	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345083	B. WING		C 01/09/2025
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
HILLTOP I	HEALTH AND REHABILI	TATION		18 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 000		
F 000	investigation survey v 01/06/2024 through 0 found in compliance v	1/09/2024. The facility was with the requirement CFR Preparedness. Event ID	F 000		
F 679 SS=E	survey was conducte 01/09/2024. Event IE intakes were investig NC00219427, NC002 NC00212761 and NC 10 of 10 complaint all deficiency. Activities Meet Interest	18479, NC00215231,	F 679		1/22/25
	§483.24(c) Activities. §483.24(c)(1) The fact the comprehensive as and the preferences of program to support re- activities, both facility individual activities ar designed to meet the physical, mental, and each resident, encour and interaction in the This REQUIREMENT by: Based on record revi and resident and staff to ensure group activ- outside of the facility	is not met as evidenced ew, facility activity calendar, f interviews, the facility failed ities were planned for		 Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outsid of the facility to meet the needs of 	

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.

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		OMB NO. 0 (X3) DATE SUF	
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>	G		COMPLET	
						С	
		345083	B. WING			01/09/	2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE		
HILLTOP	HEALTH AND REHABILI	TATION		188 OSCAR JUST			
				RUTHERFORD	TON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BI S-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) OMPLETIC DATE
F 679	Continued From page	e 1	F 6	79			
		activities outside of the			vho expressed that it was		
		lents reviewed for activities			o them to attend group		
		26, #29, #37, #39 and #58).			utside of the facility for 7 of 7	7	
		sed not being able to leave		residents re	eviewed for activities (Reside	ent	
	-	year made them feel sad, at			26, #29, #37, #39 and #58). ⁻	The	
		ssed and they missed going			expressed not being able to		
	÷ .	engage in activities, eat at			acility for over a year made		
	restaurants, shop and	d socialize.			ad, at times lonely or	with	
	The findings included	4-			and they missed going out v o engage in activities, eat at		
		4.			s, shop and socialize.		
	A review of the 2024	and January 2025 activity			rent facility Residents are at	risk	
		ctivities for inside of the			fected by the deficient practi		
	facility during the wee	ek and on the weekends.			5, the Administrator, Activities		
	There were no activit	ies scheduled for outside of			nd designated Leadership		
	the facility.				bers performed 100% audit		
					ts to assess each Resident's	s	
	Oh			_ · ·	for out-of-facility group		
		25 at 10:00 AM revealed the a rural area that was within		accordingly	re plans were updated		
		ng distance to numerous			y. leasures that have been put	in	
		I shops, grocery stores, fast			sure the deficient practice d		
	food, and sit-down re				re as follows: The Activity		
	,				as educated by the		
					tor on the scheduling of out	of	
	a. Resident #1 was a	idmitted to the facility on		-	vities on 1/21/2025. New		
	12/18/22.				irectors will be educated upo		
					working their first shift. has		
		Minimum Data Set (MDS) ed Resident #1 felt that it			ed quarterly out-of-facility gro		
		b have activities that included			appropriate into the Activitie o include any Resident who	э 	
		acility and doing things in a		wishes to p			
		sessment further indicated			dministrator will complete an		
	Resident #1 was cog				onthly Resident Council minu		
		-		x3 months	to ensure all Residents feel		
		nducted with Resident #1 on			ut-of-facility activity preferen		
		uring Resident Council		-	net. The facility will monitor i	ts	
		re had not been a scheduled			actions to ensure that the	.	
	group activity outside	e of the facility over the past		deficient pr	ractice is corrected and will r	not	

Facility ID: 923556

If continuation sheet Page 2 of 13

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345083	B. WING		01/09/2025	
NAME OF F	ROVIDER OR SUPPLIER		1	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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLET	
F 679	 year at least. She agr Council members that during some of their F but they only had one people, and not enou accommodate everyor agreement with the or members that not beil and participate in gro sad and sometime de was not always able f and she would enjoy restaurant and order other people outside to look at Christmas I personal items. b. Resident #17 was 8/08/22. An annual Minimum I 8/14/24 indicated Resivery important to hav going outside of the fa group setting. The as Resident #17 was con 1/07/25 at 2:00 PM do meeting revealed she the past couple years scheduled group activid during Christmas 202 	reed with the other Resident t they had discussed this Resident Council meetings, a van that held only two gh transportation to one. Resident #1 was also in ther Resident Council ng able to leave the facility up activities made her feel epressed and that her family to come and visit with her being able to go to a her own food, socialize with of the facility, go bowling or ights, and shop for her own Data Set (MDS) dated sident #35 felt that it was e activities that included acility and doing things in a sessment further indicated gnitively intact. ducted with Resident #17 on uring Resident Council e had been at the facility for a and believed their last vity outside of the facility was t3. She was observed agreement with the other mbers that they had	F 67		uality ement : by the y ement	

Facility ID: 923556

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/27/2025 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345083	B. WING					C 09/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP	CODE		
				1	88 OSCAR JUSTICE ROAD			
HILLIOP	IEALTH 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B		(X5) COMPLETION DATE
F 679	other Resident Council able to leave the facilit activities made her fer would also enjoy bein socialize with other per shop for her own pers Christmas lights. c. Resident #26 was a 9/14/21. An admission Minimu 9/23/24 indicated Res very important to have going outside of the fa group setting. The ass Resident #26 was council meeting on 07 Resident #26 who wa President. She reveal had been no schedule facility since December able to go and look at stated during their res had discussed with th scheduling activities of current van only held to find transportation the everyone. She reveal activities outside of the and sometimes depre agreement with other that she would also lik activities that included	ves in agreement with the cill members that not being ity and participate in group el sad and unhappy and she g able to go to a restaurant, cople outside of the facility, sonal items, and to look at admitted to the facility on m Data Set (MDS) dated sident #26 felt that it was e activities that included acility and doing things in a sessment further indicated gnitively intact. ducted during the Resident 1/07/25 at 2:00 PM with s also the Resident Council ed during the meeting there ed activities outside of the er 2023 when they were c Christmas lights. She sident council meetings they e Activities Director about putside of the facility, but the two people, and it was hard that could accommodate ed not having scheduled e facility made her feel sad essed and she was in Resident Council members ke to have scheduled d going out to eat at a	F	679				
		l going out to eat at a Christmas lights, going to						

Facility ID: 923556

If continuation sheet Page 4 of 13

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/27/2025 MAPPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345083	B. WING		_		C 09/2025
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				188 OSCAR JUSTICE ROA	AD		
HILLTOP I	HEALTH AND REHABILIT	ATION		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 CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	- 4	F 67	9			
	the movies or bowling socializing with other	, going shopping, and people outside of the facility.					
	d. Resident #29 was a 8/22/20.	admitted to the facility on					
	very important to have going outside of the fa	esident #29 felt that it was activities that included acility and doing things in a sessment further indicated					
	1/07/25 at 2:00 PM du meeting revealed sind facility there had beer outside of the facility s stated they had discu- Director during their F about scheduling acti- and she believed the Administration about i one van that held two they didn't have enou accommodate everyo	ducted with Resident #29 on uring the Resident Council are she had been at the in no scheduled activities since Christmas 2023. She assed this with the Activities Resident Council meetings vities outside of the facility AD went and spoke with the t, but they currently only had people in wheelchairs, so gh transportation to ne. Resident #29 stated not y to participate in activities					
	outside of the facility of sometimes depressed have family that visite ordering items online shopping for them in- felt like the facility cou- with them being able group activity even or once a quarter. Resid like to be able to go to	nade her feel sad and I especially since she didn't d with her that often, and					

Facility ID: 923556

If continuation sheet Page 5 of 13

	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUU	וחו		(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		345083	B. WING				09/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH AND REHABILI			·	188 OSCAR JUSTICE ROAD		
THELTOP				I	RUTHERFORDTON, NC 28139		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
					DEFICIENCY)		
F 679	Continued From page	e 5	F	679	9		
		o to a Christmas parade or					
	to look at Christmas I	ights.					
	e. Resident #37 was	admitted to the facility on					
	4/23/21.						
	An annual Minimum [Data Sat (MDS) datad					
		Data Set (MDS) dated sident #37 felt that it was					
		e activities that included					
		acility and doing things in a					
		sessment further indicated					
	Resident #37 was co	gnitively intact.					
	An interview was con	ducted with Resident #37 on					
		uring Resident Council					
		ce she had been at the					
	•	n no scheduled activities					
	-	over the past year. She was					
	-	r head in agreement with the cil members that they had					
		some of their Resident					
		t they only had one van that					
	held only two people.	Resident #37 was also in					
	agreement with the o	ther Resident Council					
		ng able to leave the facility					
		up activities made her feel					
		epressed and she would to go to a restaurant and					
		ocialize with other people					
		watch a Christmas parade,					
	or to look at Christma						
	f. Resident #39 was a	admitted to the facility on					
	7/01/21.						
	An annual Minimum [Data Set (MDS) dated					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/27/2025 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345083	B. WING					C 09/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HILLTOP H	IEALTH 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 PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD B		(X5) COMPLETION DATE
F 679	very important to have going outside of the fa group setting. The ass Resident #39 was coo An interview was con 1/07/25 at 2:00 PM du meeting revealed sind facility there had beer outside of the facility i observed nodding her other Resident Counc discussed this during Council meetings, but held only two people. her head in agreemer Council members that facility and participate feel sad and sometim would also enjoy bein and order her own foo people outside of the	sident #39 felt that it was e activities that included acility and doing things in a sessment further indicated	F	679				
	g. Resident #58 was a 3/19/24.	admitted to the facility on						
	3/25/24 indicated Res very important to have going outside of the fa group setting. The as Resident #58 was cog							
	An interview was con	ducted with Resident #58 on						

Facility ID: 923556

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			OMB NO. 0938-039
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345083	B. WING		C 01/09/2025
		STREET ADDRESS, CITY, STA	•
		188 OSCAR JUSTICE ROAD)
IION		RUTHERFORDTON, NC	28139
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION CED TO THE APPROPRIATE EFICIENCY)
ng Resident Council she had been to the no scheduled activities he agreed with the other pers that they had vities Director during ngs about scheduling facility, but their current le, and they didn't have a r transport everyone. t having the opportunity to butside of the facility made mes lonely and she would o to a restaurant and d socialize with other shopping, go bowling or to at Christmas lights acted with the Activity 5 at 2:15 PM during the ng revealed she had been e facility for the past 3 sponsibilities was enting resident activities e facility for each month. egan working at the facility been able to schedule any soutside of the facility sportation issues. She uled outing was in dieved they were able to and a contracted that is no longer urrently the facility only had ly accommodate two	F	679	
	A 345083 TON MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION) And Resident Council she had been to the o scheduled activities he agreed with the other ers that they had ities Director during has about scheduling facility, but their current e, and they didn't have a transport everyone. having the opportunity to utside of the facility made mes lonely and she would to a restaurant and socialize with other shopping, go bowling or to at Christmas lights Cted with the Activity at 2:15 PM during the hg revealed she had been e facility for the past 3 sponsibilities was enting resident activities a facility for the facility portation issues. She led outing was in lieved they were able to and a contracted that is no longer rrently the facility only had	A BUILDI B. WING ID ID IMENT OF DEFICIENCIES ID ID ID ID PREFI ID ID PREFI ID PREFI TAG File Instant State Precedulation of the set	A BUILDING 345083 STREET ADDRESS, CITY, STA 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC ID PROVIDERS UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) ID PROVIDERS (EACH CORRES) UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) PREFIX REAL COUNCIL she had been to the o scheduled activities he agreed with the other ers that they had tites Director during gas about scheduling facility, but their current e, and they didn't have a transport everyone. having the opportunity to utside of the facility made mes lonely and she would to to a restaurant and socialize with other shopping, go bowling or to at Christmas lights cted with the Activity 6 at 2:15 PM during the gra revealed she had been facility for the past 3 sponsibilities was enting resident activities facility for the past 3 sponsibilities was inting resident activities facility for each month. gan working at the facility oper able to schedule any outside of the facility sportation issues. She uled outing was in lieved they were able to and a contracted that is no longer rrently the facility only had y accommodate two a time and was primarily

Facility ID: 923556

If continuation sheet Page 8 of 13

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/27/2025 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345083	B. WING				C / 09/2025
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 679	believed they were try with transportation so activities outside of th accommodate everyo been doing personal so they could continue to and assisting resident understood that was r being able to leave th themselves, eat a me go bowling, or to go o Christmas parade or to felt like activities outsi residents who could p their overall well- bein independence and so facility. During an interview or Administrator on 1/09 had been employed a Administrator since So believed the last sche facility was probably i stated the facility curr was only able to accoo time and was primaril appointments. He rev non-emergent transpo outings, but currently offered in their county transport or non-emer appointments only. Th agreed that activities of important for resident	ssue to Administration and ving to work on a solution they could schedule e facility and be able to one. She stated she had shopping for residents so or receive their preferences ts with on0line shopping, but not the same as residents e facility and shop for al together at a restaurant, in an outing to see the the lights. She revealed she ide of the facility for those participate were important for ag and allowed them some icialization outside of the n December 2023 and iduled activity outside of the n December 2023. He ently only had one van that immodate two residents at a y used for medical ealed they had looked at ortation for scheduled the only transportation if was either emergency rgent transport for medical he Administrator stated he outside of the facility were s and allowed them to keep	F	679			
	transport or non-emer appointments only. The agreed that activities important for resident	rgent transport for medical ne Administrator stated he outside of the facility were s and allowed them to keep idence and normalcy and he					

Facility ID: 923556

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		MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
ND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345083	B. WING		C 01/09/2025	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	01/00/2020	
HILLTOP I	HEALTH AND REHABILI	TATION	18 RI			
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
F 679	Continued From page	e 9	F 679			
	that were ambulatory be contacting transpo	residents especially those and in the meantime would ort companies to see if they em for some scheduled				
F 880 SS=D			F 880		1/22/25	
	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				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatir and communicable d staff, volunteers, visit providing services un arrangement based u	ipon the facility assessment to §483.71 and following				
	procedures for the pr but are not limited to:	llance designed to identify ble diseases or				

Facility ID: 923556

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					FORM	APPROVED 0. 0938-0391
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345083	B. WING				C 09/2025
ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			18	88 OSCAR JUSTICE ROAD		
	TATION		R	UTHERFORDTON, NC 28139		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		x			(X5) COMPLETION DATE
persons in the facility (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement that least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on observatio	in possible incidents of the or infections should be asmission-based precautions ent spread of infections; plation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable in lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact. and for recording incidents for ity's IPCP and the en by the facility. le, store, process, and to prevent the spread of riew. ct an annual review of its r program, as necessary. is not met as evidenced ins, record review and staff	F	880			
	S FOR MEDICARE & I S FOR MEDICARE & I PEDEFICIENCIES CORRECTION ROVIDER OR SUPPLIER HEALTH AND REHABILIT SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR I Continued From page persons in the facility: (ii) When and to whor communicable disease reported; (iii) Standard and trant to be followed to prev (iv)When and how isconselection resident; including but (A) The type and duration depending upon the initian involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances must prohibit employed disease or infected secontact with residents contact with residents contact will transmit the (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A systemi identified under the factor corrective actions take §483.80(e) Linens. Personnel must hand transport linens so ass infection. §483.80(f) Annual revert The facility will condu IPCP and update theit This REQUIREMENT by: Based on observation interviews, the facility	CORRECTION IDENTIFICATION NUMBER: JOENTIFICATION NUMBER: 345083 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A BUILDI 345083 B. WING ROVIDER OR SUPPLIER B. WING REALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIN Continued From page 10 persons in the facility; ID persons in the facility; ID (III) Standard and transmission-based precautions to be followed to prevent spread of infections; File (IV)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. 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WING	S FOR MEDICARE & MEDICAID SERVICES 0F DEFICIENCIES CORRECTION (X1) PROVIDERSUPFLERICLA DEPICIENCIES 345083 (X2) MULTIPLE CONSTRUCTION A BUILDING MULTIPLE CONSTRUCTION A BUILDING 345083 STREET ADDRESS, CITY, STATE, 2IP CODE 188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYING INFORMATION) FROM DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYING INFORMATION) Continued From page 10 persons in the facility; (ii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident, including but not limited to: (d) A Trequirement that the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. F 880 (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with resident contact. S483.80(a)(A) A system for recording incidents identified under the facility, \$483.80(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. \$483.80(I) Annual review. The facility Will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff int	MENT OF HEALTH AND HUMAN SERVICES OMB NC FORM EDICARE & MEDICALD SERVICES OMB NC PERFORMED (INTERCATION INMERIA 10ENTIFICATION INMERIA 345083 B. WING

Facility ID: 923556

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	MPLETED
						С
		345083	B. WING		(1/09/2025
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 880	Continued From page	e 11	F 88	30		
		ear gloves while performing a		and procedures when Nurse #	1 failed to	
		se test for Resident #36. This		wear gloves while performing		
	deficient practice occ			blood glucose test for Resider		
		or infection control practices.		deficient practice occurred for		
				members observed for infection		
	The findings included	1:		practices. Upon notification of		
				practice on 1/7/25, Director of		
		dated) entitled "Personal		(DON) provided immediate ed		
		t" read in part: "Personal t", or PPE refers to a variety		Nurse #1 on infection control procedures for capillary blood		
		e or in combination to protect		checks.	glucose	
	skin, from contact wit	-		2. Facility Residents who re-	ceive	
		Il staff who have contact with		capillary blood glucose tests a		
		PPE as appropriate during		being affected by the deficient		
		es in which exposure to blood		On 1/21/25, the DON and Nur		
	is likely.			Administration Team audited F	Residents	
				receiving capillary blood gluce		
		idated) entitled "Blood		to ensure staff were using glov		
		read in part: Procedure: 2.		indicated during procedure. The		
		ment and supplies: Gloves,		no significant concerns noted	during the	
	3. don gloves. 17. Re	emove and discard gloves.		audit. 3. The measures that have l	boon nut in	
	An observation was d	completed on 1/7/2025 at		place to ensure the deficient p		
		performing a blood glucose		not recur are as follows: 100%		
		. After entering Resident		completed on 1/21/25 to all lic		
		1 located Resident #36's		nurses and Certified Medicatio		
		is stored in a top drawer.		infection control policies and p		
	Nurse #1 was observ	ed opening an alcohol pad		when performing capillary bloc	od glucose	
		and wipe Resident #36's		tests. Newly hired licensed nu	-	
	-	ol pad. When asked if she		and certified med aides not ec	-	
	normally wore gloves			1/21/2025 will be educated pri	or to	
		rs Nurse #1 stated, "I do with		working their next shift.	min toom	
		#1 continued to use a p of blood from Resident		4. The DON and Nursing Ad		
		ied the blood to the test strip		will complete an audit of 5 Res receiving capillary blood gluce		
		ometer without wearing		to ensure staff were using glov		
		od glucose results were		indicated during procedure 3 t		
	-	laced the glucometer into		for four (4) weeks, then week	-	
		ack into Resident #36 s top		weeks, then bi-weekly x four (

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 01/27/2025 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING			(X3) DATE SURVEY COMPLETED		
345083		B. WING			C 01/09/2025			
NAME OF PROVIDER OR SUPPLIER			•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HILLTOP HEALTH AND REHABILITATION				188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 drawer. Nurse #1 collected all trash and used supplies, holding the used test strip and gauze from Resident #36 in a paper towel. Nurse #1 returned to the medication cart, disposed of lancet in the sharps container, threw away trash, cleansed her hands with alcohol-based hand sanitizer. During an interview on 01/07/25 at 4:17pm the Director of Nursing (DON) stated she expected the nurses to follow proper guidelines for performing blood glucose monitoring. The DON expected nurses to perform hand hygiene before putting on gloves, then for the nurses to perform blood glucose monitoring per facility protocol, then to take gloves off and perform hand hygiene. During an interview on 1/9/2025 at 12:25pm the Administrator stated he expected nurses to wear gloves when completing blood sugar checks, and to follow the facility's Personal Protective Equipment and Blood Glucose Monitoring policies.		F	880	The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur reviewing information collected during audits and reporting to Quality Assurant Performance Improvement Committee Data will be brought by the Administrat to review in Quality Assurance Performance Improvement meetings a changes will be made to the plan as necessary to maintain compliance. 5. Completion Date: 1/22/25	nce tor		

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