulder to the lap belt, similar to a car seatbelt. The wheelchair locks were then secured. Unloading Resident #3 was accomplished by securing the safety strap across the back of the lift, rolling the wheelchair backwards onto the lift, securing the wheelchair breaks, and lowering the resident to ground level. The wheelchair locks were released before the safety strap was removed and the resident was rolled off the lift.</p> <p>Interview on 04/30/25 at 11:50 AM with Resident #3 revealed the procedure Driver C had performed for the transport was how all of his previous transports had been done. He stated he had no concerns with being transported via the facility van.</p> <p>Interview on 04/30/25 at 11:53 AM with Driver C revealed she had been re-trained on driving and transport procedures in March and April, and they now had two drivers present in the van to minimize the risk for errors or injuries.</p> <p>Interviews on 04/30/25 from 12:00 PM-12:35 PM with four residents (Residents #3, #4, #5, and #6) that had been transported via the van on a regular basis for dialysis or other appointments revealed none had any concerns about how they were secured in the van, and all felt confident in the skills of the drivers.</p> <p>Interview on 04/30/25 at 4:23 PM with the Maintenance Director revealed his inspection of the van after both incidences revealed all equipment was in working order.</p> <p>An interview was attempted with Driver B via telephone; however, the attempt was unsuccessful. A voicemail message was left for Driver B, but Driver B did not return the call.</p> <p>Record review of Driver B's driver training revealed Driver B had initially been trained for driving the van on 05/17/23 and her last re-training was on 01/30/25.</p> <p>Record review of in-service training records reflected the facility provided Van Training to staff, who drove the facility van following the incident.</p>		