DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_		OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMF	E SURVEY PLETED
		345083	B. WING			C /13/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
	HEALTH AND REHABILI	TATION	1	88 OSCAR JUSTICE ROAD		
HILLIOPI		IATION	F	RUTHERFORDTON, NC 28139		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	complaint survey was through 9/13/2023. Through normalized series that the series of t	-site recertification and conducted on 9/11/2023 ne facility was found to be requirement CFR.483.73, ess. Event ID# PVL011.	F 000			
	complaint survey was through 9/13/2023. Tl investigated NC0020 NC00206849, NC002 of the 8 allegations re ID #PVL011.	05038 and NC00204033. 2 sulted in a deficiency. Event				
F 550 SS=G	J .		F 550			9/18/23
	self-determination, ar access to persons an	ht to a dignified existence, ad communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that e or enhancement of his or ognizing each resident's ity must protect and				
	access to quality care severity of condition, must establish and m	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					10/04/2023

Electronically Signed

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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/12/2023 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345083	B. WING				C 13/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP H	IEALTH AND REHABILIT	TATION			38 OSCAR JUSTICE ROAD UTHERFORDTON, NC 28139		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	[(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE
F 550	Continued From page	• 1	E f	550			
		under the State plan for all					
		of Rights. right to exercise his or her the facility and as a citizen					
	or resident of the Unit	5					
	resident can exercise	ility must ensure that the his or her rights without , discrimination, or reprisal					
	from the facility.						
		sident has the right to be oercion, discrimination, and					
		ty in exercising his or her orted by the facility in the					
	subpart.	rights as required under this					
	by:	is not met as evidenced					
	Based on observation				1. The facility failed to treat a resider	nt in	
		sident and staff, the facility ent in a dignified manner by			a dignified manner by ensuring a dependent resident could access and		
		t resident could access and			activate the call light to request assista	ance	
	activate the call light t	o request assistance from			from staff for 1 of 1 resident reviewed	for	
	staff for 1 of 1 residen				dignity (Resident #122). Resident #122		
	· ,	ident #122 stated having to			stated having to yell out for assistance made her feel upset, aggravated and	!	
	yell out for assistance aggravated and mad.	-			mad. On 9/11/23, Resident #122 was		
	aggravatoa ana maa.				placed on every 15-minute checks whi	le	
	The findings included	:			awaiting the delivery of the new call system. The new breath-activated call		
	Resident #122 was a	dmitted to the facility on			system was delivered, installed, and	l	
	08/18/23 with diagnos	ses which included			tested for proper functioning on 9/18/2	3.	
		s of all four limbs) and			Resident education provided by the		
	hemiplegia (paralysis	of one side of the body).			Administrator with successful return		
	An admission Minimu	m Data Set (MDS) dated			demonstration. Care plan and Kardex updated accordingly.		

Facility ID: 923556

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	DATE SURVEY	
					С		
		345083	B. WING			09/13/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD			
HILLIOP		TATION		RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 550	Continued From page	e 2	F 5	50			
		esident #122 was moderately	1.0.				
		dependent upon two staff		2. All current facility resident	s are at risk		
		bility, eating, toilet use,		of being affected by the deficie			
		d bathing. The resident was		On 9/13/23 a full house audit v	•		
	coded as having upp	er and lower extremity		completed by the Maintenance	Director to		
		ides of the body. The MDS		ensure current facility resident			
		22 had clear speech and		appropriate working call light to			
	was able to make her	rself understood.		needs. No further concerns we	ere noted		
	On 00/11/22 on obse	rvation was conducted of		during the audit.			
		01 AM. Resident #122 was		3. To ensure this deficient pr	actice does		
		her neck resting back on the		not recur we put the following			
	-	on her face. A square metal		effective 9/18/23, current facili			
		ed in the middle of the		agency staff were educated by			
	-	that were lying flat to her		development coordinator on re			
	side. Resident#122's	call light was observed to be		rights to be treated in a dignifie	ed manner		
	off.			including the right to have a ca	-		
				that meets their care needs. N			
		ed on 09/11/23 with Resident		and agency staff and staff that			
		vealed she was having		unable to complete education	-		
		neck not having a pillow		will be educated prior to workin	ng their first		
		She stated, "I need a drink of		or next shift.			
	water, nobody will he	22 could not move her arms		4. The Maintenance Director	or		
		that was lying between her		Administrator will complete au			
		n. The surveyor left the room		facility call lights to ensure res			
		NA) #1 Resident #122		a properly functioning call syst			
	needed assistance.			their needs 3 times a week for			
				then 2 times a week for 4 wee			
				weekly for 4 weeks. The data			
		conducted on 09/11/23 at		audits will be brought to the m			
	-	lacing a pillow under the		Quality Assurance Performance			
	resident's neck for su	er so she could drink. NA #1		Improvement (QAPI) Committe by the Administrator monthly for			
		g the residents call bell back		and changes will be made to the			
		between her arms before		necessary to maintain complia			
		er NA #1 left the room,		time the QAPI committee will e			
		I, "Do you see what I mean,		effectiveness of the interventio			
	they just don't unders			determine if continued auditing			

Facility ID: 923556

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345083	B. WING				C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				18	88 OSCAR JUSTICE ROAD		
HILLTOP I	HEALTH AND REHABILIT	TATION			UTHERFORDTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	normally would not us needed something. S just yell out if she nee stated she went into F complete rounding ev revealed the last time room with Resident # the breakfast meal and An interview was come AM with Family Member #1 sta facility that day, Resid that she needed assiss the facility could get a resident could blow in assistance, so she did #122 stated she could press the call bell, and cord draped over her press the call bell. Sh staff made her upset, staff. Resident #122 s in a soiled brief and w because she could no The interview reveale staff were not listening told them she would b	AM an interview was She stated Resident #122 wher call bell when she he stated the resident would ded assistance. NA #1 Resident #122's room to ery 2 hours. The interview she had walked into the 122 was to assist her with bound 9:00 AM. ducted on 09/12/23 at 11:10 per #1 and Resident #122. ated when he came to the lent #122 was yelling out stance. He stated he felt like to to turn the light on for d not have to yell. Resident d not move her arms to d she refused to have the when she was unable to e stated having to yell for aggravated and mad with stated she often had to wait	F	550	adjustments. 5. Completion Date: 9/18/23		
	On 09/12/23 at 10:20 conducted of Residen behind her on the bec	AM an observation was It #122's call bell located Iside dresser. Resident Ied her blinds closed and a the observation. The					

Facility ID: 923556

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	: 10/12/2023 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(3) DATE COMP	SURVEY LETED
		345083	B. WING				(09/	C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	188 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 PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	Ē	(X5) COMPLETION DATE
F 550	Continued From page surveyor left the room		F	550				
	with NA #2 revealed F yelling out if she need time she was admitted was yelling out every could not use her call witnessed Resident #	ed on 09/12/23 at 12:13 PM Resident #122 had been led assistance since the d. She stated the resident 20-30 minutes because she bell. NA #2 stated she had 122 become frustrated with s unable to use her call bell essing her needs.						
	with Nurse #1 revealed out if she needed ass her call bell becauses arms. She stated she her the resident could she knew it anyway.	ed on 09/12/23 at 2:25 PM ed Resident #122 would yell istance and could not use she could not move her did not recall NA #2 telling not use her call bell, but The interview revealed she the Director of Nursing yas aware.						
	with Certified Occupa (COTA) #1 revealed s Resident #122 and sh and they were placing shoulder at one time, uncomfortable. She s call light under her ch stated that was also u revealed the resident they passed by to obt	ed on 09/12/23 at 10:33 AM tional Therapist Assistant the had been working with he had spoken with staff, her call light behind her but the resident said it was tated the staff placed the in after, but the resident uncomfortable. The interview was yelling out to staff when ain assistance.						
	AM with Physical The revealed she had bee #122 for therapy. The	rapy Assistant (PTA) #1 in working with Resident interview revealed PTA #1 ent #122 yelling out for						

Facility ID: 923556

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 10/12/202 1 APPROVE). 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/13/2023	
		345083	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
HILLTOP H	IEALTH AND REHABILI	TATION		88 OSCAR JUSTICE ROAD		
				RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 550	Continued From page	e 5	F 550			
		ons. She stated she thought				
	AM with the Director the interview he state two different call bells the resident was not thought another call be Business Office Man Resident #122 was y staff assistance. The should have to yell for An interview conduct with the Administrato facility and had just s stated he was not aw unable to use her cal new bell on order sin	ed on 09/13/23 at 3:00 PM r revealed he was new to the tarted the week prior. He vare of Resident #122 being I bell and the facility had a ce the survey started. He				
F 558 SS=G	stated no resident sh assistance from staff Reasonable Accomm CFR(s): 483.10(e)(3)	odations Needs/Preferences	F 558			9/18/23
	services in the facility accommodation of re preferences except w endanger the health other residents. This REQUIREMENT	sident needs and				
	interviews with the re failed provide an ada	on, record review and esident and staff, the facility ptive call bell the resident for assistance. This resulted		1. The facility failed to provide an adaptive call bell the resident could activate to call for assistance. This resulted in the resident relying on her		

Event ID: PVL011

Facility ID: 923556

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		COMPLETED		
			-			С		
		345083	B. WING			09/13/2023		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	E, ZIP CODE			
				188 OSCAR JUSTICE ROAD				
HILLIOP	HEALTH AND REHABILI	TATION		RUTHERFORDTON, NC 28	3139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIC DATE		
F 558	Continued From page	e 6	F 5	58				
		g on her voice to yell for		voice to yell for assist	ance. This deficient			
		icient practice occurred for 1		practice occurred for				
		d for accommodation of		reviewed for accomm				
	needs (Resident #12			(Resident #122). Upo				
				issue the facility order	red a specialized call			
	The findings included	1:		light system on 9/12/2				
				and placed resident o				
		dmitted to the facility on		checks while awaiting				
	08/18/23 with diagno	is of all four limbs) and		new system. The new was delivered and ins				
		s of one side of the body).			stalled 011 9/10/23.			
		of one side of the body).		2. All current facility	residents are at risk			
	An admission Minimu	ım Data Set (MDS) dated		of being affected by th				
		esident #122 was moderately		On 9/13/23 a full hous				
	cognitively intact and	dependent upon two staff		completed by the mai	ntenance director to			
		bility, eating, toilet use,		ensure current facility				
		d bathing. The resident was		appropriately function				
		er and lower extremity		to meet their needs a				
	impairment on both s			residents were able to No further concerns w	•			
		rvation was conducted of 01 AM. Resident #122 was		audit.				
		her neck resting back on the		3. To ensure this de	ficient practice does			
		on her face. A square metal		not recur we put the fe				
	flat call bell was place	ed in the middle of the		effective 9/18/23, curr	ent facility and			
		that were lying flat to her		agency staff were edu				
		call light was observed to be		development coordina				
	off.			rights of accommodat				
	An interview conduct	ed on 09/11/23 with Resident		including right to have the resident is able to	•			
		realed she was having		and in the event a res	-			
		neck not having a pillow		the call light system, s				
	placed underneath. S	She stated, "I need a drink of		Administrator, Directo	or of Nursing, or			
	-	lp me." The interview		Maintenance Director	-			
		22 could not move her arms		agency staff and staff				
	-	that was lying between her		complete education b				
		n. She stated, "they need to In blow into." She stated she		educated prior to worl shift.	king their first or next			
	0	ff she could not use the call		Simi.				

Facility ID: 923556

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETED	
					С	
		345083	B. WING		09/13/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD		
HILLIOP	NEALTH AND REHADILI	TATION		RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
F 558	Continued From page	e 7	F 55	58		
		changed. The surveyor left	1.00	4. The Maintenance Director or		
		rse Aide (NA) #1 Resident		Administrator will complete audits	on	
	#122 needed assista			facility call lights to ensure residen		
				properly functioning call lights to		
	An observation was o	conducted on 09/11/23 at		accommodate their needs 3 times	a week	
		lacing a pillow under the		for 4 weeks, then 2 times a week f		
	resident's neck for su			weeks, and then weekly for 4 week		
		er so she could drink. NA #1		data from the audits will be brough		
		g the residents call bell back		monthly Quality Assurance Perform		
	she left the room.	between her arms before		Improvement (QAPI) Committee m	-	
				by the Administrator monthly for 3 and changes will be made to the p		
	On 09/11/23 at 11·15	AM an interview was		necessary to maintain compliance.		
		1. She stated Resident #122		time the QAPI committee will evalu		
		se her call bell when she		effectiveness of the interventions to		
	•	She stated the resident would		determine if continued auditing or		
	just yell out if she nee	eded assistance. NA #1		adjustments.		
		Resident #122's room to				
		very 2 hours. The interview		5. Completion Date: 9/18/23		
		the call light back onto her				
		ne thought she had seen her				
		. The interview revealed the				
		isted the resident was to eakfast meal around 9:00				
		did have access to the				
		but did not look at it prior to				
	entering the resident					
		ducted on 09/12/23 at 11:10				
	-	ber #1 and Resident #122.				
	•	ated when he came to the				
		lent #122 was yelling out for				
		the felt like the facility could ell the resident could blow				
	-	n for assistance, so she did				
		dent #122 stated she could				
		press the call bell, and she				
		ord draped over her when				
		ess the call bell. Resident				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 10/12/2023 MAPPROVED O. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345083	B. WING				C 0/13/2023
NAME OF P	ROVIDER OR SUPPLIER	-		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	HEALTH AND REHABILI	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 PREF TAG	I IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 558	#122 stated she ofter and was left without v get staff into her room On 09/12/23 at 10:20 conducted of Resider behind her on the bed #122 stated she need drink of water during f surveyor left the room Resident #122's call I yelling when the surve An interview conducted with NA #2 revealed F yelling out if she need time she was admitte was yelling out every could not use her call the call bell was place resident still could not press the button. She #1 a few weeks ago t use the call bell but n An interview conducted with Nurse #1 revealed out if she needed ass her call bell because arms. She stated she her the resident could she knew it anyway. had not reported it to because she felt he w An interview conducted with Certified Occupa	A had to wait in a soiled brief water because she could not n. AM an observation was at #122's call bell located diside dresser. Resident led her blinds closed and a the observation. The and notified NA #2. ight was not on nor was she eyor entered the room. ed on 09/12/23 at 12:13 PM Resident #122 had been led assistance since the d. She stated the resident 20-30 minutes because she bell. NA #2 stated even if ed beside her head the t turn her neck enough to e stated she had told Nurse he resident was unable to ever heard anything else. ed on 09/12/23 at 2:25 PM ed Resident #122 would yell istance and could not use she could not move her did not recall NA #2 telling I not use her call bell, but The interview revealed she the Director of Nursing yas aware. ed on 09/12/23 at 10:33 AM tional Therapist Assistant	F	558			
HILLTOP I (X4) ID PREFIX TAG	HEALTH AND REHABILIT SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I Continued From page #122 stated she ofter and was left without v get staff into her room On 09/12/23 at 10:20 conducted of Resider behind her on the bed #122 stated she need drink of water during f surveyor left the room Resident #122's call I yelling when the surve An interview conducted with NA #2 revealed F yelling out if she need time she was admitte was yelling out every could not use her call the call bell was place resident still could not press the button. She #1 a few weeks ago t use the call bell but n An interview conducted with Nurse #1 revealed out if she needed ass her call bell because arms. She stated she her the resident could she knew it anyway. had not reported it to because she felt he w An interview conducted with Certified Occupa	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF	IX	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	

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	-	D HUMAN SERVICES //EDICAID SERVICES				FORM): 10/12/2023 MAPPROVED). 0938-0391
STATEMENT OF E	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345083	B. WING				C 13/2023
NAME OF PROV	/IDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				18	38 OSCAR JUSTICE ROAD		
HILLIOP HE	ALTH AND REHABILIT	ATION		RI	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
R pri w retr m w th st h s s lig reth b u re b d d c c c A A re # o s t s l p R T at ro lig re th b u re th s th s s th s s th s th s th s th s	revention. She stated rere very tight and sh esident's arms to stre- eatment encounters. novement she had se ras when she actively he muscle tone would tated the resident wa er arms or legs herse poken with staff, and ght behind her should esident said it was ur he staff placed the ca ut the resident stated ncomfortable. The in esident was yelling or y to obtain assistance epartment had not ex all bell for Resident # all bell options availa n interview was cond M with Physical The evealed she had bee 122 for therapy. She n range of motion on tretching of both legs he had completed ca ositioning to prevent tesident #122 could r he interview revealed to be the call bell on he tated she had not loo esident another type	tching and contracture d the resident's muscles e had been moving the stech them during the She stated the only een from the resident's arms y moved them outward, and d move them back in. She is unable to actively move elf. She stated she had they were placing her call der at one time, but the noomfortable. She stated II light under her chin after, d that was also terview revealed the ut to staff when they passed e. She stated the therapy xplored other options for a ef122 and was unsure of the ble. ducted on 09/12/23 at 11:30 rapy Assistant (PTA) #1 n working with Resident stated they were working her knees and gentle a. The interview revealed regiver training with bed skin breakdown. She stated not move her legs or arms. d normally did not pay II when she entered the knew the resident did not r or below her chin. She	F 5	58			

Facility ID: 923556

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345083	B. WING				(13/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
HILLTOP I	HEALTH AND REHABILI	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	9 10	F	558			
F 756 SS=E	AM with the Director of the interview he state two different call bells a flat pancake style be they switched to a lar bell that sat up onto the he was aware the ress bell and thought anoth ordered by the Busine stated he did not know the invoices. The interview was aware Resident a hall for staff assistance An interview conducted with the Administrator facility and had just st stated he was not awa unable to use her call new bell on order since Drug Regimen Review CFR(s): 483.45(c)(1)(1) §483.45(c)(2) This rev of the resident's media §483.45(c)(4) The pha- irregularities to the att facility's medical direct and these reports mu	ess Office Manager. He w a date but would check erview revealed the DON #122 was yelling out into the ee. ed on 09/13/23 at 3:00 PM revealed he was new to the carted the week prior. He are of Resident #122 being bell and the facility had a ce the survey started. w, Report Irregular, Act On 2)(4)(5) men Review. ug regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the ctor and director of nursing,	F	756			9/18/23

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/12/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 09/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
HILLTOP I	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD	
				RUTHERFORDTON, NC 2813	39
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C PROVIDER'S PLAN C (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE
F 756	Continued From pag	e 11	F7	256	
1 100		criteria set forth in paragraph		50	
		an unnecessary drug.			
		noted by the pharmacist			
	during this review mu	ust be documented on a			
	separate, written rep				
		and the facility's medical			
		of nursing and lists, at a nt's name, the relevant drug,			
	· ·	ne pharmacist identified.			
		ysician must document in the			
	resident's medical record that the identified				
		reviewed and what, if any,			
		n to address it. If there is to medication, the attending			
		cument his or her rationale in			
	the resident's medica				
		cility must develop and			
		procedures for the monthly			
		that include, but are not the different steps in			
		s the pharmacist must take			
		tifies an irregularity that			
		n to protect the resident.			
		T is not met as evidenced			
	by:				
		view and interviews with the ultant Pharmacist, and the		1. The Consultant Pha identify drug irregularitie	
	Medical Director (MD	-		recommendations for 2	•
		identify drug irregularities		reviewed for unnecessa	
		endations for 2 of 6 residents		(Resident #10 and #40)	. On 9/13/23, the
		ssary medications (Resident		Director of Nursing (DO	
	#10 and #40).			medical provider of med	
	The findings includes	4.		no new orders were rec	
	The findings included			the Regional Director of (RDCS) notified the Pha	
	1. Resident #10 was	admitted to the facility on		of deficient practice and	
		ses that included diabetes		reeducation on (Regulat	-
	mellitus (DM).			medication regime revie	

Event ID: PVL011

Facility ID: 923556

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		NSTRUCTION		ATE SURVEY OMPLETED
		345083	B. WING				C
	ROVIDER OR SUPPLIER	0.0000			ET ADDRESS, CITY, STATE, ZIP CODE		09/13/2023
	NOVIDER OR SOLT EIER				SCAR JUSTICE ROAD		
HILLTOP	HEALTH AND REHABILI	TATION			HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 756	Continued From page	e 12	F 75	6			
	Resident #10 was at is sugars due to diabeted free of complications the next review date. administer medication The significant chang Set (MDS) assessme Resident #10 with interface the was receiving insurants assessment period. Review of physician's revealed Resident #1 units of Novolog insult daily with meals for dait to hold the insulin who blood glucose (CBG) milligrams per decilited Novolog order change subcutaneously once same parameter of hoc CBG was lower than A review of medication.	te in status Minimum Data ent dated 06/15/23 coded act cognition and indicated llin daily during the 7-day s orders dated 07/05/23 0 had an order to receive 10 lin subcutaneously 3 times iabetes. The order specified en Resident #10's capillary was lower than 200 er (mg/dL). On 08/17/23, the ed to 10 units daily in the morning with the olding the insulin when the 200 mg/dl. en administration records ndicated Resident #10 had		a re a 2. o b R W R R N R N R N S N C N C C M C C M C C C C C C C C C C C	acilities expectation for irregularities ddressed during monthly medication eviews. Both residents □ blood sug- re stable currently. Current facility residents with in- rders with parameters are at risk o- eing affected by this deficient practi- esident insulin orders with parame- ere reviewed for irregularities by the DCS on 9/13/23. No further issues boted during the audit. To ensure this deficient practice of recur we put the following into p- he RDCS completed education with harmacy consultant and the DON of (13/23 the medication regimen revi- oblicy and the facilities expectation regularities to be addressed by the consultant pharmacist during month- iedication reviews. New DON □s at onsultant pharmacists will be educ pon hire by the RDCS. The DON we eview pharmacy consultant report a ecommendations monthly to ensur- esidents on insulin treatment are eviewed by the consulting pharmaco- ith appropriate recommendations of	on ars sulin f tice. ters ne swere does lace; h the on for for for ated <i>v</i> ill and e sist	
	subcutaneously erron nurses for 19 times w through 09/11/23) wh	neously from 5 different rithin 69 days (from 07/05/23 en his CBGs were less than e insulin injections for the		4.	identify drug irregularities.	on	
	- 07/06/23 noon whe - 070/7/23 morning w	vhen CBG = 176 mg/dL vhen CBG = 161 mg/dL		re di co w	ecommendations as necessary to i rug irregularities. Monitoring will be ompleted twice weekly for 4 weeks eekly for 8 weeks. The facility will onitor the corrective actions to en-	dentify e then	

Facility ID: 923556

If continuation sheet Page 13 of 36

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI			(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		345083	B. WING				13/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2020
				18	88 OSCAR JUSTICE ROAD		
HILLTOP	HEALTH AND REHABILI	TATION		R	UTHERFORDTON, NC 28139		
(X4) ID			ID			-	(X5) COMPLETION
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 756	Continued From page	e 13	F	756			
	- 07/08/23 evening w	/hen CBG = 147 mg/dL			that the deficient practice is corrected a	and	
	- 07/09/23 noon whe	n CBG = 137 mg/dL			will not recur by reviewing information		
		hen CBG = 116 mg/dL			collected during audits and reporting to)	
		hen CBG = 171 mg/dL			Quality Assurance Performance		
	-	/hen CBG = 120 mg/dL			Improvement committee (QAPI) by the		
	- 07/16/23 noon whe	•			DON monthly for three (3) months and		
		/hen CBG = 132 mg/dL /hen CBG = 173 mg/dL			make changes to the plan as necessar At that time the QAPI committee will	у.	
	- 07/20/23 noon whe				evaluate the effectiveness of the		
		/hen CBG = 188 mg/dL			interventions to determine if continued		
	-	/hen CBG = 191 mg/dL			auditing or adjustments.		
	- 08/06/23 morning w	/hen CBG = 197 mg/dL					
		/hen CBG = 178 mg/dL			5. Completion Date: 9/18/23		
		/hen CBG = 94 mg/dl					
	- 09/07/23 morning w	/hen CBG = 106 mg/dl					
	Review of medical re	cords revealed Resident					
	#10's CBGs were sta	ble at the baselines ranged					
	from 76 to 280 mg/dl	over the past 3 months.					
	Review of medical re	cord revealed the Consultant					
	Pharmacist had cond	ucted monthly medication					
		Resident #10 in the past 5					
	months on 04/20/23,						
		23. However, he did not					
	identify any drug irreg						
	unnecessary insulin a	-					
	nursing staff to correct	ations to the physician or					
		onducted on 09/11/23 at					
		10 stated his CBGs were					
	stable in the past 3 m	onths.					
	2 Resident #40 was	admitted to the facility on					
	02/07/23 with diagnos	-					
	mellitus (DM).						
	The care plan initiated	d on 03/12/23 revealed					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMP	
		345083	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	HEALTH AND REHABILIT	TATION			88 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 756	Resident #40 was at i sugars due to diabete free of complications the next review date. administer medication Review of physician's revealed Resident #4 units of Humalog insu daily before meals. Th parameters for this or The quarterly MDS as coded Resident #10 v indicated she was red the 7-day assessmen Review of medical red Consultant Pharmacis medication regimen re the past 7 months on 04/20/23, 05/20/23, 0 08/21/23. The Consul identify any drug irreg incorrect holding of in specified recommend nursing staff to correct During an interview cd 1:04 PM, Resident #4 her insulin as ordered A review of MARs on #40's Humalog had b different nurses for 14 07/01/23 through 09/2	risk for fluctuating blood is. The goal was to remain related to diabetes through Intervention included to as as ordered. orders dated 06/17/23 0 had an order to receive 20 lin subcutaneously 3 times he physician did not set any der. seessment dated 08/18/23 with intact cognition and reiving insulin daily during t period. cords revealed the st had conducted monthly eviews for Resident #40 in 02/20/23, 03/21/23, 6/25/23, 07/21/23, and tant Pharmacist did not ularities related to the sulin and did not make any ations to the physician or it the error. onducted on 09/11/23 at 0 stated she was not getting at times. 09/13/23 revealed Resident een held incorrectly by 2 4 times within 74 days (from 12/23) for the following held per parameters" or	F	756			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG.			C
		345083	B. WING				13/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 756	 07/07/23 noon 07/12/23 noon 07/12/23 noon 07/12/23 noon 07/26/23 evening 07/31/23 evening 08/23/23 evening 08/24/23 evening 09/02/23 noon 09/03/23 evening 09/03/23 evening 09/03/23 evening 09/11/23 noon 09/11/23 evening 09/11/23 evening 09/12/23 evening Review of medical rea #40's CBGs were stal ranged mostly from 10 past 3 months. During a phone intervat 11:06 AM, the Conswas an error to admir following the paramet added the nurse shouthe physician before Humalog insulin. He emultiple areas when here the physician before for Resident #10 and oversight. A joint interview was a Director of Nursing (II on 09/13/23 at 1:37 Paramet 1:37 Paramet 1:37 Paramet 1:37 Paramet 2:37 Par	cords revealed Resident ble at the baselines. It 00s to low 300s mg/dl in the riew conducted on 09/13/23 sultant Pharmacist stated it hister Novolog insulin without ers for Resident #10 and ald have at least consulted holding Resident #40's explained he had to cover he performed the monthly eviews. The Consultant ated his failure to identify the ated to insulin administration Resident #40 was an conducted with the Interim DON) and the Administrator 'M. Both expected the st to identify and report the	F	756			

Facility ID: 923556

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/12/2023 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345083	B. WING				C / 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP H	EALTH AND REHABILIT	ATION			88 OSCAR JUSTICE ROAD UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From page		F	756			
	performing the month reviews.	ly medication regimen					
F 760 SS=E	at 2:17 PM, the Medic the Consultant Pharm and report the drug irr manner when perform regimen reviews. It wa nurses to follow the or parameter carefully be for Resident #10, and making any changes Resident #40. Residents are Free of CFR(s): 483.45(f)(2)	hing the monthly medication as her expectation for rder and check the set efore administering insulin to consult her before to the insulin order for	F	760			9/18/23
	medication errors. This REQUIREMENT by: Based on record revir resident, staff, Consul Medical Director (MD) significant medication to follow the physician during insulin adminis Resident #10 had rec unnecessary Novolog Resident #40 had miss insulin within 73 days residents reviewed for (Resident #10 and #4 The findings included)	ts are free of any significant is not met as evidenced ew and interviews with the ltant Pharmacist, and the), the facility failed to prevent errors when nurses failed of sparameter as ordered stration. As a result, eived 19 doses of insulin within 69 days, and assed 14 doses of Humalog . This affected 2 of 6 r unnecessary medications 0).			 The facility failed to prevent signimedication errors when nurses failed follow the physician's parameter as ordered during insulin administration. result, Resident #10 had received 19 doses of unnecessary Novolog insulin within 69 days, and Resident #40 had missed 14 doses of Humalog insulin within 73 days. This affected 2 of 6 residents reviewed for unnecessary medications (Resident #10 and #40). 9/13/23, the director of nursing (DON notified the medical provider of medications within time no new orders within the factor of the subscription of the subscription. At which time no new orders within the subscription of the subscription of the subscription. 	to As a n l On pation vere	

Event ID: PVL011

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		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	<u>. 0938-039</u> SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPL	
						;
		345083	B. WING		09/1	3/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
		TATION		188 OSCAR JUSTICE ROAD		
HILLIOP	HEALTH AND REHABILI	TATION		RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 17	F 76	50		
	03/22/23 with diagno mellitus (DM). The care plan initiate Resident #10 was at sugars due to diabete free of complications the next review date. administer medicatio The significant chang Set (MDS) assessme Resident #10 with int he was receiving insu assessment period. Review of physician's revealed Resident #1 units of Novolog insu daily with meals for d to hold the insulin wh blood glucose (CBG) milligrams per decilite	ses included diabetes d on 04/28/23 indicated risk of fluctuating blood es. The goal was to remain related to diabetes through Intervention included to ns as ordered. ge in status Minimum Data ent dated 06/15/23 coded fact cognition and indicated ulin daily during the 7-day s orders dated 07/05/23 10 had an order to receive 10 lin subcutaneously 3 times liabetes. The order specified ten Resident #10's capillary was lower than 200 er (mg/dL). On 08/17/23, the		 Current facility residents with orders with parameters are at risk being affected by this deficient pr Resident insulin orders with para were reviewed for errors by the F Director of Clinical Services (RDC 9/13/23. No further issues were r during the audit. To ensure this deficient pract doesn trecur the facility has put following into place; effective 9/1 staff development coordinator (S educated the facility and agency nurses and medication aides on medication administration, process help reduce the risk of medication insulin administration, and following parameters for insulin administration Newly hired facility and agency linurses and medication aides not education by 9/18/23 will be education 	k of actice. meters Regional CS) on noted tice the 8/23, the DC) licensed sses to n errors, ng tion. censed receiving cated	
	same parameter of h CBG was lower than A review of medicatio (MARs) on 09/11/23 received 10 unit of N subcutaneously error nurses for 19 times w	e daily in the morning with the olding the insulin when the 200 mg/dl. on administration records indicated Resident #10 had ovolog insulin neously from 5 different vithin 69 days (from 07/05/23		 upon hire or prior to working their shift. 4. DON will monitor residents of treatment with parameters to ensimedication is given as ordered. Monitoring will be completed for fresidents twice weekly for 4 week weekly for 8 weeks. The facility we monitor the corrective actions to the the deficient practice is corrective. 	n insulin ure ïve (5) ‹s then <i>r</i> ill ensure	
	200 mg/dL prior to th following doses: - 07/06/23 noon whe	en his CBGs were less than e insulin injections for the en CBG = 182 mg/dL when CBG = 176 mg/dL		that the deficient practice is corre- will not recur by reviewing inform collected during audits and repor Quality Assurance Performance Improvement committee (QAPI) I DON monthly for three (3) month	ation ting to by the	

Facility ID: 923556

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/12/2023 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345083	B. WING			C 09/13/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH AND REHABILI	τατιών		18	38 OSCAR JUSTICE ROAD			
				R	UTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 760	 07/08/23 noon whe 07/08/23 evening w 07/09/23 noon whe 07/10/23 evening w 07/11/23 evening w 07/16/23 morning v 07/16/23 noon whe 07/16/23 noon whe 07/20/23 noon whe 07/20/23 morning v 07/20/23 evening w 07/20/23 evening w 07/20/23 evening w 07/20/23 evening w 07/22/23 evening w 08/06/23 morning v 08/07/23 morning v 09/07/23 morning v During an interview c 	vhen CBG = 161 mg/dL n CBG = 172 mg/dL /hen CBG = 147 mg/dL n CBG = 137 mg/dL /hen CBG = 116 mg/dL /hen CBG = 171 mg/dL vhen CBG = 120 mg/dL /hen CBG = 100 mg/dL /hen CBG = 132 mg/dL vhen CBG = 173 mg/dL	F	760	 changes will be made to the plan as necessary. At that time the QAPI committee will evaluate the effectivent of the interventions to determine if continued auditing or adjustments. 5. Completion Date: 9/18/23 	ess		
	CBGs were stable in An interview was con PM. Nurse #2 confirm Novolog insulin for Re when his CBGs were acknowledged that it that she had forgotter	ducted on 09/12/23 at 2:51 ned she had administered esident #10 several times lower than 200 mg/dl and was an error. She explained n to check the parameter set						
	During an interview c 3:15 PM, Nurse #3 c administered Novolog	re administering the insulin. onducted on 09/12/23 at onfirmed she had g insulin for Resident #10 is CBGs were less than 200						

Facility ID: 923556

If continuation sheet Page 19 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 10/12/2023 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345083	B. WING			-		C 13/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HILLTOP	HEALTH AND REHABILIT	TATION			188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 760	mg/dl and acknowled stated that she could medication pass and parameter with the No An interview was com Manager (UM) on 09/ expected nursing staf and review the param medication. She state should be held when 200 mg/dl and acknow 2. Resident #40 was at 02/07/23 with diagnos mellitus (DM). The care plan initiated Resident #40 was at a sugars due to diabete free of complications the next review date. administer medication Review of physician's revealed Resident #4 units of Humalog insu daily before meals. Th parameters for this or The quarterly MDS as coded Resident #10 v indicated she was rec the 7-day assessmen During an interview co	ged that it was an error. She have been distracted during forgotten to follow the boolog order. ducted with the Unit '12/23 at 3:21 PM. She f to follow physician's order neter before administering ed Resident #10's Novolog his CBGs were less than wledged that it was an error. admitted to the facility on ses included diabetes d on 03/12/23 revealed risk for fluctuating blood es. The goal was to remain related to diabetes through Intervention included to as as ordered. corders dated 06/17/23 0 had an order to receive 20 lin subcutaneously 3 times he physician did not set any der. seessment dated 08/18/23 with intact cognition and ceiving insulin daily during t period.	F	760				

Facility ID: 923556

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345083	B. WING				C 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HILLTOP	HEALTH AND REHABILI	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 760	A review of MARs on #40's Humalog had b different nurses for 14 07/01/23 through 09/ doses due to either "h "Insulin not required": - 07/07/23 noon - 07/12/23 noon - 07/12/23 noon - 07/22/23 noon - 07/26/23 evening - 08/10/23 noon - 08/23/23 evening - 08/24/23 evening - 08/24/23 evening - 09/03/23 noon - 09/03/23 noon - 09/03/23 evening - 09/11/23 noon - 09/03/23 evening - 09/11/23 noon - 09/12/23 evening - 09/11/23 noon - 09/11/23 noon - 09/12/23 evening - 09/11/23 noon - 09/11/23 noon - 09/12/23 evening - 09/11/23 noon - 09/03/23 evening - 09/11/23 noon - 09/03/23 evening - 09/11/23 noon - 09/03/23 evening - 09/03/23 eve	09/13/23 revealed Resident een held incorrectly by 2 4 times within 74 days (from 12/23) for the following held per parameters" or 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	F	760			

If continuation sheet Page 21 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
		345083	B. WING				13/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP H	HEALTH AND REHABILI	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	before holding Reside During a phone interv at 11:06 AM, the Con- was an error to admir following the paramet added the nurse shou the physician before H Humalog insulin. He v incidents would be co- medication error. A joint interview was of Director of Nursing (II on 09/13/23 at 1:37 P staff to follow physicia medication pass and making any changes the Administrator ack	er and consult the physician ent #40's insulin. riew conducted on 09/13/23 sultant Pharmacist stated it hister Novolog insulin without ers for Resident #10 and ald have at least consulted holding Resident #40's	F	760			
F 761 SS=E	at 2:17 PM, the Media nurses to follow the o parameter carefully b for Resident #10 and making any changes Resident #40. She wa definition of significan unable to determine it medication error. Label/Store Drugs an	efore administering insulin to consult her before to the insulin order for as unclear about the it medication error and t was a significant d Biologicals	F	761	1		9/18/23
		of Drugs and Biologicals a used in the facility must be					

Facility ID: 923556

If continuation sheet Page 22 of 36

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 10/12/202 DRM APPROVEI NO. 0938-039	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345083	B. WING			C 09/13/2023		
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	HEALTH AND REHABILI	TATION		18	88 OSCAR JUSTICE ROAD			
HILLIOF	TEALTH AND REHADILI	TATION		R	UTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 761	Continued From page	e 22	F	761				
	labeled in accordance professional principle	e with currently accepted es, and include the						
	appropriate accessor instructions, and the applicable.							
	§483.45(h) Storage c	of Drugs and Biologicals						
		ordance with State and ility must store all drugs and						
	biologicals in locked	compartments under proper , and permit only authorized						
	personnel to have ac	cess to the keys.						
	locked, permanently storage of controlled	cility must provide separately affixed compartments for drugs listed in Schedule II of						
	Control Act of 1976 a	Drug Abuse Prevention and and other drugs subject to the facility uses single unit						
	package drug distribu	ution systems in which the nimal and a missing dose can						
	be readily detected. This REQUIREMENT by:	Γ is not met as evidenced						
	Based on observation record reviews, the factors	on, staff interviews, and acility failed to remove			1. The facility failed to remove ex over the counter (OTC) medications	s in		
	accordance with the	nter (OTC) medications in manufacturer's expiration ation rooms observed during			accordance with the manufacturer's expiration date for 1 or 2 medication rooms observed during medication			
	-	hecks (Medication Room B).			storage checks (Medication Room I Upon notification the director of nur	sing		
	The findings included				(DON) removed the expired medica and disposed of them as indicated.	auons		
	-	e audit was conducted on			2 All ourropt for ility regider to an	otrial		
		for Medication Room B in			2. All current facility residents are			
		Jnit Manager (UM). The dications were found in			of being affected by this deficient pr The Unit Manager audited all facility			
		and ready to be used:			medication storage on 9/14/23 to er			

Facility ID: 923556

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188 OSCAR JUSTICE ROAD	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO HILLTOP HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF C PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF C F 761 Continued From page 23 F 761 a. 9 unopened bottles of Senna syrup expired on 07/31/22. Each bottle contained 237 milliliters (ml) of syrup. F 761 b. 1 opened bottle contained 100 tablets of Calcium 600 milligrams (mg) with Vitamin D3 expired on 10/31/22. F 761 c. 5 unopened bottles of Geri-Lanta antacid suspension expired on 06/30/23. Each bottle contained 335 ml of suspension. S. To ensure the deficient dollowing into place; effective was responsible to check and rotate the OTC medications on regular basis. She audited medications on regular basis. She audited medication sorage at times as a follow-up to ensure compliance. In addition, the Consultant Pharmacist would spot check medication storage during his monthly visits. A. niterview was conducted with the Central Supply Clerk on 09/12/23 at 5:57 PM. He denied it was his responsibility to check the expiration and rotate the OTC medications as he did not even have the key to access the medication	COMPLETED
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and rotate the OTC medications as he did not even have the key to access the medicationfacility will monitor the correct to ensure that the deficient p	mes a week
even have the key to access the medication to ensure that the deficient p	
information collected during	
A joint interview was conducted on 09/13/23 at reporting to Quality Assurance	
2:17 PM with the Interim Director of Nursing Performance Improvement of	
(IDON) and the Administrator. Both stated the UM (QAPI) by the DON monthly	or three (3)
was responsible to oversee medication storage in months and changes will be	
the facility. It was their expectation for all the plan as necessary. At that til	
nursing staff to follow facility's medication storagecommittee will evaluate thepolicy and procedure to ensure the facility wasof the interventions to deterring	
free of expired medication.	

Event ID: PVL011

Facility ID: 923556

If continuation sheet Page 24 of 36

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · · ·	MPLETED
			-			С
		345083	B. WING			9/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	HEALTH AND REHABILI	ΤΑΤΙΟΝ		188 OSCAR JUSTICE ROAD		
				RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page	e 24	F 76	-		
F 812 SS=E		tore/Prepare/Serve-Sanitary 2)	F 8 ⁻	5. Completion Date: 9/18/23	3	9/18/23
	§483.60(i) Food safet The facility must -	ty requirements.				
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foor (iii) This provision doe from consuming food	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.				
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to remove expired food items in 2 of 2 nourishment rooms. These practices had the potential to affect food served to residents.	nce with professional rvice safety. is not met as evidenced ns, record review and staff failed to remove expired ourishment rooms. These		1. The facility failed to remo food items in 2 of the 2 nouris rooms. These practices had t to affect food served to reside notification on 9/11/23, the ex were removed by the nursing	hment he potential ents. Upon pired items	
	Nurse Aide (NA) #3 ir 200 on 09/11/23 at 11 milk cartons with exp	nterview conducted with n nourishment room on hall I:00 AM revealed two fat free iration date of 09/09/23, Iwich with discard date		2. All current facility resident potential to be affected by this practice. Food storage areas by the dietary manager on 9/2 ensure food was in date and s correctly. No further issues w	ts have the deficient were audited I4/23 to stored	

Facility ID: 923556

If continuation sheet Page 25 of 36

TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMPLETED
		345083	B. WING		C 09/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				188 OSCAR JUSTICE ROAD	
HILLIOP	IEALTH AND REHABIL	ITATION		RUTHERFORDTON, NC 28139	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 812	Continued From pag	e 25	F 81	2	
1 012	• • • • • • • • • • • • • • • • • • •		FOI	2	
		andwich with discard date her revealed staff had been			
		vay expired food and drinks		3. To ensure the deficient practice d	oes
		en thrown away already.		not recur the facility has put the follow	
				into place; the staff development	
		nterview conducted with		coordinator (SDC) educated current	
		nent room on hall 100 on		facility dietary staff and current facility	and
		/l revealed a tuna salad d date 08/29/23. Nurse #4		agency nursing staff on facilities food storage policy. The dietary staff were	also
		ary was responsible for		educated about checking the nourishr	
		nt rooms daily, but nursing		rooms daily for expired foods and to	
		ted to throw away expired		remove the expired items. The nursing	g
	food and drinks. Nur	se #4 indicated the expired		staff were also educated to remove	-
	sandwich should hav	e already been discarded.		expired items when identified by 9/18/	
	A i			Newly hired dietary staff and nursing s	
		ted with Dietary Manager 11:45 AM revealed dietary		and staff unable to complete educatio prior to 9/18/23 will complete educatio	
		sible for checking the		upon hire or before next scheduled sh	
		wice a day. The DM further			int.
		ff were also educated on		4. The dietary manager will audit fac	cility
	discarding expired for	ood if observed in the		food storage 5 times a week for 4 wee	eks,
		The DM stated she expected		2 times a week for 4 weeks, and week	•
		e in the nourishment rooms		for 4 weeks The facility will monitor th	e
	and should have bee	en discarded.		corrective actions to ensure that the	nat
	An interview conduct	ted with the Administrator and		deficient practice is corrected and will recur by reviewing information collected	
		DON) on 09/13/23 at 2:15		during audits and reporting to Quality	
	• •	ere not aware expired food		Assurance Performance Improvement	t l
		rved in both nourishment		committee (QAPI) by the Director of	
		ther revealed nursing staff		Nursing monthly for three (3) months	
		during orientation to throw		make changes to the plan as necessa	ary.
	-	and drink and had been		At that time the QAPI committee will	
		staff. The Administrator d the expired food or drinks		evaluate the effectiveness of the interventions to determine if continued	4
	-	the nourishment rooms.		auditing or adjustments.	a
				5. Completion Date: 9/18/23	
F 867 SS=D	QAPI/QAA Improven	nent Activities	F 86	7	9/18/23

Facility ID: 923556

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/12/2023 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345083	B. WING		_		C 13/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HILLTOP H	IEALTH AND REHABILII	TATION		88 OSCAR JUSTICE ROA RUTHERFORDTON, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page CFR(s): 483.75(c)(d)(§483.75(c) Program f		F 867				
	policies and procedur collections systems, a adverse event monito	and monitoring, including					
	systems to obtain and from direct care staff, resident representativ information will be use	maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and ovement.					
	systems to identify, co information from all do not limited to the facili §483.70(e) and include	maintenance of effective ollect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance					
	and evaluation of perf	blogy and frequency for such					
	including the methods systematically identify analyze and use data adverse events in the	adverse event monitoring, s by which the facility will v, report, track, investigate, and information relating to facility, including how the ta to develop activities to					

Facility ID: 923556

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 10/12/2023 1 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION			LETED
		345083	B. WING				C 13/2023
NAME OF PI	ROVIDER OR SUPPLIER		- ·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HILLTOP I	HEALTH AND REHABILIT	TATION		188 OSCAR JUSTICE ROA RUTHERFORDTON, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	systemic action. §483.75(d)(1) The factor aimed at performance implementing those at and track performance improvements are read §483.75(d)(2) The factor implement policies add (i) How they will use at determine underlying impacting larger system (ii) How they will dever will be designed to effi- level to prevent quality safety problems; and (iii) How the facility will of its performance implement at improvem §483.75(e)(1) The factor performance improve high-risk, high-volume consider the incidence	tts. systematic analysis and cility must take actions a improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and ldressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to nents are sustained. activities. cility must set priorities for its ment activities that focus on a, or problem-prone areas; e, prevalence, and severity	F 86	7	DEFICIENCY)		
	outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy	nance improvement nedical errors and adverse					

Facility ID: 923556

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345083	B. WING				C 13/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				18	88 OSCAR JUSTICE ROAD		
	HEALTH AND REHABILI	IAHON		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 867	facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci- and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analysi (c) and (d) of this sec §483.75(g) Quality as §483.75(g)(2) The quassurance committee governing body, or define functioning as a gover activities, including improgram required unce (ii) Develop and imple action to correct idented (iii) Regularly review a data collected under the resulting from drug real available data to make This REQUIREMENT by: Based on observatio interviews, the facility	and learning throughout the s of their performance s, the facility must conduct improvement projects. The ey of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). s must include at least t focuses on high risk or identified through the data is described in paragraphs tion. seessment and assurance. ality assessment and reports to the facility's esignated person(s) ming body regarding its oplementation of the QAPI der paragraphs (a) through e committee must: ement appropriate plans of tified quality deficiencies; and analyze data, including the QAPI program and data ogimen reviews, and act on e improvements. is not met as evidenced ns, record review and staff 's Quality Assessment and	F	867	1. The facility's Quality Assessment a Assurance (QAA) Committee failed to	and	
	-	mmittee failed to maintain			Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in		

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 09/13/2023
NAME OF P	ROVIDER OR SUPPLIER	•	- I T	STREET ADDRESS, CITY, STATE, ZIP	
				188 OSCAR JUSTICE ROAD	
HILLTOP	HEALTH AND REHABILI	TATION		RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLET THE APPROPRIATE DATE
F 867	Continued From page	a 20	F 8	67	
	recertification survey deficiency was cited survey of 9/13/2023 i Control (F880). The f during two Federal S the facility's inability f program. The findings included F-880: Based on reco staff interviews, the fa their infection control Nurse #5 failed to ch Protective Equipmen out of her surgical ma mask, prior to enterin enhanced droplet pre observation occurred Covid-19 for 1 of 2 rc precautions for positi	ord review, observations and acility failed to implement policies for Covid-19 when ange into full Personal t (PPE), to include changing ask and applying a N95 og a room that was on ecautions for Covid-19. This during an active outbreak of poms on enhanced droplet		 place following the recerting 4/27/2022. The repeat decited on the current recert of 9/13/2023 in the area of Control (F880). The facility failure during two Federal showed a pattern of the factor sustain an effective QA Facility had an Ad Hoc QA 9/14/23 to review repeat of plans put in place to previous citations and have a succor productive Quality Assurate Performance Improvement Committee. 2. All residents have the affected by this deficient productive facility initiated a weekly of meeting to review the rest ongoing audits per the place and its continued effective 9/18/23. Changes will be as necessary to maintain 	ficiency was tification survey of Infection sy's continued Surveys acility's inability A program. API meeting on citations and ent future essful and ince and ht (QAPI) e potential to be practice. The QAPI risk ults of the an of correction eness on made to the plan
	on 4/27/2022 the facility was cited for failure to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for Covid-19 when 1 of 3 staff members failed to wear full Personal Protective Equipment (PPE) when entering a resident's room on enhanced droplet precautions. The Administrator was interviewed on 9/13/2023 at 2:00 PM: The Administrator stated he was the head of the QAA committee which met monthly. He revealed he completed a QA assessment tool monthly to determine if an issue needed to be			 a. The measures that here are a structure of the second second	PI program to ave been put into ent practice does The Regional es educated s on maintaining n and monitoring citations on s to be held needed by the

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345083	B. WING		C 09/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HILLTOP	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 867	and identify a root ca would be completed a conducted. The audit and reviewed, and he monthly QAA meeting would be corrected a The audits are kept in responsible for bringi meeting. The Adminis cause of the repeated was lack of education utilize agency staff fo he was responsible for	e Improvement Plan in place use of the failure. Education with staff and audits s would be brought to him e would then bring to the g. Any changes to the plan t that time and implemented. In a notebook, and he was ing the binder to the QAA strator stated he felt the root d infection control deficiency n, and that the facility had to r licensed nurses. He stated for ensuring staff education that staff understood their	F 867	 members of the QAPI committee not educated by 9/18/23 will be educated upon hire or next shift worked. 4. The Regional Director of Clinical Services (RDCS) or Vice President Operations (VPO) will monitor week 4 weeks then, monthly for 2months compliance with daily/weekly/monthly/PRN Ad Hoc Or risk review of audits of repeat tags f proper monitoring of effectiveness be QAPI committee to maintain an effer QAPI program that prevents repeat citations by effective monitoring. Ref of monitoring will be presented to the Quality Assurance Performance Improvement committee (QAPI) by administrator monthly for three (3) months. At that time the QAPI commit and RDCS or VPO will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction necessary. 	ed al of dy for for QAPI for by ective esults ie the mittee
F 880 SS=D	Infection Prevention a CFR(s): 483.80(a)(1)		F 880	5. Completion Date: 9/18/23	9/18/23
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345083	B. WING				 13/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HILLTOP	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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	 §483.80(a) Infection program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visite providing services under arrangement based under conducted according accepted national stational stational stational station (a) (2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable diseases reported; (iii) When and to whom communicable diseases reported; (iii) Standard and trant to be followed to preview (iv) When and how isom resident; including bur (A) The type and durate depending upon the initiation of the set restrictive possible circumstances. (v) The circumstances 	brevention and control blish an infection prevention IPCP) that must include, at ring elements: Im for preventing, identifying, g, and controlling infections seases for all residents, bors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and bogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of the or infections should be semission-based precautions ent spread of infections; dation should be used for a t not limited to: at not limited to: at not limited to: at the isolation should be the obe for the resident under the s under which the facility we with a communicable	F	880			

Facility ID: 923556

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
					С
		345083	B. WING		09/13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	° CODE
	HEALTH AND REHABILI	τατιοΝ		188 OSCAR JUSTICE ROAD	
		IAHON		RUTHERFORDTON, NC 28139	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 880	Continued From page	e 32	F 88	30	
		s or their food, if direct	1.00		
	contact will transmit the disease; and				
	(vi)The hand hygiene procedures to be followed				
	by staff involved in di	rect resident contact.			
	\$492 90(a)(4) A	§483.80(a)(4) A system for recording incidents			
	identified under the fa				
	corrective actions tak				
	§483.80(e) Linens.				
		le, store, process, and			
		s to prevent the spread of			
	infection.				
	§483.80(f) Annual rev	view			
	,	ct an annual review of its			
		ir program, as necessary.			
	This REQUIREMENT	is not met as evidenced			
	by:				
		iew, observations and staff		1. The facility failed to i	-
	-	failed to implement their		infection control policies f	
		ies for Covid-19 when Nurse to full Personal Protective		when Nurse #5 failed to c Personal Protective Equip	
		include changing out of her		include changing out of h	
	, ,	plying a N95 mask, prior to		and applying a N95 mask	
	· ·	was on enhanced droplet		entering a room that was	•
	precautions for Covid			droplet precautions for Co	
		ctive outbreak of Covid-19		observation occurred dur	0
		ms on enhanced droplet		outbreak of Covid-19 for	
	precautions for positiv	ve Covia-19.		rooms on enhanced drop for positive Covid-19. Nur	
	The findings included	:		immediately reeducated of	
				doffing proper personal p	-
	The facility's policy er	ntitled "Covid-19 Prevention,		equipment when resident	
	Response and Repor	ting" implemented		precautions and how to d	-
		d on 8/5/2023 indicated		needs to be worn by the s	
	under #9 Source cont Source control option			development coordinator 9/11/23.	(SDC) on

Event ID: PVL011

Facility ID: 923556

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OLIVIEN		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
						С
		345083	B. WING			09/13/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
HILLTOP	HEALTH AND REHABILI	TATION		188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 2813	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From page	e 33	F 88	30		
	-	particulate respirator with	1.00	2. Current facility resid	lents are at risk to	
	N95 filters or higher.			be affected by the deficie		
				SDC began education w		
		d under standards used in		and agency staff on 9/11		
		re like NIOSH-approved		and doffing proper perso		
	N95 filtering facepiec	e respirators.		equipment when resider		
	A h			precautions and how to	-	
		ng that meets ASTM F302-21 ng Workplace Performance		needs to be worn by the	SDC.	
	and Workplace Perfo			3. The following meas	ures have been	
				put into place to ensure		
	A well-fitting face mas	sk.		practice does not recur a		
				current facility and agen	cy staff will be	
		e used for an entire shift		educated on donning an		
		soiled, damaged, or hard to		personal protective equi	-	
	breathe through.			resident is on precautior distinguish what needs t		
	If source control is us	sed during the care of a		staff development coord	•	
		NIOSH-approved particulate		completed by 9/18/23.	()	
		sk is indicated for PPE, they		and agency staff and fac		
	should be removed a	nd discarded after the		staff that did not complete	te education by	
	resident care encoun	ter and a new one donned.		9/18/23, will complete ed		
				and prior to working thei	r next shift.	
		ommended for individuals in		4 The Director of Num	sing on Chaff	
	healthcare settings w	110.		4. The Director of Nurs Development Coordinate	•	
	Have suspected or co	onfirmed SARS-CoV-2		random audits three (3)	•	
	infection or other resp			four (4) weeks, then two		
				for 4 weeks, then weekly		
		cility on 9/11/2023 there were		ensure compliance. The	-	
		0 hall with diagnoses of		monitor its corrective act		
		nts were in room #507 and		that the deficient practice		
		had enhanced droplet he front of the door, that		will not recur by reviewin	•	
	stated, "All Healthcar			collected during audits a Quality Assurance Perfo		
				Improvement Committee		
	Clean hands before e	entering and when leaving		audits will be brought by		
	room.	. .		review in Quality Assura		
				Improvement meetings a		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/12/202 MAPPROVEI D. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345083	B. WING				/13/2023
	ROVIDER OR SUPPLIER HEALTH AND REHABILI	TATION	STREET ADDRESS, CITY, STATE, ZIP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	entering the room and Wear Protective eyer goggles). Wear gloves when err before leaving. Place in a private roo to do so). An observation on 9/ revealed Nurse #1 ar gown, gloves, and a f observed wearing a se prior to entering Resi did not apply an N95 room. An enhanced of on the outside of the PPE of gowns, gloves shields was available entered room #507 a When Nurse #1 exite removed her PPE an provided in the room surgical mask and co nurses station. An interview was con 9/11/2023 at 11:38 Al that Resident #226 h Covid-19. She stated enhanced droplet pre-	evel respirator before d remove after exiting. wear (face shield or htering room and remove om. Keep door closed (if safe 11/2023 at 10:40 AM oplying PPE to include, face shield. She was surgical mask, in the hall and dent #226's room. Nurse #1 mask prior to entering the droplet precaution sign was door and a caddy containing s, N95 masks and face e on the door. Nurse #1 nd assisted Resident #226. d the room, she had already d placed in a trash can by the door. She kept on her intinued down the hall to the	F	380	be made to the plan as needed. 5. Completion Date: 9/18/23		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/12/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345083	B. WING			C /13/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH AND REHABILI	ΓΑΤΙΟΝ		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page the room and apply a the enhanced droplet stated it was her mist the N95 mask before should have removed mask when exiting the been trained on infect and knew she should N95 mask when takin patient. An interview was com Nursing (DON)/Infect 9/11/2023 at 11:42 AM have known to wear f room, to include chan mask and applying a Resident #226's room positive residents eac precaution sign on the PPE. The DON stated the door that instructed needed to enter the ro wearing a N95 mask room with enhanced of instructions included of protection and N95 m room. He indicated h	e 35 N95 as was instructed by precaution sign. Nurse #1 ake and she knew to apply entering the room and she l it and applied another e room. She stated she had tion control and prevention wear full PPE, including an g care of a Covid-19 ducted with Director of ion Preventionist on M: He stated staff should ull PPE in Resident #226's iging out of the surgical N95 mask prior to entering n. He revealed Covid-19 ch had an enhanced droplet eir door and a caddy with d staff had instructions on ed staff on what PPE was bom, this guidance included or higher before entering a droplet precautions. The wear gown, gloves, eye iask prior to entering the e would re-educate staff	F 880	DEFICIENCY)		
	special droplet contact that all staff are instru- hire, annually and any	PPE for residents with of precautions. He stated locted on infection control on ytime there is a need. The re-educate Nurse #1 one				

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