

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

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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 07/23/2026
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East Thompson Street 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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 5 residents (Resident #1) reviewed for change of condition. The facility staff failed to notify the NP or Physician when Resident #1 began to have a change of condition on [DATE] when he experienced lethargy, clammy skin, was unable to verbally talk to staff, and did not appear to be himself. Resident #1 continued to have a change of condition until [DATE] when he was sent to the hospital and passed away. The noncompliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of harm and/or serious injury for unreported changes of condition to the NP or physician. Findings included: Review of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 6 which indicated severe cognitive impairment. His MDS indicated he did not have behaviors of rejection of care. His active diagnoses included heart failure, renal insufficiency/renal failure/or end-stage renal disease (a condition where the kidneys can no longer function adequately), and non-alzheimer's dementia (a cognitive disorder severe enough to interfere with daily life). Review of Resident #1's Discharge summary, dated [DATE], reflected he discharged on [DATE] as he was sent to ER in cardiac/respiratory failure. Resident receiving CPR at time of discharge and passed in ER. Review of Resident #1's SBAR, dated [DATE], reflected the following information:-His blood pressure read 90/40-His pulse read 156-His respirations were 32-His temperature read 100.2 F-His O2 saturation read 79-His symptoms or signs were: Change in condition with decreased level of consciousness, fever, tachypnea, tachycardia, oxygen saturation dropped to 79% on room air. Use of accessory muscles to breathe. Review of Resident #1's care plan, revised on [DATE], reflected the following: Focus: Cancelled: [Resident #1] has Congestive Heart Failure.Interventions: Cancelled: Monitor/document/report to MD PRN any s/sx of Congestive Heart Failure.cool skin, dry cough.weakness.Cancelled: Monitor/document/report to MD PRN any s/sx of hypokalemia in residents receiving diuretic therapy: Fatigue, muscle, weakness, diminished appetite, nausea and vomiting.Focus: Cancelled: [Resident #1] has renal insufficiency r/t Kidney disease Stage 4.Interventions: Monitor and report changes in mental status: lethargy; tiredness; fatigue; tremors; seizures. Review of Resident #1's Progress Notes for [DATE] reflected:-LVN A wrote on [DATE] at 8:24 PM that Resident #1 had refused his Albuterol Sulfate Inhalation Nebulization Solution-LVN B wrote on [DATE] at 8:57 AM that Resident #1 refused his Breo Ellipta Inhalation Aerosol Powder (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. This was determined to be a Past Non-Compliance Immediate Jeopardy on [DATE] at 5:14 PM. The DON was notified. The DON was provided with the IJ template on [DATE] at 5:14 PM. The facility took the following actions to correct the non-compliance prior to the survey: An in-service dated [DATE] reflected the following information given to staff: Change of Condition! Any change of condition is a reason for concern. If you notice a resident is not themselves, they are eating less, not drinking as much. State [sic] that they do not feel well, if you look at them and they do not look the same you must report to the Charge nurse [sic] immediately if you feel [sic] the Charge Nurse is not responding timely call the DON immediately at [the DON's phone number]. 77 staff had signed off they had received the information. An undated in-serviced reflected the following information give to staff: .Change of condition.If you notice any change of condition in a resident you are to immediately report it to the charge nurse. Change could be they just don't look themselves [sic]; they seem agitated and it's not their normal, their appetite has decrease, they are not wanting to drink anything. If you feel charge nurse is not responding or addressing, you are to call DON [DON's phone number]. This information was sent as a text message to 89 staff. Resident safe surveys were completed on [DATE] that did not result in any findings where residents felt staff did not listen to their concerns and act on them appropriately. An in-service dated [DATE] reflected the following information given to staff: Change of Condition Notification.Notify DON, Notify MD, Notify RP, Notify hospice if appropriate.All changes in condition must be reported and SBAR completed. This is mandatory. No exception. 77 staff had signed off they had received the information. An in-service dated [DATE] reflected staff had been given the steps on where to find and how to complete an SBAR in a resident's chart. 58 staff had signed off they had received the information. Review of an Employee Disciplinary Report, signed [DATE], reflected LVN A had been suspended pending an investigation related to allegations of documentation from an incident that happened on [DATE]. Review of an Employee Disciplinary Report, signed [DATE], reflected LVN B had been suspending pending an investigation related to employee misconduct from an incident that happened on [DATE]. Interviews on [DATE] from 12:03 PM to 3:06 PM with the following staff: MA D, CNA E, MA G, RN C, CNA H, CNA I, LVN F, LVN B, HA J, LVN A, and the DON confirmed they had been in-serviced regarding the following: any change of condition to a resident must be reported to the charge nurse, any change in condition must also be reported to the MD, any change in condition required that a SBAR must be completed, staff were aware of where to locate the SBAR and how to fill it out.		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to assess and follow-up on Resident #1's change of condition which began on [DATE] when he experienced lethargy, clammy skin, was unable to verbally talk to staff, and did not appear to be himself. Resident #1 was found on [DATE] around 4 PM by staff to have shortness of breath and appeared to be in distress where he was sent to the hospital and passed away. The noncompliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk for worsening conditions that have not been assessed or followed up on by staff which could lead to respiratory illnesses, hospitalization, and death. Findings: Review of Resident #1's Quarterly MDS Assessment, dated [DATE], reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 6 which indicated severe cognitive impairment. His MDS indicated he did not have behaviors of rejection of care. His active diagnoses included heart failure, renal insufficiency/renal failure/or end-stage renal disease (a condition where the kidneys can no longer function adequately), and non-alzheimer's dementia (a cognitive disorder severe enough to interfere with daily life). Review of Resident #1's Discharge summary, dated [DATE], reflected he discharged on [DATE] as he was sent to ER in cardiac/respiratory failure. Resident receiving CPR at time of discharge and passed in ER. Review of Resident #1's SBAR, dated [DATE], reflected the following information: -His blood pressure read 90/40-His pulse read 156-His respirations were 32-His temperature read 100.2 F-His O2 saturation read 79-His symptoms or signs were: Change in condition with decreased level of consciousness, fever, tachypnea, tachycardia, oxygen saturation dropped to 79% on room air. Use of accessory muscles to breathe. Review of Resident #1's care plan, revised on [DATE], reflected the following: Focus: Cancelled: [Resident #1] has Congestive Heart Failure.Interventions: Cancelled: Monitor/document/report to MD PRN any s/sx of Congestive Heart Failure.cool skin, dry cough.weakness.Cancelled: Monitor/document/report to MD PRN any s/sx of hypokalemia in residents receiving diuretic therapy: Fatigue, muscle, weakness, diminished appetite, nausea and vomiting.Focus: Cancelled: [Resident #1] has renal insufficiency r/t Kidney disease Stage 4.Interventions: Monitor and report changes in mental status: lethargy; tiredness; fatigue; tremors; seizures. Review of Resident #1's Progress Notes for [DATE] reflected:-LVN A wrote on [DATE] at 8:24 PM that Resident #1 had refused his Albuterol Sulfate Inhalation Nebulization Solution-LVN B wrote on [DATE] at 8:57 AM that Resident #1 refused his Breo Ellipta Inhalation Aerosol Powder Breath Activated since he wasn't feeling well-RN C wrote on [DATE] at 4:30 PM the following The hospital ER called to request information about health history because the paramedics did not leave them the information that was sent with the resident. I was informed that the resident had expired and the [family member] was present at the ER.-RN C wrote on [DATE] at 7:35 PM the following The resident had a change in condition and is non responsive. Oxygen placed at 2 LPM via mask, MD, [family member] and 911 were notified. Review of Resident #1's [DATE] MAR reflected he refused his morning medications on [DATE] which consisted of bupropion, folic acid, magnesium, metformin, metoprolol succinate, potassium chloride, sertraline, and Eliquis.Further review reflected his blood pressure on [DATE] was 137/78 and on [DATE] it was 110/68. His pulse was 108 on [DATE] and 88 on [DATE]. Resident #1's hospital and EMS records (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were requested but not received prior to exit. Interview on the telephone on [DATE] at 10:53 AM with Resident #1's RP who said she felt if things happened differently last weekend then there would have been a different outcome for Resident #1. Resident #1's RP said someone had called her last Sunday ([DATE]) at 9:20 AM letting her know he had not eaten or drank fluids through the weekend. Resident #1's RP said she told them to offer Resident #1 a shake so he could have some sustenance but never heard back from the staff to know if he accepted the shake or not. Resident #1's RP said she got another call at 4 PM on Sunday ([DATE]) from a nurse who said Resident #1 was struggling to breathe and was running a fever. Resident #1's RP said she requested Resident #1 be sent to the hospital which the facility had planned to do. Resident #1's RP said she was told Resident #1 had passed away by the hospital staff. Interview on [DATE] at 12:03 PM with MA D said she worked with Resident #1 from Friday ([DATE]) to Sunday ([DATE]). MA D said she passed Resident #1 his medications which he accepted on Friday and Saturday, but he refused his medications on Sunday. MA D said on Sunday Resident #1 appeared flushed and his skin color was orange and pinkish in color on his face which was the only part of him she could see. MA D said it was not normal for Resident #1 to look that way, nor was it normal for him to refuse his medications. MA D said she reported her observations to LVN B who was caring for Resident #1. MA D said she did not see Resident #1 any other time after passing his medications to him. MA D said she had been in-serviced to let the nurse know any time there was a change to a resident and if the nurse was not listening to go to the ADON or DON about her observations. Interview on [DATE] at 12:13 PM with CNA E who said she worked with Resident #1 from Friday ([DATE]) to Sunday ([DATE]). CNA E said she worked from 6 AM to 6 PM with Resident #1 on Saturday and she noticed he had a change in condition and went to tell the nurse he was not himself. CNA E said she noticed this change in him shortly after breakfast because he did not look right or act right. CNA E said he could hardly talk to her when he was normally very talkative. CNA E said she also noticed he looked flushed and the color in his face was off. CNA E said the nurse she reported the change to was LVN B. CNA E said she was not sure what LVN B did after she reported the changes to her since she was busy caring for other residents. CNA E said she was told by LVN B to offer him a shake since he did not eat his breakfast that morning but he had refused it. CNA E told LVN B Resident #1 had refused the shake. CNA E said sometimes Resident #1 would eat all of his meal and other days he would not, but it just depended on the day. CNA E said when she came in on Sunday to care for Resident #1 she noticed he was in the same state as before until after 4 PM. CNA E said LVN B was Resident #1's nurse for part of the shift on Sunday and she reported to her that morning that Resident #1 still did not seem like himself. CNA E said RN C took over the shift and care for Resident #1 and she told RN C Resident #1 did not seem like himself which was why RN C and LVN F went to check on him around 4 PM. CNA E said she noticed he was struggling to breathe because he was taking shallow and quick breaths and was not opening his eyes or talking. CNA E said she had last checked on him at 2:45 PM and he seemed to be breathing well. CNA E said the nurses began to apply oxygen to Resident #1 and had planned to send him to the hospital. CNA E said the next thing she knew Resident #1 had CPR being performed on him and she was not sure what happened after that. CNA E said she knew to let the nurse know any time a resident had a change to their condition and if they were not listening then she was supposed to go the ADON or DON. Interview on [DATE] at 12:30 PM with MA G who said she did not care for Resident #1 from Friday ([DATE]) to Sunday (07/19/26) but she had cared for him in the past. MA G said CNA E asked her to check on Resident #1 on Saturday because she noticed he was not himself. MA G said when she saw Resident #1 he did not look good, he was not talking and the look on his face was not his normal. MA G said she saw Resident #1 was red in the face but it could have been from his breathing treatment. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-serviced and knew to report any change to a resident to the provider immediately. Interview on the telephone on [DATE] at 1:46 PM with LVN B who said she worked with Resident #1 on Friday through Sunday ([DATE] to [DATE]). LVN B said on Friday she was told by the aide that he was not acting like himself, that he was weaker than normal but not that much. LVN B said she went to check on him, took his vital signs, and completed an assessment; she said everything was normal with Resident #1, including his vital signs. LVN B said nothing else was reported to her during her shift that day and she did not notice anything else wrong with him. LVN B said he had refused his nebulizer treatment that day but that was normal for him. LVN B said on Saturday he was about the same but she was told he had thrown up and thought it was because he had not been eating much and took his medications on an empty stomach. LVN B said she was not sure who reported to her that he had thrown up and it was already cleaned up by the time she was told about it. LVN B said she checked on Resident #1 after being told this and he was his normal self. LVN B said on Friday he was weak and tired and was the same on Saturday. LVN B said she did not take his vital signs or do an assessment on him because she thought it was related to him taking his medications on an empty stomach which would make anyone sick and possibly throw up. LVN B said she was told by the aide on Saturday that he was refusing to eat which was not normal for him. LVN B said she went to his room multiple times during her shift on Saturday to check on him and she never saw a major change in him. LVN B said she also did not document her assessments or check ins on him or any of the vital signs she took during her assessments. LVN B said on Sunday he was not any better or worse and he had reported to her he had felt about the same as the day before. LVN B said she did not take his vital signs or do an assessment on him on Sunday when she checked on him. LVN B said she did not report to the doctor any of the changes he experienced or that he had vomited on Saturday. LVN B said all the symptoms he experienced did not seem as if they were that much of a change for him to warrant reporting them to the doctor. LVN B said she knew he seemed weaker but it was not enough of a change to call the doctor about so she just kept monitoring him. LVN B said she left early on Sunday during her shift and gave report to RN C but did not say anything about Resident #1 to her. LVN B said she knew to report a significant change in condition to the doctor, or if the resident's vital signs were not within normal limits. LVN B said she had been in-serviced that any change in condition should be reported immediately to the doctor. Follow-up interview on [DATE] at 2:05 PM with CNA E who said she could not remember if Resident #1 had thrown up or not, but if he did she reported it to the nurse immediately. Interview on the telephone on [DATE] at 2:14 PM with HA J who said she worked with Resident #1 on Friday ([DATE]). HA J said she noticed he did not eat his dinner and she was worried about him not eating so she asked why he did not eat. HA J said no sound came out of his mouth and he just mouthed the word no. HA J said that was weird because he liked to eat, so she asked if wanted a shake instead and again he mouthed the word no. HA J said she reported this change to LVN A who said she would be down to his room in a bit to check on him. HA J said she told LVN A it seemed as if Resident #1 was running a fever because when she touched him he felt warm. HA J said LVN A told her she checked on him and his vital signs were good. HA J said normally Resident #1 was very talkative with staff so it was strange and not good that he was only able to whisper or mouth words to the staff. HA J said she cared for him Saturday ([DATE]) night as well and he was a little better than Friday but was still not talking and she could tell he was not feeling well. HA J said she reported the change to LVN A again because Resident #1 looked like he was about to die since he was so pale and sick looking. HA J said he was not bouncing back at all and she asked if he wanted to go to the hospital and he mouthed the word no. HA J said she was in-serviced to report any change in a resident to the nurse and if the nurse did not listen to tell the ADON or DON. Follow-up interview (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on [DATE] at 2:24 PM with CNA I who said Resident #1 did not throw up during her shift that she could recall, but if he did she reported it to the nurse immediately. Interview on the telephone on [DATE] at 2:27 PM with Resident #1's Physician who said he was on vacation so had limited information. Resident #1's Physician said he was contacted on Sunday ([DATE]) about a change in condition before he passed away later that day. Resident #1's Physician said he did not have the on-call phone the staff may have used to communicate at other times with the provider. Interview on the telephone on [DATE] at 2:41 PM with the ADON who said he was on vacation that week and was not at work. The ADON said he did go to the facility for a few hours on Sunday ([DATE]) to meet a new admission but he was not there to work. The ADON said he asked in general how the residents were doing and was told by CNA E Resident #1 had not been eating again but that was not uncommon for him. The ADON said he looked in Resident #1's chart and saw that the staff were documenting he was eating so he told CNA E to be sure to let the nurse know about it. The ADON said he left after that and was not involved in anything else. Interview on the telephone on [DATE] at 2:46 PM with LVN A who said she cared for Resident #1 from Friday to Sunday ([DATE] to [DATE]). LVN A said she noticed he had been declining for a while and someone commented to her on Saturday that he was not feeling well. LVN A said she talked with him for a while and offered a breathing treatment which he refused and pain medications which he refused as well. LVN A said while she was assessing him she went through all his systems and could not pin point what was wrong. LVN A said she offered to send him to the hospital and he did not want that. LVN A said she thought she had charted all of her assessments and check ins with him but had not. LVN A said on Friday while she was caring for Resident #1 she noticed he was quiet and did not have a lot to say, but his vital signs were good. LVN A said everything seemed fine and he was at his baseline. LVN A said she noted the same on Saturday as well. LVN A said HA J told her he was not feeling good but she had already taken his vital signs but she got another set and talked to him for a while. LVN A said on Sunday when she got to work he had already passed away. LVN A said she did not report anything to the doctor because no one had reported any changes to her and nothing was significant enough to tell the doctor about. LVN A said she had been in-serviced that when someone reported a change in a resident she was supposed to do an assessment and report it to the doctor immediately. Interview on the telephone on [DATE] at 2:52 PM with the NP who said he had the on-call phone last weekend from Friday to Sunday ([DATE] to [DATE]). The NP said the only time he heard from the facility regarding Resident #1 was on Sunday at 9:35 PM where he received a text saying he had passed away at the ER. The NP said he was not aware that Resident #1 went to the ER. The NP said normally he would be notified if a resident had a change in condition. The NP said staff were supposed to text if they had any resident who had a decline in health status that would require an intervention. The NP said it would have been appropriate to report any changes to him in Resident #1's status and he would have gone through the steps with staff to see what could have been done for him. The NP said he wanted to know when a resident had a change in their status even if it was slight or small. The NP said it was normal for staff to report to him if a resident was not eating, looking lethargic, appeared sleepy, or was looking pale/clammy/flushed. The NP said any change was important to report to him and he would have expected the staff to have reported any of those to him at the time they happened. Interview on [DATE] at 3:06 PM with the DON who said she was here on Friday ([DATE]) but did not work over the weekend ([DATE] and [DATE]). The DON said she had no contact with Resident #1 nor did anyone bring anything to her attention about him either. The DON said she was called on Sunday around 4 PM by the staff who said Resident #1's blood pressure was low and his pulse was high. The DON said staff confirmed they had already called the doctor and were sending him to the (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital. The DON said she was told when the EMT's walked into his room he was not breathing so they had to start CPR on him. The DON said later on, LVN A called to tell her he had passed away. The DON said the next day on Monday ([DATE]) she began to in-service the staff on change of condition and notifications to the doctor. The DON said she started reviewing Resident #1's chart and talking to staff which resulted in finding out they did not notify the doctor when Resident #1 had a change in condition beginning on Friday ([DATE]). The DON said LVN A and LVN B should have notified the doctor immediately when it was reported he had a change in condition. The DON said she was told Resident #1 did not look good on Sunday morning and LVN B should have notified the doctor. The DON said LVN B did not notify the doctor and different staff, RN C and LVN F, had called the doctor and sent him to the hospital. The DON said even if Resident #1's vital signs were within normal limits during assessments by the nurses after a change of condition was reported, LVN A and LVN B still should have called the doctor to report they symptoms he was experiencing. The DON said the symptoms should have made it obvious to LVN A and LVN B that something was going on with him. The DON said LVN A and LVN B told her they did not call the doctor because his vital signs were normal during their assessments so they did not think there was a problem with him. The DON said just because a resident had a habit of something did not mean that was their normal. The DON said during the investigation, both LVN A and LVN B were suspended pending termination. The DON said neither LVN A or LVN B documented any of their assessments or vital signs taken during assessments with Resident #1 so she was not sure what they did or what their assessments found. The DON said all nurses had the number to contact the doctor to report any change in condition to them immediately. The DON said all nurses were aware that any change in condition, whether it was considered significant or not, was supposed to be immediately reported to the doctor. The DON said the purpose of reporting any change in condition to the doctor was so that they could get orders for labs or x-rays or something else to try and figure out what was happening to the resident. The DON said the communication also helped so that if the resident's condition got worse the doctor was already aware of their previous condition. The DON said she expected staff to notify the doctor as soon as the resident was noted to have a change in condition. The DON said in this case, Resident #1 had a change in condition on Friday under the care of LVN A and LVN B who should have contacted the doctor but did not. The DON said both LVN A and LVN B had been told by multiple staff about Resident #1's changes in condition. The DON said if the nurses did not notify the doctor of a change in condition with a resident a lot of different things could happen, death was one of those, and others could be the resident not getting the care they needed. Review of the facility's undated policy titled Completing an SBAR reflected the following: An SBAR is required when you are reporting a change in condition to the physician or NP. If not an emergent situation, the SBAR should be completed and read to the doctor or NP so that they are well informed of the resident's condition. Begin completing the SBAR as you would any other assessment. This was determined to be a Past Non-Compliance Immediate Jeopardy on [DATE] at 5:14 PM. The DON was notified. The DON was provided with the IJ template on [DATE] at 5:14 PM. The facility took the following actions to correct the non-compliance prior to the survey: An in-service dated [DATE] reflected the following information given to staff: Change of Condition! Any change of condition is a reason for concern. If you notice a resident is not themselves, they are eating less, not drinking as much. State [sic] that they do not feel well, if you look at them and they do not look the same you must report to the Charge nurse [sic] immediately if you feel [sic] the Charge Nurse is not responding timely call the DON immediately at [the DON's phone number]. 77 staff had signed off they had received the information. An undated in-serviced reflected the following information give to staff: .Change of condition. If you notice any change of (continued on next page)		

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 07/23/2026
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East Thompson Street 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition in a resident you are to immediately report it to the charge nurse. Change could be they just don't look themselves [sic]; they seem agitated and it's not their normal, their appetite has decrease, they are not wanting to drink anything. If you feel charge nurse is not responding or addressing, you are to call DON [DON's phone number]. This information was sent as a text message to 89 staff. Resident safe surveys were completed on [DATE] that did not result in any findings where residents felt staff did not listen to their concerns and act on them appropriately. An in-service dated [DATE] reflected the following information given to staff: Change of Condition Notification. Notify DON, Notify MD, Notify RP, Notify hospice if appropriate. All changes in condition must be reported and SBAR completed. This is mandatory. No exception. 77 staff had signed off they had received the information. An in-service dated [DATE] reflected staff had been given the steps on where to find and how to complete an SBAR in a resident's chart. 58 staff had signed off they had received the information. Review of an Employee Disciplinary Report, signed [DATE], reflected LVN A had been suspended pending an investigation related to allegations of documentation from an incident that happened on [DATE]. Review of an Employee Disciplinary Report, signed [DATE], reflected LVN B had been suspending pending an investigation related to employee misconduct from an incident that happened on [DATE]. Interviews on [DATE] from 12:03 PM to 3:06 PM with the following staff: MA D, CNA E, MA G, RN C, CNA H, CNA I, LVN F, LVN B, HA J, LVN A, and the DON confirmed they had been in-serviced regarding the following: any change of condition to a resident must be reported to the charge nurse, any change in condition must also be reported to the MD, any change in condition required that a SBAR must be completed, staff were aware of where to locate the SBAR and how to fill it out.		