PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345083	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 2		03/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA FICIENCY)	
F 000	INITIAL COMMENTS		F	000		
F 600 SS=J	through 03/31/23. The investigated NC00200 NC00192957, NC001 NC00200254. 3 of the deficiency. Intake NC NC00200254 resulte Immediate Jeopardy CFR. 483.12 at tag F(J) CFR. 483.12 at tag F(K) The tags F600 and F(Quality of Care. Immediate Jeopardy removed on 03/29/23 was conducted. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as deincludes but is not lim corporal punishment, any physical or chem treat the resident's message of the second s	92847, NC00200073 and e 8 allegations resulted in a 0020019, NC00200073 and d in Immediate Jeopardy. was identified at: 600 at a scope and severity 607 constituted Substandard began on 03/22/23 and was . A partial extended survey Neglect m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This aited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or	F	500		4/1/23
I ARORATORY	 	SUPPLIER REPRESENTATIVE'S SIGNATUR) F	TITLE		(X6) DATE

Electronically Signed 04/19/2023

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.

PRINTED: 05/02/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE C 03/31/202 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139 CX4) ID PROVIDER'S PLAN OF CORRECTION (X COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION (X4) ID PREFIX TAG CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM THE REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM CRASS TREET ADDRESS, CITY, STATE, ZIP CODE 180 SCAR JUSTICE ROAD RUTHERFORDTON, NC 28139 THE PROVIDERS PLAN OF CORRECTIVE ACTORS SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY The facility failed to protect a resident. # 13 L The facility failed to protect a resident. # 13 Life f							1	-	
The facility failed to protect a resident, family, staff, Nurse Practitioner (NP), Medical Director (MD), and Law Enforcement interviews the facility failed to protect residents approximately 5:30 AM when an agency staff member was rough, causing pain to the resident #1 while performing incontinence care. Resident #1 felt fearful, dirty, humiliated, violated, and borderline raped. The immediate jeopardy began on 3/22/23 when an agency staff member care causing the resident pain. The immediate jeopardy was removed on 3/29/23 when the facility implemented a credible allegation of immediate jeopardy performed and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) be ensure monitoring systems put into Resident for procession of the practical procession in the resident and potential for minimal harm that is not Immediate Jeopardy) be ensure monitoring systems put into			345083	B. WING			03/	31/2023	
CALID CALI	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RUTHERFORDTON, No. 28139 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES FRETERING FROWIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPRICENCY MUST BE PRECEDED BY FULL TAG) FROM FR	ни і тор і	HEALTH AND REHARILI	TATION		18	88 OSCAR JUSTICE ROAD			
FREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 600 Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Nurse Practitioner (NP), Medical Director (MD), and Law Enforcement interviews the facility failed to protect residents' rights to be free from sexual abuse for 1 of 3 residents sampled for abuse (Resident #1). The allegation of abuse occurred on 3/22/23 at approximately 5:30 AM when an agency staff member was rough, causing pain to the resident #1 while performing incontinence care. Resident #1 while performing incontinence care. Resident #1 while performing incontinence care. Resident #1 was re-interviewed on 3/27/23 when an agency staff member inserted his finger into the vagina of Resident #1 was re-interviewed on 3/27/23 when statement was changed to indicate abuse. On 3/27/23 at 11:100am, the licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughter and was tearful and appeared emotionally distressed. On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were observed. On 3/27/23 at 11:15am, the licensed nurse completed a body audit for Resident #1 and no visual signs of injury were observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care plan was implemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident #1 and gave new orders for	IIILLIOF	ILALIII AND ILLIADILI	IATION		R	UTHERFORDTON, NC 28139			
involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Nurse Practitioner (NP), Medical Director (MD), and Law Enforcement interviews the facility failed to protect residents' rights to be free from sexual abuse for 1 of 3 residents sampled for abuse (Resident #1). The allegation of abuse occurred on 3/22/23 at approximately 5:30 AM when an agency staff member was rough, causing pain to the resident #1 while performing incontinence care. Resident #1 will performing incontinence care. Resident #1 felt fearful, dirty, humiliated, violated, and borderline raped. The immediate jeopardy began on 3/22/23 when an agency staff member inserted his finger into Resident #1's vagina and was rough during incontinence care causing the resident pain. The immediate jeopardy was removed on 3/29/23 when the facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
The findings included: Resident #1 was re-admitted to the facility on 9/29/22 with diagnoses that included chronic pulmonary embolism, senile degeneration of the brain, adult failure to thrive, epilepsy, anxiety, depression, and a personal history of traumatic brain injury. On 3/28/23, Psychiatry Services were provided and will be providing ongoing as needed. On 3/27/23 at 11:30am, the Administrator notified Nurse Aide #1, who was not in facility at time of notification, and the contracted staffing agency that Nurse Aide #1 is immediately suspended and will not be allowed back in the facility. 2. Effective 3/28/23, the Social Worker	F 600	involuntary seclusion This REQUIREMENT by: Based on observation resident, family, staff Medical Director (MD interviews the facility rights to be free from residents sampled for allegation of abuse or approximately 5:30 A member was rough, or and inserted his finge #1 while performing i #1 felt fearful, dirty, he borderline raped. The immediate jeopard an agency staff mem Resident #1's vagina incontinence care can immediate jeopardy when the facility imple allegation of immediate facility will remain out scope and severity of potential for minimal Jeopardy) to ensure in place are effective. The findings included Resident #1 was re-a 9/29/22 with diagnose pulmonary embolism brain, adult failure to depression, and a pe	ons, record review, and Nurse Practitioner (NP), o), and Law Enforcement failed to protect residents' sexual abuse for 1 of 3 rabuse (Resident #1). The ccurred on 3/22/23 at M when an agency staff causing pain to the resident er into the vagina of Resident noontinence care. Resident numiliated, violated, and ardy began on 3/22/23 when ber inserted his finger into and was rough during using the resident pain. The was removed on 3/29/23 emented a credible ate jeopardy removal. The tof compliance at a lower of "D" (no actual harm with a harm that is not Immediate monitoring systems put into des that included chronic, senile degeneration of the thrive, epilepsy, anxiety,	F	6000	resident □s right to be free from abuse when a resident (Resident #1) alleged 3/22/23, a male Nurse Aide (NA #1) on night shift inserted his finger into her vagina during incontinence care. On 3/22/23, Resident #1 was interviewed the Administrator and Unit Manager, ar was determined that abuse did not occ and then Resident #1 was re-interviewed in the Resident #1 was re-interviewed in dicate abuse. On 3/27/23 at 11:00ate licensed nurse reported to the Administrator that Resident #1 was observed in her room with her daughte and was tearful and appeared emotion distressed. On 3/27/23 at 11:15am, the licensed nurse completed a body audit Resident #1 and no visual signs of injurwere observed. On 3/27/23, the Social Worker (SW) completed a Psychosocial Assessment, and a trauma care plan wimplemented. On 3/27/23 at 6:15pm, the Nurse Practitioner (NP) assessed Resident #1 and gave new orders for Trazodone 50mg at bedtime for insomm On 3/28/23, Psychiatry Services were provided and will be providing ongoing needed. On 3/27/23 at 11:30am, the Administrator notified Nurse Aide #1, was not in facility at time of notification, and the contracted staffing agency that Nurse Aide #1 is immediately suspende and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed back in the facility and will not be allowed	oy nd it ur ed ed am, r ally for ry al vas ne nia. as vho		

Facility ID: 923556

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						(
		345083	B. WING _			03/	31/2023	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				18	88 OSCAR JUSTICE ROAD			
HILLTOP I	HEALTH AND REHABILI	TATION		R	UTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Continued From page A quarterly Minimum 1/19/23 indicated Re cognitively impaired a understood and unde extensive assistance toileting, and persona further indicated Res such as resistive to c aggression, hallucina assessment indicated incontinent of bladde of bowel. A review of a hospice revealed Resident #1 hospice services on diagnosis of idiopathi record did not reflect discharge from hospi of 3/19/23 through 3 A Brief Interview of M indicated Resident # A facility internal alleg 3/22/23 provided by t 3/22/23 "Resident #1 third shift male nurse vagina when he was movement." It indicated	Data Set (MDS) dated sident #1 was moderately and was able to be extands. She required of two staff for bed mobility, all hygiene. The assessment ident #1 had no behaviors are or physical or verbal stions, or delusions. The deleta Resident #1 was always and frequently incontinent enote dated 3/10/23 had been admitted to 10/14/22 for a primary ic epilepsy. The medical a note for a formal ce services during the week	TAG	6000 s		the al to ght		
	was told by Resident cleaning her from a be finger went into her v during the interview, Administrator and the NA #1 to finish her ca further care to her an	#1 that the male NA was lowel movement and his agina. It further indicated,			recognizing what constitutes abuse (Examples included; resident, staff or family report of abuse, physical marks such as bruises appearing as hand or I marks, injury of unknown source, sudd unexplained changes in behavior such withdrawal from care, fear of certain persons or expressions of guilt or sham	en as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345083	B. WING	<u>-</u>	o	3/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
				188 OSCAR JUSTICE ROAD			
HILLTOP	HEALTH AND REHABILI	TATION		RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 3	F 60	0			
	not his intent to make document indicated in believed that it happer clean the feces off her intentional. An observation and in 3/27/23 at 9:15 AM reported on 3/22/23; began to roll down her discussing that morn made her feel fearful and borderline raped finger from his right in performing incontines be tearful, Resident #5:30 AM on the morn pressed her call light Resident #1 stated a administered her pail leaving the room, NA asked if he could help still on. Resident #1 state incontinence care to right side of her bed. pulled back the coveremoved her soiled be on her left side, but sassistance, so he plas shoulder to hold her iverbalized as NA #1 ran his entire hand be manner, which made she said "ouch". Resident Residen	e her uncomfortable. The Resident #1 stated that she ened because he needed to er and that it was not exceeded Resident #1 on evealed Resident #1 then she paused and tears er cheeks, and stated ing bothered her because it dirty, humiliated, violated, when in NA #1 inserted a stated into her vagina while ence care. While continuing to extract a tapproximately sing of 3/22/23 she had for pain medication. If the nurse had en medication and was extracted and her because the light was extated she told NA #1 that the langed due to an incontinent do he would provide her as he approached the Resident #1 indicated NA#1 are to the foot of the bed, wrief, then he told her to roll he needed a little physical laced his left hand on her right in place. Resident #1 began incontinence care, he etween her legs in a rough her feel uncomfortable and	FOU	2) recognizing and understand behavioral symptoms of reside may increase the risk of abuse aggressive wandering or elope resistance to care, outbursts, y difficulty adjusting to new routing and 3) that there is zero tolerare resident abuse in the facility. A questionnaires were also computerent facility and agency staff competency of education receidentify any additional allegation abuse. No additional concerns The Administrator and Director will be responsible for ensuring are trained by tracking and revenew hire and agency orientation for evidence of abuse training acknowledgement of receipt didaily reconciliation process. The reconciliation process is compounded and to ensure that new facility and agency staff have represented and to ensure that new facility and agency staff and stereceiving education by 3/28/23 receive education prior to first by the Administrator and/or Director and prior to first shift worked. In the facility sends background so all agency staff 24 hours a day week and the scheduler and Diresponsible for reviewing before were allowed to work. Effective	ents that e such as ement, velling, nes or staff nce for abuse bleted with if to validate ived and to ons of reported. of Nursing g all staff riewing the on packets and signed uring the ne daily leted by the ing and aff hours vly hired eceived entation Newly hired aff not s, will worked shift rector of ng agency creens for v, 7 days a ON were re staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		(,	
		345083	B. WING			1	31/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2020	
				18	88 OSCAR JUSTICE ROAD			
HILLTOP I	HEALTH AND REHABILI	TATION		R	UTHERFORDTON, NC 28139			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 600	Continued From page	e 4	F	600				
				000	staff to work their first shift at the facility	,		
	so roughly or puts their fingers there, neither should you," before telling him to put her brief on				Effective 3/28/23, the Administrator and			
	-	her room. Resident #1 said			DON will complete abuse questionnaire			
		ifter placing her brief on and			with facility and agency staff to ensure			
		again that morning until right			understanding of the Abuse, Neglect a	nd		
		he asked Resident #1 if			Exploitation Policy and to identify and			
	she needed anything	else before he left. Resident			prevent resident abuse and to validate			
		ghtened while lying in bed in			understanding that the facility has a ze	ro		
		vhen a Nurse Aide (NA #2)			tolerance for resident abuse. Effective			
	entered her room to	check on her around			3/28/23, agency orientation will be			
	breakfast time, she re	ecalled NA #2 asking her if			conducted by the Administrator or Dire	ctor		
	she was ok and told I	ner she was not acting like			of Nursing and will include an abuse			
	herself and encourag	ed her to share what was			questionnaire along with abuse educat	ion		
	bothering her that mo	orning. Resident #1			to ensure staff competency.			
	confirmed that she be	egan telling NA #2 what had						
	happened and then N	NA #2 told her to wait			4. To ensure the deficient practice do	es		
	because she needed	another staff member			not recur the Director of Nursing or			
	(NA#3) to hear what	Resident #1 had to say. NA			Administrator will complete abuse			
		and Resident #1 told both			questionnaires with 5 staff weekly for 1			
		t an African American male			weeks. The Director of Nursing or Unit			
		on night shift had inserted his			Managers will complete body audits on			
		while providing incontinence			cognitively impaired residents 2 times a			
	care shortly before ni	ght shift ended.			week for 4 weeks and weekly for 8 wee			
					The Administrator or Social Worker will			
		23 at 11:40 AM with NA #1			complete abuse questionnaires on 3			
		n employed through an			cognitively intact residents 2 times a w			
		to work night shift as a NA.			for 4 weeks and then weekly for 8 week	KS.		
	_	view, NA #1 indicated he did			The facility will monitor the corrective			
	not recall Resident #				actions to ensure that the deficient	h		
		on the unit which Resident			practice is corrected and will not recur	by		
	**	ndicated he had worked in			reviewing information collected during	100		
	· ·	PM to 7:00 AM on Thursday,			audits and reporting to Quality Assuran	.c c		
	JIZJIZJ, DUL WAS NOL	assigned to Resident #1.			Performance Improvement committee (QAPI) by the Administrator monthly fo	r		
	On 3/27/23 at 12:20 I	PM, a follow up interview			three (3) months. At that time the QAP			
		NA #1 which revealed NA #1			committee will evaluate the effectivene			
		the facility to reach the			of the interventions to determine if	33		
	survey team and was	_			continued auditing or adjustments to the	_		
	_	o unected to the			nlan of correction are necessary			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345083	B. WING				31/ 2023	
	ROVIDER OR SUPPLIER	TATION		188	REET ADDRESS, CITY, STATE, ZIP CODE B OSCAR JUSTICE ROAD JTHERFORDTON, NC 28139	1 037	51/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page allegation being invest NA #1 then stated the him that Resident #1 sexual abuse against into her vagina during morning of 3/22/23 arpending the facility's indicated he did not retelling him not to proving however, if resident, he would ha care to her at 1:00 AN that morning and he will done that during care. An interview on 3/27/2 revealed she was ass from 7:00 AM to 3:00 stated shortly after shoreakfast time) she e and noticed Resident #2 asked Resident#1	e 5 stigated by the state agency. Administrator had notified had made an allegation of him for inserting his finger incontinence care on the highest dependence on the highest dependence of the highest		600	5. 4/1/23			
	her. NA #2 immediate NA #3 to come in the agency NA and felt at needed to also hear a Resident #1. NA #2 s the room, Resident # both her and NA #3 the placed his finger into incontinence care and stated she stayed wit went to tell the Unit M deliver Resident #1's waited, but NA #2 indupset to eat that morn	a 3rd shift male NA had hurt ely yelled in to the hallway for room because she was an employee of the facility any allegations made by tated when NA #3 entered 1 remained crying and told hat a 3rd shift male NA						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345083	B. WING				31/ 2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2023
	IEALTH AND DELLADIUS			1	88 OSCAR JUSTICE ROAD		
HILLIOP	HEALTH AND REHABILIT	ATION		F	RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Administrator what Re	e 6 esident #1 had alleged and	F	600			
	then went to finish de	livering breakfast trays to					
	for Resident #1 along	unit. NA #2 stated she cared with NA #3 for the					
		and noticed that Resident					
	#1 did not eat lunch the continued to cry intern	nat day as well and mittently throughout the day.					
		nt #1 was hesitant and					
	attempted to provide	ach time she and NA #3					
	Resident #1 on 3/22/2						
		23 at 12:02 AM with NA #3					
	revealed she was not						
		ently passed breakfast trays					
		ated on the morning of sing breakfast trays and					
		for her to come into the					
		then she entered the room					
		IA #2, Resident #1 was very					
		ng her and NA #2 that a					
	male NA on 3rd shift I	nad inserted his finger into					
		ontinence care and that it					
		fortable. NA #3 stated she					
	,	oom and went to the Unit					
		of what Resident #1 had					
	_	the Unit Manager was					
		nd she went to her office to sident #1 appeared and					
		when talking about the					
		lained after speaking to the					
		turned to the unit and began					
	_	s to the remainder of the					
		e recalled Resident #1 being					
		ne and NA #2 attempted to					
		care to her the remainder of					
	_	x#3 also noticed when she					
		a bath to Resident #1 today It #1 was again tearful and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345083	B. WING			1	24/2022	
NAME OF D	ROVIDER OR SUPPLIER	343003	B: Willo		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2023	
NAME OF T	NOVIDER OR SOLI LIER							
HILLTOP I	HEALTH AND REHABILIT	TATION			188 OSCAR JUSTICE ROAD			
					RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	e 7	F	300				
	slightly hesitant to allo assistance.	ow her to provide bathing						
	Manager revealed sh 3/22/22 at approxima approached by NA #3 to notify her immediat Resident #1 who had accusations of sexual shift. The Unit Managinto an office close by Resident #1 had madhead inserted his fing incontinence care at a the morning of 3/22/2. The Unit Manager statelephone the Adminidue to low signal in thinitiated a text service Administrator. The Unit Manager statelephone the service Administrator immedinotifying her he was a would be to speak to Manager stated upon came to her office and allegations made by Fine Unit Manager inconduction and the service of the Unit Manager inconduction of the Unit Mana	made her aware of I abuse by NA #1 during 3rd Her stated she took NA #3 I where NA #3 told her He allegations that NA #1 Her into her vagina during I approximately 5:30 AM on 2 and was upset about it. I ated she initially attempted to I strator but was unsuccessful I he facility and therefore I to contact the Initi Manager indicated the I ately returned a text I entering the facility and I her momentarily. The Unit I arrival the Administrator I d NA #3 notified him of the I desident #1 against NA #1.						
	noted by Resident #1 Manager indicated sh findings directly to the exam. The Unit Mana	obvious discomfort to touch during the exam. The Unit me provided her assessment e Administrator following the ager and the Administrator sident #1 in her room and						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	0.1000		STREET ADDRESS, CITY, STATE, ZIP	CODE	03/31/2023		
HILLTOP	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD				
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B	5.475		
F 600	Continued From page found her less tearful #1 had inserted his fi incontinence care on thought it was becaused and not necessarily in also verified Residen from hospice service 3/19-3/25; however, sexact date. An observation and in Family Member on 3, Family Member state from the Administrate at work who said her of a sensitive topic. Fadministrator called ther Resident #1 had nurse aide (NA #1) howagina while perform that he felt it was not had reported NA #1 to done intentionally and NAs to provide perioderally Member state would have NA #1 no Resident #1 and place.	when she told them that NA nger into her vagina during the morning of 3/22/22 and se he had to get her clean ntentional. The Unit Manager t #1 had been discharged s during the week of she was not able to verify the nterview with Resident #1's /27/23 at 9:55 AM revealed of she received a phone call or on 3/22/23 while she was needed to make her aware family Member stated the ner in the afternoon to tell made an allegation that a ad inserted his finger into her ing incontinence care and intentional and Resident #1 old her during care it was not d that she did not want male care for her after this incident. In the did the Administrator said he of provide further care to		DEFICIEN SOOD	ICY)			
	female NAs to provid arrived at the facility of 3/22/23 and notice and not of her norma asked Resident #1 al happened on night sl stated Resident #1 b explaining she was fr like he had likely don not want him care for	te peri-care. She stated she around 6 PM on the evening and Resident #1 was tearful I demeanor. Family Member bout the occurrence that nift regarding NA #1 and ecame increasingly tearful rightened by NA #1 and felt e it on purpose, and she did ther again. She stated and how rough NA #1 cleaned						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345083	B. WING				31/2023
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				1	188 OSCAR JUSTICE ROAD		
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F 600	Continued From pag	ne 9	F	600			
. 000	· -			000	<u>'</u>		
		1 inserting his finger into her					
	_	d discomfort. The Family					
		er friend contacted law					
		ported what happened to					
		on 03/23/23. Family Member					
		conversation the friend					
		member provide a name of					
	the accused (NA#1)						
	with local law enforc						
	explained the follow						
	facility and spoke to						
	requesting the name						
		inwilling to provide a name at					
		/ Member stated she returned					
	to the facility around	6:30 PM on 3/23/23 to visit					
	Resident #1. The Fa	amily Member went on to					
	explain at approxima	ately 7:30 PM, she was sitting					
	at the bedside of Re	sident #1 and noticed a					
	gentleman in the hal	llway entering the closet					
	which was located d	liagonally across the hallway					
	from Resident #1's o	door. She stated NA #1					
	glanced into Reside	nt #1's room. The Family					
	Member immediatel	y asked Resident #1 if this					
		llway was the staff member					
	she had described w	vho had touched her					
	inappropriately durin	ng care. The Family Member					
		esident #1 was positioned in a					
		s unable to visualize NA #1;					
		exited the door across the hall					
		to a staff member outside of					
		Resident #1 immediately					
		fied this gentleman to be NA					
		stated at the time she was					
		ul to confront the gentleman					
		visiting for approximately three					
		ening, she again contacted					
		ned her the local law					
		en contacted and would					
	handle the concern	without her having to cause					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 03/31/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 600	PM revealed the She intake report for an in 11AM, Attempt 2nd I included details [Res genital area with a her vagina. Page 2 of following narrative: "female is a patient or eported to the facility shift) CNA/Care provof this report). [Residue to a toileting near of this report). [Residue to a toileting near of this finder in her vagi [family member] that was hurting her. [Remember that no other that way. The facility [family member]. [Refacility since Septem for her toileting. She needs physical assis An interview with local detectives on 3/27/2 Detective #1 and Deto this case and indice Resident #1 just price and found her to be on 3/22/23 a male N provided her incontires.	e facility employees. e report dated 3/23/23 at 2:00 eriff's Department filed a ncident labeled as "14-27.5 Degree Sex Offense" which sident #1] was touched in her and and fingers inserted into of the report included the [Resident #1] a 72 year old if the [facility]. [Resident #1] by staff that her nighttime (3rd wider (name unknown at time dent #1] asked for changing ed. A male CNA came in and his hand, ran it up her private table way and then inserted ha. [Resident #1] told her is she yelled out to him that he sident #1] told the family er staff had ever cleaned her if Administrator notified the esident #1] has been in the sider 2022 and wears briefs is mentally competent but stance." eal law enforcement 3 at 3:30 PM revealed tective #2 had been assigned cated they had interviewed for to this interview on 3/27/23 every tearful as she explained A (NA #1) on night shift had hence care in a manner that	F 60		
	finger into her vagina and Detective #2 wo	nfortable and inserted his a. Detective #1 indicated he uld be conducting a full ng background check and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	An interview on 3/Administrator reveallegation of poter Resident #1 on the received a text from Administrator indices approximately 8:00 unit manager's office to allegation. The Administrator at a resident #1's Resonotify her of her madministrator explain and her Responsagreement with the intervention to Rethe preference to provide incontiner actions were taken An interview with 8:3/28/23 at 8:30 All of the allegation manager and some approximately 8:00 unit manager's office to approximately 8:00 unit	ecks on NA #1 and the local law estigation would be ongoing. 27/23 at 10:20 AM with the ealed he was made aware of the nitial sexual abuse related to be morning of 3/22/23 when he are the Unit Manager. The cated he proceeded to the Unit Lupon arriving at the facility at 0 AM. When he arrived at the fice, he was notified that alleged that NA #1 had inserted vagina while providing and that she was upset about Administrator indicated he whom Resident #1 had talked with that morning. The stated after he was notified of and the Unit Manager went to be into interview her regarding the laministrator stated Resident #1 incident occurred while NA #1 continence care. The lead on 3/22/23, he contacted sponsible party by telephone to nother's allegation. The lained he thought both Resident insible party where in the resolution to add an esident #1's care plan to include thave female nurse aides and care and therefore no other.	F	500		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED	
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	ROVIDER OR SUPPLIER HEALTH AND REHABIL	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	•	00/01/2025
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	on 3/27/23 and felt intact and able to maknown history of del NP indicated Reside from hospice service improvement. The Administrator wigeopardy via telephoral The facility provided Allegation of Immed F600: Identify those or likely to suffer, as result of the noncomoral The facility failed to free from abuse whe alleged on 3/22/23, night shift inserted hadring incontinence On 3/22/23, Resider Administrator and U determined that abuse Resident #1 was restatement was channown on 3/27/23 at 11:00 reported to the Administrator and under the Administrator and under the Administrator and U determined that abuse Resident #1 was restatement was channown on 3/27/23 at 11:00 reported to the Administrator and appropriated a body a visual signs of injury the Social Worker (State Social Worker)	Resident #1 to be cognitively ake her needs known with no usions or hallucinations. The ent #1 had been discharged es the week prior due to as notified of immediate one on 3/28/23 at 12:30 PM. Ithe following Credible iate Jeopardy removal: residents who have suffered, serious adverse outcome as a appliance: protect a resident's right to be en a resident (Resident #1) a male Nurse Aide (NA #1) on his finger into her vagina care. Int #1 was interviewed by the nit Manager and it was see did not occur and then interviewed on 3/27/23 when ged to indicate abuse. am, the licensed nurse inistrator that Resident #1 room with her daughter and eared emotionally distressed. am, the licensed nurse udit for Resident #1 and no were observed. On 3/27/23,	F6			

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED		
		345083	B. WING _				31/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139			01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	the Nurse Practitione #1 and gave new ord bedtime for insomnia Services were provid ongoing as needed. On 3/27/23 at 11:30a Nurse Aide #1, who w notification, and the of that Nurse Aide #1 is will not be allowed be Effective 3/28/23, the abuse questionnaires cognitively intact resi and reporting without additional concerns re Effective 3/28/23, the body audits on cognitidentify any signs of a observed. On 3/28/2023, the Qu Improvement (QAPI) Director of Nursing (I Clinical Services (RD Vice President of Ope President of Clinical a Medical Director (MD discuss root cause at to protect a resident in Root cause analysis	d. On 3/27/23 at 6:15pm, r (NP) assessed Resident ers for Trazodone 50mg at On 3/28/23, Psychiatry ed and will be providing m, the Administrator notified was not in facility at time of contracted staffing agency immediately suspended and ack in the facility. Social Worker completed and abuse education with dents to include identification fear of retaliation. No eported. licensed nurses completed cively impaired residents to abuse. No concerns uality Assurance Process Committee (Administrator, DON), Regional Director of CS), Social Worker (SW),	F	500				
	The following plan wa to address the identif	as formulated by the facility ied issues:						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 03/31/2023
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	1 33/0 112323
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 600	Continued From page 14		F 600		
	agency staff were in Neglect and Exploit Director of Clinical Social Worker and Aincluded 1) prohibiti recognizing what coincluded; resident, sphysical marks such hand or belt marks, sudden unexplained withdrawal from car expressions of guilt and understanding residents that may i such as aggressive resistance to care, of adjusting to new root is zero tolerance for Abuse questionnair current facility and a competency of educany additional allegation concerns reported.	Il current facility staff and in-serviced on the Abuse, ation Policy by the Regional Services, Director of Nursing, Administrator. Training topics ing, preventing and institutes abuse (Examples staff or family report of abuse, in as bruises appearing as injury of unknown source, dichanges in behavior such as e, fear of certain persons or or shame), 2) recognizing behavioral symptoms of increase the risk of abuse wandering or elopement, butbursts, yelling, difficulty utines or staff and 3) that there is resident abuse in the facility. The ses were also completed with agency staff to validate cation received and to identify ations of abuse. No additional and Director of Nursing will be uring all staff are trained by ing the new hire and agency			
	orientation packets and signed acknow the daily reconciliation proce Administrator, Directo validate actual stensure that newly have received abus orientation and prior	for evidence of abuse training ledgement of receipt during ledgement of receipt during lon process. The daily ss is completed by the stor of Nursing and Scheduler aff hours worked and to ired facility and agency staff e education during the r to first shift worked. Newly ency staff and staff not			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION IG	, ,	ATE SURVEY DMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	education prior to firs Administrator and/or The contracted staffi background screens a day, 7 days a weel were responsible for allowed to work. Effe Administrator and the documents before all their first shift at the Effective 3/28/23, the will complete abuse and agency staff to e Abuse, Neglect and identify and prevent validate understanding tolerance for residen Effective 3/28/23, ag conducted by the Ad Nursing and will incluation and will incluate along with abuse educompetency. Effective 3/28/23, the responsible for the irricompletion of this resultance and additional tolerance for residen along with abuse educompetency. Effective 3/28/23, the responsible for the irricompletion of this resultance and additional tolerance for residen and will include a subject to the irricompletion of this resultance and they had responsible to the property was validated by the revealed they had read they had	by 3/28/23, will receive bet worked shift by the Director of Nursing. Ing agency currently sends for all agency staff 24 hours of and the scheduler and DON reviewing before staff were bective 3/28/23 the period DON will review these lowing agency staff to work facility. In Administrator and/or DON questionnaires with facility ensure understanding of the Exploitation Policy and to resident abuse and to regident abuse and to regident abuse and to regide the facility has a zero trade an abuse questionnaire ducation to ensure staff In Administrator is ultimately inplementation and moval plan.	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 600	and understanding be abuse and that there the facility. Abuse que and competency valid	stitutes abuse, recognizing chavioral symptoms of is zero tolerance of abuse in estionnaires were reviewed dation of education.		500				
F 607 SS=K	CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi	y must develop and icies and procedures that: t and prevent abuse,	F	607			4/1/23	
	to investigate any suc §483.12(b)(3) Include paragraph §483.95,	esident property, sh policies and procedures ch allegations, and e training as required at						
	QAPI program require §483.12(b)(5) Ensure occurring in federally- facilities in accordance Act. The policies and but are not limited to	-						
	(3) of the Act. §483.12(b)(5)(iii) Pro retaliation, as defined (2) of the Act.	hibiting and preventing at section 1150B(d)(1) and is not met as evidenced						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 607	Continued From page	e 17	F 60	7			
	by: Based on record reviresident and staff, the residents when contrawas allowed to work a providing resident call the NA stuck his finger cleaning her from a befailed to implement the reporting when the all was not reported to lead to a contract the NA stuck his finger cleaning her from a befailed to implement the reporting when the all was not reported to lead to a contract the stage of the facility far agency of an allegation hours. This was for 1 reviewed for abuse at the potential to affect. The immediate jeopathe facility allowed NA assignment after Resinserted his finger into incontinence care. The removed on 03/29/23 implemented a credib removal. The facility of a lower scope and sewith potential for harm	ew and interviews with the e facility failed to protect acted Nurse Aide (NA) #1 an entire 12 hour shift re after Resident #1 reported er in her vagina when he was owel movement and they eir abuse policy for legation of sexual abuse ocal law enforcement, and ides (APS) within 2 hours. In ailed to notify the state on of sexual abuse within 2 of 3 residents (Resident #1) and the deficient practice had other facility residents. Try began on 03/22/23 when A #1 to work a resident care ident #1 reported that NA #1 or her vagina during the immediate jeopardy was		1. The facility failed to protect residents after a resident (Residents after a resident (Resident) alleged a male Nurse Aide (NA night shift inserted his finger into vagina during incontinence care NA #1 continued to work in the after the allegation was made. Further failed to assess all resident abuse and failed to report the authorized the facility Section (NP). #1 admitted to the facility for lor care on 8/27/22 with diagnosis degeneration of the brain, traundinjury, depression, anxiety, epilogastritis, and adult failure to thrice recently discharged from hospid on 3/24/23. On 3/22/23, after in interviews, assessments and investigation, the facility determoresident abuse did not occur, and plan updated to reflect resident preference for female caregiver incontinence care. On 3/27/23 and 11:00 am, the licensed nurse reputhe Administrator that Resident observed in her room with her cand was tearful and appeared each.	dent #1) #1) on o her e and the facility The facility ents for llegation to MD) Resident ng-term of senile natic brain epsy, ve and ce services itial ined that nd care during at corted to #1 was daughter		
	scope and severity of Findings included:	r's policy titled, "Abuse,		distressed. Administrator and N Manager immediately interview Resident #1 and documented h statement of 3/22/23 incident w allegation of abuse and emotion distress. Nurse aide #1 was immediately suspended pending investigation 3/27/23 at 11:15am, the license completed a body audit for Res	ed er verbal ith an nal mediately on. On d nurse		
	03/02/2023 indicated			and no visual signs of injury we			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE S COMPL	
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HILLIOP	HEALTH AND REHABILIT	ATION		RUTHERFORDTON, NC 28139		
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F 607	Continued From page	: 18	F 6	07		
F 607	involving abuse are re Administrator, state a required agencies (e.g. (APS) and local law e applicable) within the immediately, but no la allegation is made, if allegation involved ab bodily injury or b) not event cause the alleg or do not result in serior Resident #1 was re-a 9/29/22. A quarterly Minimum 1/19/23 indicated Rescognitively impaired. An internal facility docreport" dated 3/22/23 indicated on 3/22/23 istaff that the third shift stuck his finger in her cleaning her from a bindicated the Adminis interviewed Resident Resident #1 that the refrom a bowel movement her vagina. It further in	eported immediately to the gency, and to all other g., Adult Protective Services inforcement when specified timeframes: a) after than 2 hours after the event that cause the buse or result in serious later than 24 hours if the ation do not involve abuse fous bodily injury. Idmitted to the facility on Data Set (MDS) dated dident #1 was moderately Exament titled "allegation written by the Administrator of the male nurse aide [NA #1] vagina when he was owel movement." It trator and Unit Manager #1 #1 and were told by male NA was cleaning her ent and his finger went into	F 6	observed. On 3/27/23, the Social (SW) completed a Psychosocial Assessment, and a trauma care implemented. On 3/27/23 at 6:1 Nurse Practitioner (NP) assessed Resident #1 and gave new order Trazodone 50mg at bedtime for On 3/28/23, Psychiatry Services provided and will be providing on needed. 2. On 3/28/23, the Administrating Regional Director of Clinical Service eviewed resident grievances be 1/1/23-3/28/23 to identify any post allegations of abuse for approprinvestigation and reporting. No a concerns identified. Effective 3/2 Social Worker completed abuse questionnaires and abuse eduction cognitively intact residents to incidentification. No additional concerne ported. Effective 3/28/23, the nurses completed body audits of cognitively impaired residents to any signs of abuse. No concern observed. On 3/28/2023, the Quasimple (Administrator, Direct Nursing (DON), Regional Direct	e plan was 5pm, the ed ers for insomnia. s were ingoing as tor and rvices etween otential riate additional 28/23, the e ation with clude out fear of on o identify is uality int (QAPI) ctor of	
	care and not provide a	asked NA #1 to finish her any further care to her. 's Facility Reported Incident e incident between Resident on 3/22/23 was not		Clinical Services (RDCS), Social (SW), Vice President of Operation (VPO), Vice President of Clinical Quality (VPCQ) and Medical Direction (MD) held an Ad Hoc meeting to root cause analysis of the facility	ons al and rector o discuss y∪s failure	
		aw enforcement or APS neframes for submission of		to1) protect all residents after an allegation of sexual abuse was		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	E SURVEY IPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		3/3 1/2023	
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F 607	Continued From pa	age 19	F 6	07			
	the initial report. The allegation was not reported by the facility to APS or local law enforcement until 3/27/23.			2) assess all other residents ar the allegation to the facility □s I NP. Root cause analysis deter appropriate resident protection	MD and/or mined that ,		
	interventions taker	able to provide evidence of to identify and protect other		assessment and reporting was completed due to the facility s	failure to		
		no could have been affected by		properly identify what constitut			
	abuse following the allegation of staff to resident abuse involving NA #1 and Resident #1 on			allegation of abuse during the i process and initiate appropriate			
	3/22/23.	(#1 and itesluent #1 on		following an abuse allegation.	е экерэ		
	AM revealed on 3/2 entered her room to breakfast time. She was ok and tole herself and encour bothering her that confirmed that she happened and the because she need #3) to hear what Rentered the room aphysical appearance worked the night shad inset with the second shadow in the se	Resident #1 on 3/27/23 at 9:15 22/23 Nurse Aide (NA #2) o check on her around he recalled NA #2 asking her if d her she was not acting like haged her to share what was horning. Resident #1 hegan telling NA #2 what had h NA #2 told her to wait hed another staff member (NA hesident #1 had to say. NA #3 hand Resident #1 described the had her to wait her to wait her and told both NA #2 and NA herted his finger into her vagina horning.		3. Effective 3/28/23, the Reg Director of Clinical Services (R completed education with the Administrator, DON, Social Wo Nurse Managers on completing comprehensive investigation at interview to fully analyze and pidentify and respond to potential Education included protection of from physical and psychosocial during and after the investigation immediate response by removing alleged staff from resident care resident safety, assessing all of residents for abuse, reporting the Administrator, Medical Director Nurse Practitioner, state agence examining the alleged victim for	orker and g a and quality properly al abuse. of residents al harm on, ing the e to ensure other or and/or sies,		
	Manager revealed 3/22/22 at approxing approached by NA to notify her immed Resident #1 who haccusations of sex shift. The Unit Marinto an office close	27/23 at 1:32 PM with the Unit she arrived to the facility on mately 8:00 AM when she was #3 who indicated she needed diately of a concern for ad made to her aware of ual abuse by NA #1 during 3rd tager stated she took NA #3 by where NA #3 told her tade allegations that NA #1		of injury, increasing supervision protection from retaliation and emotional support and counsel resident during and after the in as needed. Newly hired Admin Director of Nursing, Social Wol Nurse Managers will receive eduring orientation and prior to f shift. The RDCS or Vice Presid Operations (VPO) will be response.	n, providing ling to the vestigation istrators, rkers, and ducation first worked dent of		

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930 - 0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
				_		(c
		345083	B. WING			1	31/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				18	88 OSCAR JUSTICE ROAD		
HILLIOP	HEALTH AND REHABILI	IATION		R	UTHERFORDTON, NC 28139		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)				DEFICIENCY)	\\\L	
F 607	Continued From page	e 20	F	607			
	inserted his finger into				providing and tracking completion of		
		approximately 5:30 AM on			leadership training. Effective 3/28/23, a		
	_	2 and was upset about it.			current facility staff and agency staff w	ere	
	_	ated she initially attempted to			in-serviced on the Abuse, Neglect and		
		strator but was unsuccessful			Exploitation Policy by the Regional		
	due to low cellular sig	•			Director of Clinical Services, Director of		
		ext message to contact the			Nursing, Social Worker and Administra	tor.	
	Administrator via an internal text system utilized for staff communication. The Unit Manager				Training topics included 1) prohibiting,		
					preventing and recognizing what		
		trator immediately returned			constitutes abuse (Examples included;		
	a text notifying her he was entering the facility				resident, staff or family report of abuse		
		k to her momentarily. The			physical marks such as bruises appear	-	
	Unit Manager stated	•			as hand or belt marks, injury of unknov		
		o her office and NA #3			source, sudden unexplained changes i		
		egations made by Resident			behavior such as withdrawal from care		
		e Unit Manager indicated or spoke with NA #2 and NA			fear of certain persons or expressions guilt or shame), 2) recognizing and	JI	
		Resident #1's room where			understanding behavioral symptoms of	:	
	she found her tearful				residents that may increase the risk of		
		assessed Resident #1's skin			abuse such as aggressive wandering of	۱r	
	_	neal area) and found there to			elopement, resistance to care, outburs		
		on, or obvious discomfort to			yelling, difficulty adjusting to new routir		
		ent #1 during the exam. The			or staff, 3) immediately ensuring reside		
	Unit Manager indicate				safety by removing accused individual		
	_	directly to the Administrator			from residents □ care and 4) reporting		
	_	he Unit Manager and the			allegations of abuse to the Administrate	or	
	_	interview Resident #1 in her			and/or the Director of Nursing in-perso		
	room and found her le	ess tearful when she told			verbally immediately following resident		
	them that NA #1 had	inserted his finger into her			protection and 5) a zero tolerance for		
		nence care on the morning			resident abuse in the facility. Abuse		
		nt it was because he had to			questionnaires were also completed to	ĺ	
	get her clean and not	necessarily intentional.			validate staff competency of education		
					received and to identify any additional		
	A review of the timeca	ard for NA #1 revealed he			allegations of abuse. No additional		
	worked from 7:03 PM	on 3/23/23 through 7:00			concerns reported. The Administrator a	and	
	AM on 3/24/23.				Director of Nursing will be responsible		
					ensuring all staff are trained by tracking	j	
	A review of the daily r	nurse staffing schedule			and reviewing new hire and agency	ĺ	
		ed NA #1 was assigned a			orientation packets for evidence of abu	se	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 BOILES			C 03/31/2023	
		345083	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	0.000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2023
TO THE OT THE	TO VIDER OR GOLF EIER				88 OSCAR JUSTICE ROAD		
HILLTOP I	HEALTH AND REHABILIT	TATION			EUTHERFORDTON, NC 28139		
				, n	UTHERFORDTON, NC 20139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 607	Continued From page	e 21	F	607			
	· -	nent which covered rooms			training and signed acknowledgement	of	
		e entire 500 hall from 7:00			receipt during the daily reconciliation	,	
		further revealed NA #1 was			process. The daily reconciliation proces	ss	
	assigned to a residen	t care assignment which			is completed by the Administrator,		
	_	the 400 and 500 hall unit			Director of Nursing and Scheduler to		
	from 11:00 PM on 3/2	23/23 until 7:00 AM on			validate actual staff hours worked and	io l	
	3/24/23.				ensure that newly hired facility and age	ncy	
					staff have received abuse education		
		23 at 11:40 AM with NA #1			during the orientation and prior to first s		
		n employed through an			worked. Newly hired facility and agend	- 1	
		to work night shift (7:00 PM			staff and staff not receiving education b	y	
	,	a. During the initial interview,			3/28/23, will receive education prior to		
		d not recall Resident #1 at			next worked shift by the Administrator		
		cally did not work on the unit			and/or Director of Nursing. Effective	tor	
		sided. During the interview, ad not been contacted by the			3/28/23, the Administrator and/or Direct of Nursing completed abuse	IOI	
		allegation made by Resident			questionnaires with current facility and		
		he had worked a resident			agency staff to ensure understanding of	ıf	
		e facility from 7:00 PM to			the Abuse, Neglect and Exploitation Po		
	_	nto the morning of 3/24/23			and to identify and prevent resident ab	- 1	
		to Resident #1. He stated			and to validate understanding that the		
	he had not worked in				facility has a zero tolerance for residen	t	
		owever, was scheduled to			abuse. Effective 3/28/23, the Vice		
	work later in the weel	ζ.			President of Operations, Vice Presiden	t of	
					Clinical and Quality and/or Regional		
	•	with the Unit Manager on			Director of Clinical Services will provide		
		revealed she was asked			regional oversight to the facility in-pers	on	
		Administrator on 3/22/23 to			or via telephone for any allegation of		
		residents on the assignment			resident abuse to ensure all residents a		
		on 3/22/23 which resulted in			protected after an allegation of abuse is		
		om care noted and had she			made to include immediate removal of		
		nt in the investigation. The			alleged perpetrator, assessment of all		
	Unit Manager stated				residents and notification to the Medica	d	
		oriented residents in the			Director or Nurse Practitioner.		
		ntial abuse or whether they			4 To oppure the deficient practice de	.00	
	-	. The Unit Manager stated al body exams performed on			To ensure the deficient practice do not recur the Director of Nursing or	೮১	
		the facility on 3/22/23 when			Administrator will complete abuse		
		ade with the exception of			guestionnaires with 5 staff weekly for 1	2	

NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) RUTHERFORD TON, NC 28139 DPROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 607 Continued From page 22 F 607		
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	03/31/2023	
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 607 Continued From page 22 RUTHERFORDTON, NC 28139 RUTHERFORDTON, NC 28139 RUTHERFORDTON, NC 28139 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 607 Continued From page 22 RUTHERFORDTON, NC 28139 PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
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5500	DATE	
1 001		
Posident #1 and hady checks were not works. The Director of Nursing or Unit		
Resident #1 and body checks were not weeks. The Director of Nursing or Unit conducted on any other resident until another Managers will complete body audits on 3		
allegation of abuse was made on the following cognitively impaired residents 2 times a		
day which was not related to NA #1. She also week for 4 weeks and weekly for 8 weeks.		
indicated she was asked by Administration not to The Administrator or Social Worker will		
make any documentation into the medical record complete abuse questionnaires on 3		
of the physical assessment or allegations cognitively intact residents 2 times a week		
because the Administrator needed to speak to the for 4 weeks and then weekly for 8 weeks.		
family of Resident #1 about the occurrence. The The Regional Director of Clinical Services		
Unit Manager stated she had never been asked or Vice President of Operations will review		
to make any documentation after the family was grievances weekly for 12 weeks to identify		
notified of the allegation. any possible allegations of abuse and		
ensure proper reporting is completed if		
An interview on 3/27/23 at 10:20 AM with the indicated. The Regional Director of		
Administrator revealed he was made aware of the Clinical Services or Vice President of		
allegation of potential sexual abuse related to Operations will assess the Administrator,		
Resident #1 on the morning of 3/22/23 when he Director of Nursing, Social Worker, and		
received a text from the Unit Manager. The Nurse Managers competency of		
Administrator indicated he proceeded to the Unit Reporting and Identifying Abuse using		
Manager's office upon arriving to the facility at abuse questionnaires weekly for 4 weeks		
approximately 8:00 AM. When he arrived at the and monthly for two months. The facility		
Unit Manager's office, he was notified that will monitor the corrective actions to		
Resident #1 had alleged that NA #1 had inserted ensure that the deficient practice is		
his finger into her vagina while providing corrected and will not recur by reviewing		
incontinence care and that she was upset about information collected during audits and		
the situation. The Administrator indicated he reporting to Quality Assurance		
spoke to the NAs (NA #2 and NA #3) whom Performance Improvement committee		
Resident #1 had talked with about the incident (QAPI) by the Administrator monthly for		
that morning. The Administrator also stated after three (3) months. At that time the QAPI		
he was notified of the incident, he and the Unit committee will evaluate the effectiveness		
Manager went down to Resident #1's room to of the interventions to determine if		
interview her regarding the allegation. The continued auditing or adjustments to the		
Administrator stated Resident #1 informed him plan of correction are necessary.		
the incident occurred while NA #1 was providing incontinence care. The Administrator explained 5. 4/1/23		
incontinence care. The Administrator explained 5. 4/1/23 during his interview, Resident #1 indicated she		
believed the situation happened due to NA #1		
having to clean her. The Administrator stated		
because Resident #1 had not believed the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
		345083	B. WING			C 03/31/2023	
	ROVIDER OR SUPPLIER	TATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139			
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F 607	concern as a grievanthe allegation for pote Administrator stated of Resident #1's Responnotify her of the allegation to the allegation to add an it care plan to include the female nurse aides publication to add an it care plan to include the female nurse aides publication to add an it care plan to include the female nurse aides publication to add an it care plan to include the female nurse aides publication included the female nurse aides publication and protect Resident ground the sexual abuse. The forest acknowledged had the as a potential sexual responsible for notifying enforcement and APS due to the allegation intentional by the facility was not prevented from assignment following Resident #1. An interview with Reson 3/27/23 at 9:55 AM facility that evening of and she contacted at #1 had told her. Resident #1's behalf, reported the friend she incident needed to be enforcement and that Resident #1's behalf, reported what has her on 3/23/23. A review of the police	al, the facility filed the ce instead of investigating ential sexual abuse. The on 3/22/23, he contacted ensible Party by telephone to ation. The Administrator both Resident #1 and her ere in agreement with the entervention to Resident #1's the preference to have rovide incontinence care and the tions were taken by the enterty of the entervention to the residents at the Administrator enter allegation been handled abuse, he would have been enter the local law and the factor of the factor of the entervention to the entervention the entervention to the enterventi	F	807			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
	345083 B. WING			03/31/2023				
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139		0/01/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 607	labeled as "14-27.5 1 Offense" which include touched in her genital fingers inserted into her port included the form [facility]. [Resident #1 that her nighttime (3rd (name unknown at time #1] asked for changing male CNA came in an an hand, ran it up her produced for the produced form of the produced fo	ake report for an incident 1A, Attempt 2nd Degree Sex led details [Resident #1] was I area with a hand and ler vagina. Page 2 of the Illowing narrative: "[Resident ale is a patient of the] reported to the facility staff d shift) CNA/Care provider ne of this report). [Resident leg due to a toileting need. A nd rolled her over, took his vate area in an nd then inserted his finder in #1] told her [family led out to him that he was t #1] told the family member d ever cleaned her that way. ator notified the [family 2 and wears briefs for her ally competent but needs	F6	507				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345083	B. WING _			C 03/31/2023	
	ROVIDER OR SUPPLIER	1 1111		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	I	03/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	was conducted with stated he had called survey team on 3/27 Administrator who the allegation being inversion NA #1 then stated the him that Resident #1 sexual abuse against into her vagina during morning of 3/22/23 apending the facility's indicated he did not telling him not to promorning; however, if resident, he would he care to her at 1:00 A that morning and he done that during care. The Administrator was jeopardy via telephood The facility provided jeopardy removal plate F607: Identify those or likely to suffer, a second resident (Resident # (NA #1) on night shift vagina during incont continued to work in was made. The facility for abuse as second residents for abuse as second resid	PM, a follow up interview NA #1 which revealed NA #1 the facility to reach the /23 and was directed to the en informed him of the stigated by the state agency. e Administrator had notified had made an allegation of thim for inserting his finger gincontinence care on the ind he would be suspended investigation. NA #1 recall this or Resident #1 vide care to her on that he was assigned to this ave provided incontinence M, 3:00 AM, and 5:00 AM would never intentionally had e. as notified of immediate the on 3/28/23 at 12:30 PM. the following immediate an.	F	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345083 NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION			1 ` '	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345083	345083 B. WING		0.2	
			STREET ADDRESS, CITY, STATE, ZIP CO 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139		3/31/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	resident of alleged se enforcement and Adi when on 3/22/23, Re Aide (NA) #1 put his incontinent care. Resident #1 admitted care on 8/27/22 with degeneration of the depression, anxiety, failure to thrive and rhospice services on initial interviews, ass the facility determine occur, and care plan preference for female incontinence care. On 3/27/23 at 11:00a reported to the Admit was observed in her was tearful and appead Administrator and Nuinterviewed Resident verbal statement of 3 allegation of abuse a aide #1 was immedia investigation. On 3/27/23 at 11:15a completed a body au	report a crime against a sexual abuse to local law all Protective Services (APS) esident #1 reported Nurse finger in her vagina during d to the facility for long-term diagnosis of senile brain, traumatic brain injury, epilepsy, gastritis, and adult ecently discharged from 3/24/23. On 3/22/23, after essments and investigation, d that resident abuse did not updated to reflect resident	F 6	07		
	plan was implemente	er (NP) assessed Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345083 B. WING			C 03/31/2023					
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION			STREET ADDRESS 188 OSCAR JUST RUTHERFORDT		1 03/	3172023			
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F 607	bedtime for insomni Services were proviongoing as needed. On 3/27/23 at 11:00 reported to the Adm was observed in he was tearful and app Administrator and N interviewed Resider verbal statement of allegation of abuse aide #1 was immed investigation. The A initial two-hour Abust the North Carolina Services and the facility Med the allegation being On 3/28/23, the Adr Director of Clinical Segrievances between potential allegations investigation and for law enforcement and No additional concerns effective 3/28/23, the abuse questionnaire cognitively intact residual reporting without additional concerns effective 3/28/23, the body audits on cogri	ders for Trazodone 50mg at a. On 3/28/23, Psychiatry ded and will be providing am, the licensed nurse inistrator that Resident #1 room with her daughter and eared emotionally distressed. urse Manager immediately at #1 and documented her 3/22/23 incident with an and emotional distress. Nurse ately suspended pending dministrator completed an se report and submitted it to State Agency, notified Adult (APS), local law enforcement cal Director within 2 hours of made. Ininistrator and Regional Services reviewed resident at 1/1/23-3/28/23 to identify any of abuse for appropriate reporting to local d Adult Protective Services. rns identified. The Social Worker completed as and abuse education with sidents to include identification ut fear of retaliation. No	F	607					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345083	B. WING _			C	
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	1 1111		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	ı	03/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHOOL) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Improvement (QAPI) Director of Nursing (Clinical Services (RI Vice President of Op President of Clinical Medical Director (MI discuss root cause a to1) protect all reside sexual abuse was m residents and; 3) rep facility's MD and/or N determined that app assessment and rep due to the facility's fa constitutes an allega interview process an following an abuse a Actions taken to alte failure to prevent a s occurring or recurrin complete: Effective 3/28/23, the Services (RDCS) co Administrator, DON, Managers on comple investigation and qua and properly identify abuse. Education in residents from physi during and after the response by removir resident care to ensu all other residents fo Administrator, Medic Practitioner, state ag	uality Assurance Process Committee (Administrator, DON), Regional Director of DCS), Social Worker (SW), Perations (VPO), Vice and Quality (VPCQ) and D) held an Ad Hoc meeting to Perations of the facility's failure Pents after an allegation of Pents after an allegation of Pents after an allegation to the Pents after an allegation with the Pents and Pents and Pents allegation with the Pents after an all	F	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345083	B. WING _			C 03/31/2023
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CO 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139		00/01/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 607	providing emotional	e 29 on from retaliation and support and counseling to the after the investigation as	F	607		
	Social Workers, and education during orie worked shift. The RDCS or Vice P	trators, Director of Nursing, Nurse Managers will receive entation and prior to first resident of Operations (VPO) or providing and tracking				
	completion of leader Effective 3/28/23, all agency staff were in- Neglect and Exploita Director of Clinical S Social Worker and A included 1) prohibitir recognizing what cor included; resident, so physical marks such hand or belt marks, i sudden unexplained withdrawal from care expressions of guilt of the sudden and the sudden are expressions of guilt of the sudden agency and the sudden agency agency and the sudden agency a	current facility staff and eserviced on the Abuse, tion Policy by the Regional ervices, Director of Nursing, dministrator. Training topics g, preventing and estitutes abuse (Examples aff or family report of abuse, as bruises appearing as injury of unknown source, changes in behavior such as g, fear of certain persons or or shame), 2) recognizing				
	residents that may in such as aggressive variesistance to care, of adjusting to new routensuring resident satindividual from reside allegations of abuse the Director of Nursin immediately following a zero tolerance for its such as the property of the pro	ehavioral symptoms of crease the risk of abuse vandering or elopement, utbursts, yelling, difficulty cines or staff, 3) immediately fety by removing accused ents' care and 4) reporting to the Administrator and/or ng in-person or verbally g resident protection and 5) resident abuse in the facility.				

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED				
		345083	3 B. WING			C 3/34/2023				
NAME OF PROVIDER OR SUPPLIER HILLTOP HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139		3/31/2023					
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	and to identify any ac No additional concer Administrator and Dir responsible for ensur tracking and reviewir orientation packets for and signed acknowled the daily reconciliation proces. Administrator, Direct to validate actual state ensure that newly hir have received abuse orientation and prior hired facility and age receiving education be ducation prior to ne. Administrator and/or Effective 3/28/23, the Director of Nursing or questionnaires with o staff to ensure under	ency of education received diditional allegations of abuse. Ins reported. The rector of Nursing will be ring all staff are trained by any new hire and agency or evidence of abuse training adgement of receipt during an process. The daily is is completed by the for of Nursing and Scheduler of Hours worked and to red facility and agency staff aducation during the to first shift worked. Newly not staff and staff not by 3/28/23, will receive at worked shift by the Director of Nursing. The Administrator and/or completed abuse current facility and agency standing of the Abuse, tion Policy and to identify and se and to validate the facility has a zero	F6							
	and/or Regional Dire provide regional over or via telephone for a abuse to ensure all ru an allegation of abus immediate removal of	sident of Clinical and Quality ctor of Clinical Services will reight to the facility in-person any allegation of resident esidents are protected after e is made to include if alleged perpetrator, sidents and notification to the								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 03/31/2023
	ROVIDER OR SUPPLIER	ITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	33/01/23/20
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 607	Continued From pag	ge 31	F 607	7	
	Services (RDCS) con Administrator and Direporting allegations enforcement and Administrator and Direporting allegations enforcement and Administrator and properties of the services of the se	e Regional Director of Clinical f Nursing, Administrator and ded education to current staff of the requirement of gations to Adult Protective inforcement immediately, but as after the allegation is made olve abuse or result in serious facility Abuse, Neglect and and CMS guidelines. It is the Administrator to ensure g. e Administrator is ultimately implementation and emoval plan.			
		lity's immediate jeopardy ve 3/29/23 was validated by			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345083	345083 B. WING			C 03/31/2023			
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,			
HILLTOP HEALTH AND REHABILITATION			1	188 OSCAR JUSTICE ROAD					
HILLIOP	TEALIN AND RENABILI	IATION		ı	RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 607	Continued From page	e 32	F	607	,				
F 007	the following: Administrate revealed they had recompleting a comprel quality interview to full identify and respond fremoval of alleged state assignments to ensur were educated on repart Adult Protective Servi immediately, but not I allegation is made. The Exploitation policy were educated on a Jezula indicated on 3/22/23	strative staff interviews believed education on hensive investigation and ally analyze and properly to potential abuse as well as aff from resident care resident safety. All staff porting abuse allegations to ices and Law Enforcement atter than 2 hours after the the Abuse, Neglect and ere reviewed with all staff. Idocument titled "allegation written by the Administrator "Resident #1 reported to fit male nurse aide stuck his then he was cleaning her ent." It indicated the it Manager #1 interviewed told by Resident #1 that the green went into her vagina. It ing the interview, Resident attor and the Unit Manager inish her care and not are to her. It's Facility Reported Incident in incident between Resident		00/					
	allegation of potential	sexual abuse related to orning of 3/22/23 when he							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345083	B. WING			С	
	ROVIDER OR SUPPLIER HEALTH AND REHABILIT		B. WING	188	EET ADDRESS, CITY, STATE, ZIP CODE OSCAR JUSTICE ROAD THERFORDTON, NC 28139	03/3	31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Administrator indicate Manager's office upon approximately 8:00 A unit manager's office, Resident #1 had alleghis finger into her vagincontinence care and the situation. The Adr #1 informed him the if was providing incondinistrator explained Resident #1 indicated happened due to NA Administrator stated that not believed the incidifacility filed the conceinvestigating the allegabuse. The Administrator been handlabuse, he would have	the Unit Manager. The end he proceeded to the Unit on arriving at the facility	F	607			