

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 11/20/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #3) reviewed for dignity. The facility failed to allow Residents #31 to keep his electric wheelchair when he admitted to the facility. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings included: Record review of Resident #31's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart disease, end stage renal disease (a terminal illness that occurs when the kidneys can no longer function properly), and stroke. Resident #31 had a BIMS of 12 which indicated his cognition was moderately impaired. The MDS further indicated the resident had impairment on one side to his upper and lower extremities and used a wheelchair. Record review of Resident #31's care plan revised on 07/19/24 reflected the resident had an ADL self-care performance deficit and required limited assistance of one staff member for ADLs. Observation and interview on 11/19/24 at 9:11 AM revealed Resident #31 was in a manual wheelchair. The resident said when he was admitted to the facility he had an electric wheelchair and was told by someone, whom he could not recall, that it was against the rules to have the electric wheelchair unless he was given a test so he was given a manual wheelchair. Resident #31 said he did not believe it was fair that he did not get to keep his electric wheelchair and was never given a test to see if he could keep it. He stated he was just told they did not have room for it. The resident said he was able to get around good with the manual wheelchair, but he preferred to have his electric one. Record review of a progress note for Resident #31, dated 07/05/24, and documented by the previous DON reflected the following: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident arrived to the facility in electric wheelchair. Wheelchair is not a necessity and resident has not been approved for use. Manual w/c offered to resident and he is able to move w/c using legs. W/C seat added for additional height for legs. Explained reason electric w/c is not allowed and marketer to relay to family to have them pick electric w/c up Interview on 11/20/24 at 1:35 PM with Resident #31's family member revealed the resident admitted to the facility with an electric wheelchair. The family member was told, but did not recall by whom, that Resident #31 was able to use a manual wheelchair, therefore he did not need the electric chair. The family member said they did not question the request so they just took the electric chair home. They further stated they felt like Resident #31 was safe to use the electric wheelchair as he had been using it prior to being admitted to the facility. Interview on 11/19/24 at 9:30 AM with the Director of Rehabilitation revealed he had only been at the facility for about three weeks. He said if a resident was admitted to the facility and wanted to use an electric wheelchair, the resident would be given a test to ensure the resident were safe to use the electric wheelchair. He stated he was not aware Resident #31 once had an electric wheelchair. He stated if the resident wanted to use the electric wheelchair they would assess the resident for safety. He further stated he looked through the files, and he did not see that Resident #31 was ever assessed to use his electric wheelchair. Interview on 11/19/24 at 3:05 PM with the ADON revealed Resident #31 was admitted using an electric wheelchair. The ADON could not recall the situation around why the resident did not use it. The ADON said residents who admitted with electric wheelchairs were usually assessed to determine if they were safe to use it. He further stated he did not see any reason why Resident #31 would not be able to use it once he would be assessed. Record review of the facility's copy of the Resident [NAME] of Rights on 11/20/24 reflected the following: .A facility must treat each resident with respect and dignity and care for each resident in a manner an in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 2 residents (Resident #47) reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #47 after they returned from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care resulting in harm to the resident. Findings included: Record review of Resident #47's face sheet, dated 11/20/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #47 had diagnoses which included encephalopathy (brain disease that alters brain function or structure), end stage renal disease (when kidneys suddenly become unable to filter waste products from blood), acute kidney failure, fluid overload, and difficulty in walking. Record review of Resident #47's Nursing Home PA PPS Discharge Item Set, dated 11/04/24, reflected Resident #47 had a BIMS score of 12 reflecting the resident's cognition was mildly impaired. The MDS section O, related to special treatments, procedures, and programs, reflected Resident #47 received hemodialysis, which is ongoing dialysis (three to five times per week) that cleans your blood in a dialysis center. Record review of Resident #47's care plan, date initiated 08/22/24, reflected: Focus: The resident needs dialysis hemodialysis. Goals: The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Interventions: Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (specify frequency). Monitor for dry skin and apply lotion as needed. Monitor/document for peripheral edema. Monitor/document/report to MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and BP immediately. Record review of Resident #47's undated physician's order, reflected the resident was to have hemodialysis treatments performed via AV shunt on Tuesdays, Thursdays, and Saturdays. Record review of Resident #47's dialysis communication form in the facility's EHR, dated 11/07/24, reflected no pre-dialysis weight was documented, only a post-dialysis weight. Record review of Resident #47's dialysis communication form in the facility's EHR, dated 11/09/24, reflected no pre-dialysis weight was documented, only a post-dialysis weight. Record review of Resident #47's dialysis communication form in the facility's EHR, dated 11/14/24, reflected no post-dialysis weight was documented, only a pre-dialysis weight. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/18/24 at 10:52 AM revealed Resident #47 sitting in her wheelchair dressed and neat in appearance. The resident denied any pain. Resident #47 stated she received dialysis, and the facility transported her to dialysis three times per week on Tuesdays, Thursdays, and Saturdays. Resident #47 also stated the facility provided her with a sack lunch on her dialysis days. Interview on 11/20/24 at 3:03 PM with LVN B revealed it was the charge nurse's responsibility to ensure that vitals, including weights, were obtained and documented both before and after dialysis on the dialysis communication form. LVN B stated it was important to document the weights before and after dialysis to determine the amount of fluid pulled off the resident during dialysis. LVN B also said that if too much fluid was pulled off the resident, it could affect the resident's heart. LVN B stated it was the responsibility of the resident's nurse to ensure the dialysis forms were completed. LVN B also said if she noted an issue with the resident's weight, she would notify the DON. LVN B concluded by stating she did not recall the last in-service on dialysis policies and procedures provided by the facility. Interview on 11/20/24 at 3:14 PM with the ADON revealed nurses should ensure pre- and post-vitals, including weights, were completed for the dialysis residents. The ADON stated the risk to the resident if weights were not obtained would be that the resident's nurse would not know if the resident did not have sufficient fluid pulled off the resident. The ADON said that was important to the resident's health because it could make them toxic, and the resident could then become ill. The ADON further stated if the resident's nurse observed that vitals were not taken, that the nurse should report it to the primary care physician and the urologist. The ADON concluded by stating that he did not recall the last in-service on dialysis and vitals. Interview on 11/20/24 at 3:40 PM with the Regional Clinical Consultant revealed the resident's nurse was supposed to complete the communication form upon the resident's return from dialysis per facility policy. The Regional Clinical Consultant stated it was important to assess the resident upon returning from dialysis. The Regional Clinical Consultant said it was important to review the resident's vitals including pre- and post-dialysis weights because the resident could have fluid deficit or volume overload. The Regional Clinical Consultant stated she last in-serviced the nursing staff on dialysis around the 09/01/24. Record review of the facility's current Dialysis policy, dated November 2013, reflected the following: .Procedure .19. The facility will monitor departures and returns from the dialysis center. The facility will document the resident's vital signs, general appearance, orientation, and additional baseline data as needed. The resident's clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50445 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 4 medication carts (Hall C Medication Cart) reviewed for storage, in that: MA A failed to ensure the Hall C Medication cart was locked when she left it unattended for approximately two minutes. This deficient practice placed residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications. Findings included: Observation on 11/19/24 at 8:00 AM revealed the Hall C medication cart was observed unlocked and unattended on Hall C outside of the dining room for approximately two minutes. The medication cart was not within view of the dining room. Approximately 100 different types of medications including medications such as antihypertensives, anticonvulsants, and anticoagulants, were accessible inside the unlocked cart including medications in blister packs, bottles, and vials. The narcotics were noted as locked in a drawer with a second lock and were not accessible. MA A returned to the cart from the dining room after approximately two minutes. Interview on 11/19/24 at 8:02 AM with MA A revealed she confirmed the medication cart was left unlocked while she was administering medications to a resident in the dining room. MA A stated she worked at the facility for about one year. She stated she typically locked the cart before leaving it because, I have medications, and anyone can get into it. I have dementia patients who could take something. I usually keep it locked. I don't know what happened today. Interview on 11/19/24 at 9:20 AM with the DON revealed MA A had already told her she left her cart unlocked. She stated nurses and aides locked their carts when they left the carts to keep the medications secure. She stated, A resident could get into it, and you wouldn't know what they had taken. Record review of the facility's Facility Medication Administration Policy, Pharmacy Policy & Procedure Manual, dated 2003 and revised 10/25/17, reflected: During the medication administration process, the unlocked side of the cart must always be in full view of the nurse and After the medication administration process is completed, the medication cart must be completely locked and stored in a locked medication room, or otherwise secured.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48236 Based on observation, interview, and record review, the facility failed to prepare, store, distribute, and serve foods in accordance with professional standards for food service safety in the facility's only kitchen. The facility failed to ensure pork chops stored in the facility freezer were covered to prevent contamination. This failure placed residents, who received food from the kitchen, at risk for food contamination and food borne illness. Findings included: Observation of the facility freezer on 11/18/24 at 9:04 AM revealed uncovered pork chops stored in a labeled, metal pan. Interview on 11/20/24 at 3:34 PM with the [NAME] revealed all items in the facility refrigerators and freezers should be covered, labeled, and dated. The [NAME] stated the importance of covering foods was to prevent contamination. The [NAME] added that residents could get sick if they ate contaminated food. The [NAME] said he would report uncovered, labeled, and dated to his dietary manager. The [NAME] stated he was last in-serviced on food storage about a month ago. Interview on 11/20/24 at 3:37 PM with the Dietary Manager revealed the pork chops should have been covered in the freezer per facility policy. The Dietary Manager stated the importance of items being covered or in sealed containers was so that germs did not fall into or on the food. The Dietary Manager said residents could get sick if food was placed in freezers or refrigerators uncovered. The Dietary Manager stated the dietary department was last in-serviced on food storage about a month and a half ago. Record review of facility's current Food Storage and Supplies Dietary Services Policy and Procedure Manual, dated 2012, reflected the following: .Procedure: .4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened		