

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

Printed: 07/18/2026
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 02/26/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal care for 2 of 8 residents (Residents #13, and 55) reviewed for ADL care. The facility failed to ensure nail care, to include trimming and cleaning, was provided to Residents #13, and #55. The failure placed the residents at risk of hygiene and safety risks such as nail tearing, injury, and functional difficulties. Findings included: 1. Record review of Resident #13's Face Sheet, dated 02/26/26, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #13's Quarterly MDS, dated [DATE], reflected the resident had diagnoses that included: Cerebral Infarction with hemiplegia (Stroke resulting in paralysis of one side of body), Diabetes Mellitus (chronic condition in which the body does not regulate blood sugar levels), Lack of coordination, and unspecified abnormalities of gait and mobility. The MDS reflected Resident #13 had a BIMS of 15, indicating he was cognitively intact. Record review of Resident #13's Care Plan, revised 02/20/26, revealed the resident had an ADL self-care performance deficit with the following intervention, .Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. The care plan also revealed the resident had hemiplegia (paralysis of one side of the body) with an intervention to assist with ADLs and mobility and Resident #13 had Diabetes Mellitus with interventions to check body for skin breakdown and refer to podiatrist/foot care nurse to monitor foot needs. Record review of Resident #13's progress notes revealed no documentation of refusal of fingernail care. Observation and interview on 02/24/26 at 11:40 AM revealed Resident #13 had long fingernails on both his hands, measuring approximately 1/4 - 1/2 inch long with jagged, sharp edges and dark debris underneath. Observation revealed a slight contracture to Resident #13's left hand with a missing fingertip to his left thumb. Resident #13 stated he was unable to move his left arm. Resident #13 stated he wished his fingernails were shorter and was unable to recall when they were last trimmed. He stated the Treatment Nurse usually trimmed his fingernails. Observation and interview on 02/25/26 at 4:17 PM revealed Resident #13 sitting in the lobby on a recliner. Resident #13 stated his nails had not been cut. He stated the Treatment Nurse typically trimmed them for him because she was good at it. Resident #13 stated no one had offered to trim them and he had told his aide. Resident #13 stated he had wanted them cut for a couple of weeks. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of fingernails revealed long fingernails on both hands with jagged edges. Observation and interview on 02/26/26 at 9:04 AM revealed Resident #13 with fingernails ranging from 1/4 - 1/2 inch long on both hands. Resident #13 stated he received a shower last night. Resident #13 stated he wanted his fingernails cut because they were sharp. No open areas or redness was observed. Interview on 02/26/26 at 11:40 AM with CNA A revealed she worked regularly with Resident #13. CNA A stated Resident #13 was diabetic, and the nurse trimmed his fingernails. During the interview, CNA A entered Resident #13's room and stated his fingernails were long and needed to be cut. CNA A stated fingernails were trimmed during their shower if the resident was not a diabetic. CNA A stated the nurse was responsible for trimming Resident #13's fingernails. CNA A stated she had noticed Resident #13's long fingernails and let nurses know. She stated she was unable to recall all the nurses she reported the long fingernails to, but she had told LVN B. CNA A stated Resident #13 did not refuse fingernail trims. CNA A stated the risk of long fingernails was the residents scratching themselves. Interview on 02/26/26 at 11:51 AM with the Treatment Nurse revealed Resident #13 preferred that she trimmed his nails. The Treatment Nurse stated Resident #13, or his CNA would let her know when he wanted them trimmed. She stated she was not aware that Resident #13's fingernails were long. The Treatment Nurse stated the CNAs were responsible for checking on his shower days and notifying her. The Treatment Nurse stated the nurses were responsible for trimming his fingernails because he was diabetic. She stated the risk of having long fingernails was skin tears and scratches. Interview on 02/26/26 at 11:54 AM with LVN B revealed she had not observed Resident #13's long fingernails because he was new to her hallway. LVN B stated Resident #13 did not refuse any care. LVN B stated she did not recall any CNAs that notified her of his long fingernails. LVN B stated the nurses were responsible for ensuring Resident #13's fingernails were trimmed because he was diabetic. LVN B observed Resident #13's fingernails and stated they were long and sharp. She stated the risk of long fingernails was an infection risk. Interview on 02/26/26 at 12:07 PM with HA C revealed she did evening showers for residents. HA C stated she did shower Resident #13 on 02/25/26. She stated she was not aware of Resident #13's long fingernails and must have missed them. HA C stated she would notify the nurse when the nails needed to be trimmed. HA C stated the risk of residents having long fingernails was skin tears and infection control. Interview on 02/26/26 at 3:20 PM with the ADON revealed he expected residents' nails to be kept short and clean. The ADON stated fingernails should be checked every shower. He stated he expected the aides to let the nurse know or cut them if the resident was not diabetic. The ADON stated he was not aware of Resident #13's long fingernails and stated Resident #13 did not refuse fingernail trims. The ADON stated the nurses were responsible for cutting Resident #13's fingernails since he was diabetic. The ADON stated the risk of long fingernails was scratching themselves or others. He also stated debris could get underneath and be an infection risk. 2. Record review of Resident #55's Quarterly MDS assessment, dated 11/14/25, revealed Resident #55 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #55 had cognition intact with a BIMS score of 13. Resident #55 required partial/moderate assistance from staff with shower/bathes and set up / clean up with personal hygiene. Active diagnoses included high blood (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure, high blood sugar, end &ndash; stage renal disease (when kidneys can no longer function adequately to sustain life without treatment). Review of Resident #55's care plan, undated, revealed Resident #55 had a Self-Care Performance Deficit. Goal: Resident will maintain or improve current level of function personal hygiene. Interventions included to praise all efforts at self-care. Encourage resident to discuss feelings about self-care deficit. Encourage resident to use bell to call for assistance. Review of Resident #55's care plan, undated, revealed he had Diabetes. Goal: Resident will have no complications related to diabetes. Interventions included to monitor/document/report to physician as needed for signs and symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. Interview and Observation on 02/24/26 at 11:15 AM with Resident #55 revealed him laying in bed, Resident #55 stated, I wished they would cut my nails, they are too long. Resident #55 stated I have to have help to have them cut because I have nothing to cut them with. Observation of Resident #55's nails revealed they were at least one half inch long with black debris underneath each nail. According to Resident #55, he did not recall the last time anyone had trimmed his nails, or the last time he had washed his hands. Interview on 02/25/26 at 4:01 PM with LVN F revealed aides were responsible for resident nail care during shower days. According to LVN F Resident #55 refused showers a lot of the time. LVN F stated she had noticed the dark debris underneath Resident #55's nails and stated, [Resident #55] had dark debris underneath his nails because he scratched and dug in his bottom. LVN F stated not having clean hands and nails placed him at risk of infection and cross contamination. Interview on 02/26/26 at 11:50 AM with LVN B revealed CNAs are responsible for completing Resident #55's nail care on Monday, Wednesday, and Fridays during his shower. LVN B stated Resident #55 will refuse, however, when you return to ask him a second time he will agree to the shower. LVN B stated Resident #55 took a shower on 02/25/26 on the evening shift. LVN B stated if there was an issue with showers or nail care the aides were to inform the nurses so that they could address the issue with the resident and document. LVB stated she had noticed the debris under his nails. LVN B stated having debris under his nails placed him at risk of neglect, illnesses, and infections especially since he liked to eat finger foods. Interview on 02/26/26 at 2:58 PM with CNA A revealed Resident #55's shower days were Monday, Wednesday, and Fridays during the 2-10:00 PM shift. CNA A stated that CNAs providing the shower were responsible for ensuring resident nails were cleaned and trimmed. CNA A stated CNAs were supposed to indicate whether nailcare was completed or refused on the shower sheets so that the Charge Nurses could address any refusals. CNA A stated she worked with Resident #55 to complete hand hygiene and trim his nails however his hands shake and that makes him nervous and he will refuse you to trim his nails. CNA A stated Resident #55 dug in his bottom which caused him to have the debris under his nails. CNA A stated completing hand hygiene with Resident #55 was a daily thing to do, not doing so placed him at risk of health hazards, pink eye, touching others could cause infections. Interview on 02/26/26 at 4:09 PM with the Administrator revealed she expected all nails to be kept clean and trimmed if residents allowed. She stated the aides were responsible unless the resident was diabetic, then the nurse was responsible. The Administrator stated the risk of long nails was (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	puncturing the skin, especially with Resident #13's paralyzed hand and with Resident #55's digging habits. She also stated it was an infection control risk because the nails could become dirty underneath. Record review of facility Nail Care policy, undated, reflected the following: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing , and cuticle care and is usually done during the bath.GoalsNail care with be performed regularly and safely. .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 8 residents (Resident #86) and 1 of 3 staff (HA C) reviewed for infection control. 1. A medical equipment provider failed to put on PPE prior to entering Resident #86's room, while the resident was on isolation for COVID-19. 2. The facility failed to ensure HA C performed hand hygiene between residents while passing meal trays on E Hall. This failure could place residents at risk of being infected by staff/providers in contact with other residents with infections. Findings included: 1. Review of Resident #86's admission MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The residents' diagnoses included cancer, atrial fibrillation (rapid, irregular, uncoordinated beating of the heart's upper chamber), non-Alzheimer's dementia, and respiratory failure. The MDS reflected the resident had a BIMS of 13 which indicated his cognition was intact. Review of Resident #86's care plan initiated on 02/04/26 reflected the resident was at risk for signs and symptoms of COVID-19. Intervention included to follow facility protocol for COVID-19 screening/precautions. Interview on 02/24/26 at 9:35 AM with the Administrator revealed they had admitted 5 residents from their sister facility so they could be cohorted appropriately for COVID-19. The Administrator said 4 of the residents were warm (Resident #86), which meant they had been exposed to COVID-19 and 1 resident was hot, which meant he had confirmed COVID-19. Review of the sign outside of Resident #86's room reflected the following: STOP TRANSMISSION-BASED PRECAUTIONS Before entering this room, you MUST: Wear N95 or higher-level respirator. Wear Eye Protection (goggles or face shield) Wear Gown Perform Hand Hygiene when entering and exiting. Keep door closed (if possible) Limit resident movement outside the room-mask required if leaving. Use dedicated or disinfected equipment Visitor: Check with nursing staff before entering. Observation on 02/24/26 at 11:44 AM revealed the door to Resident #86's room was open and the resident was laying in bed awake. There was a medical equipment provider observed to be inside Resident #86's room with no PPE on, as he was putting a bed together. The Regional Nurse Consultant approached the provider and asked him to put on PPE from a PPE cart outside the room which contained N95 masks, gowns, gloves, and face shields, because the resident was in isolation. The provider stepped out of the room and put the appropriate PPE on as directed by the Regional Nurse Consultant. Interview on 02/24/26 at 11:53 AM with the Medical Equipment Provider revealed he was not told Resident #86 was in isolation and he needed to wear PPE prior to entering the room and he also said he did not see the sign posted outside the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/26/26 at 11:05 AM with the ADON revealed full PPE, such as gloves, gown, N95 mask, and shields should be worn prior to entering the COVID-19 isolation rooms and that included staff and outside providers. The ADON said PPE should be worn for protection of the residents and others to keep away the transmission of infections. 2. Observation on 02/25/26 from 1:30- 1:50 PM of lunch trays being passed on E Hall revealed that HA C passed meal trays to 3 rooms on the hall and failed to perform hand hygiene between each resident. HA C was observed to touch resident's floor mats, wheelchairs, and other personal items between each room, without any form of hand hygiene. Interview on 02/25/26 at 2:46 PM with HA C revealed that she worked at this facility as a Hospitality Aide for about a year and half. She revealed that she had had training on hand hygiene and thought that she used the hand sanitizer located on the hall between each tray. HA C revealed that hand hygiene should be performed between each resident, before leaving the room if you come in contact with the resident or their personal belongings, or after performing cares. She revealed that she did not sanitize between residents. Interview on 02/26/26 at 4:00 PM with the ADON revealed that all staff had been inserviced on using proper hand hygiene. The ADON stated it was expected that when staff were passing food trays or helping with meals each staff should use hand hygiene by washing their hands or using hand sanitizer between residents. ADON stated not using hygiene between residents would place residents at risk of cross contamination. Interview on 02/26/2026 at 4:16 PM with the Administrator revealed hand hygiene was expected to be completed while passing meal trays. The Administrator stated staff were to clean their hands before touching any tray and upon leaving resident rooms. The Administrator stated that not completing hand hygiene placed residents at risk of cross contamination and illness. Review of the facility's policy titled Infection Control Plan: Overview updated on 03/2024 reflected the following: Infection ControlThe facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. .1. Hand HygieneHand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:.Before and after eating or handling food.Before and after assisting a resident with meals.After handling soiled or used linens, equipment, or utensils. .Personal Protective EquipmentHCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use.N95 filters or higher, gown, gloves, eye protection (i.e., goggles or a face shield that covers the front and sides of the face).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #12) reviewed for care plans. The facility failed to ensure Resident #12's comprehensive care plan was updated to reflect his G-tube was changed in-house, as required. This failure could place the residents at risk of not receiving the necessary care and services needed. Findings included: Record review of Resident #12's Face Sheet, dated 02/26/26, reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #12's Quarterly MDS Assessment, dated 12/2/25, reflected the resident had the following diagnoses: Cerebral Palsy (neurological disorder caused by damage to the developing brain), Severe intellectual disabilities (significant cognitive impairment in daily functioning), Dysphagia (Difficulty swallowing), Gastrostomy status (presence of a G-tube used for nutrition, hydration, or medication administration), Paraplegia (paralysis of lower half of the body). The MDS also reflected that the resident had a BIMS score of 0, indicating he was severely cognitively impaired. Record review of Resident #12's Care Plan, revised 02/23/26, reflected the resident had an ADL self-care performance deficit with an intervention that he had a G-tube and was fed by nurses. The care plan reflected Resident #12 had a terminal prognosis and was receiving hospice services. The care plan also reflected the following, [Resident #12] requires tube feeding r/t dysphagia. Sometimes he pulls tube out and sent to ER for replacement. Interview on 02/24/26 at 3:35 PM with RN D revealed she had replaced Resident #12's G-tube in the facility when it became dislodged. RN D stated she notified the physician to obtain an order and had previously completed competency training for G-tube replacement. RN D stated that Resident #12's family refused for him to be sent to the hospital, so it had been changed in the facility since she had been working with him. RN D reviewed the current care plan during interview and stated the care plan had not been updated to reflect the proper interventions to change in-house instead of transfer to the ER. RN D stated it was the nursing team's responsibility to ensure the care plan was accurate. RN D stated the risk of not updating the care plan could have resulted in Resident #12 being sent to the ER, which was against the family's wishes. She stated the care plan updates were important, so all staff were on the same page. Interview on 02/24/26 at 3:25 PM with Family Member #1 revealed she had no concerns with Resident #12's G-tube. She stated when Resident #12's tube needed replaced; the nurse replaced it at the facility. Family Member #1 stated she did not want Resident #12 sent to the hospital, as leaving his normal environment made his condition worse. Interview on 02/25/26 at 12:04 PM with the Regional Nurse Consultant revealed Resident #12 was not being sent to the ER for G-tube replacement. The Regional Nurse Consultant reviewed Resident #12's care plan and stated it had not been updated and continued to reflect transfer to ER for G-tube replacement. The Regional Nurse Consultant stated the care plan needed to follow the plan of care for Resident #12, which was replacing the G-tube in house if dislodged. She stated the care plan should be reviewed Quarterly and as needed with changes. She stated it was the whole IDT's responsibility to ensure care plans were updated, but since it was a nursing care issue, the supervising nurse was overall responsible. The Regional Nurse Consultant stated the risk of not updating the care plan could have caused confusion among staff and resulted in transfer to the ER against the family's wishes. Interview on 02/26/26 at 11:14 AM with the ADON revealed his expectation for Resident #12's G-tube replacement was if it became dislodged, the nurse could replace it with a physician order and after completing competency training. The ADON stated Resident #12's family refused transfer to the ER, so the G-tube was changed in-house since admission. The (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #61) of three residents reviewed for pressure ulcers. The Wound Care Nurse failed to re-clean the wound to Resident #61's right heel after she put his foot down on the bed with the wound exposed to the drawsheet under the resident. This failure could place residents at risk for deterioration of existing wounds/skin injuries. Findings included: Review of Resident #61's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. The residents' diagnoses included heart failure, paraplegia, cognitive communication deficit, pressure ulcer of right buttock, and pressure ulcer of right heel. Resident #61 had a BIMS of 6 which indicated his cognition was severely impaired. The MDS further reflected the resident had a pressure ulcer/injury, a scare over bony prominence. Review of Resident #61's care plan revised on 08/01/25 reflected the resident had a pressure ulcer and was at risk for impaired skin integrity related noncompliance with treatment plan, impaired mobility, and cognitive impairment; right heel-stage 4. Interventions included to administer treatments as ordered and monitor for effectiveness. Review of Resident #61's Order Summary Report for February 2026 reflected the following: Cleanse right heel stage IV with wound cleanser, pat dry with gauze 4X4, apply medi honey to slough, collagen to pink tissue and calcium alginate and cover with dry dressing 3x a week and PRN. Mon, Wed, Fri for wound healing. Observation on 02/26/26 at 9:25 AM of Resident #61's wound care revealed the resident was alert and lying in bed. The Wound Care Nurse put on gloves, took/cut off the resident's bandage off the resident's right foot. The Wound Care Nurse took off her gloves and applied hand sanitizer and put on new gloves. The Wound Care Nurse cleansed the heel wound and applied gauze on the wound and put the resident's foot on the bed, and the gauze served as a barrier between the wound and the bed. The Wound Care Nurse picked up the resident's foot and cleansed the wound again and when she placed the foot back on the bed, the barrier gauze slipped up the foot, and the heel wound was placed the drawsheet under the resident. The Wound Care Nurse proceeded to apply the wound treatment and dress it and did not reclean the wound after it was placed on the drawsheet with no barrier. Interview on 02/26/26 at 2:15 PM with the Wound Care Nurse revealed she would have a CNA assist her and hold Resident #61's foot during wound care. The Wound Care Nurse said she put a gauze on the resident's heel to use as a barrier and did not notice the gauze move and thought it was still protecting the heel. The Wound Care Nurse said it was important for the wound not to touch the bed or drawsheet after it had been cleaned because it would introduce bacteria and cause infection. Interview on 02/26/26 at 11:00 AM with the ADON revealed open wounds should not touch surfaces until it is clean, treated and bandaged to prevent the introduction of new bacteria and keep the wound free of infection. Review of the facility's policy titled Pressure Injury: Prevention, Assessment and Treatment revised on 05/05/25 reflected the following: Procedure 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, and circulation to prevent breakdown, injury and infection.		