STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345083	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Health and Rehabilitation	**188 Oscar Justice Road , Rutherfordton, North Carolina, 28139**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/09/26 through 03/12/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F2D38-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/09/26 through 03/12/26. Event ID #1F2D38-H1. The following intake was withdrawn by the complainant during the survey but was unable to unlinked from the survey due to technical limitations with the IQIES system: intake #2690152.	F0000		03/27/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the	F0761	The facility failed to secure insulin injector pens during medication administration, failed to date and label opened insulin injector pens, and failed to remove expired injector pens. This deficient practice was found in 1 of 2 medication carts reviewed for medication storage (Medication Cart #1). Upon identification of unlabeled (no open date) and expired insulin on the medication cart, the insulin was immediately removed from use and properly discarded per facility policy by the Director of Nursing (DON) on 3/9/2026. A replacement insulin supply was obtained from pharmacy without delay to ensure no interruption in resident care. No adverse outcomes were identified. The licensed nurse responsible was reeducated on proper labeling and expiration requirements per facility policy and manufacturer guidelines. Current facility residents with an active order for insulin is at risk of being affected by the deficient practice. A 100% audit of all medication carts and medication rooms was conducted by the Unit Manager or designee to identify any additional unlabeled or expired insulin on 3/10/2026. This audit included verification of open dates, expiration dates, and proper storage conditions for insulin. Any discrepancies identified were immediately corrected, including removal and replacement of expired or	04/01/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0761 SS = D	Continued from page 1 facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to secure insulin injector pens during medication administration, failed to date and label opened insulin injector pens, and failed to remove expired injector pens. This deficient practice was found in 1 of 2 medication carts reviewed for medication storage (Medication Cart #1). The findings included: 1. During a continuous observation of the medication administration with Nurse #1 on Medication Cart #1, conducted on 03/09/26 at 4:00 PM through 4:39 PM, four insulin injector pens were left unattended on top of the medication cart. At 4:22 PM, Nurse #1 walked away from the medication cart, into Resident #60's room and out of eyesight of the medication cart with. The four insulin injector pens were left unattended on top of the medication cart. Nurse #1 returned to the medication cart at 4:23 PM. A Resident was sitting beside medication cart waiting for her medication when Nurse #1 walked away. At 4:38 PM, Nurse #1 walked away from the medication cart around the corner and down the hall out of eyesight of the medication cart. Nurse #1 returned to the medication cart at 4:39 PM. The four insulin injector pens were left unattended on top of the medication cart. The same Resident was still sitting beside medication cart waiting for her medication when Nurse #1 walked away. An interview with Nurse #1 was conducted on 03/09/26 at 4:40 PM. Nurse #1 stated that the insulin injector pens belonged on the other medication cart (Medication Cart #2), and she did not realize she had left the insulin injector pens unsecured on top of Medication Cart #1 when she walked away twice. Nurse #1 verbalized she knew she should not have left medication on the cart unattended. Nurse #1 explained that because the medication aide could not administer insulin, Nurse #1 had administered the insulin that morning. Nurse #1 stated she placed those insulin injector pens into Medication Cart #1 and had not returned them to Medication Cart #2 due to time constraints. Nurse #1 indicated she placed the medication on top of the cart to remind herself to return them. 2. A review of the facility policy revised 01/01/26 titled "Insulin Pen" stated in part, "insulin pens must	F0761	Continued from page 1 improperly labeled insulin. Results of the audit were documented and reviewed by the Director of Nursing (DON)/designee, with no additional systemic concerns identified beyond those corrected at the time of audit. 1 additional insulin that expired on the day of audit was pulled from medication cart. To ensure the deficient practice does not recur the facility has reinforced and standardized the process for insulin labeling and storage to ensure ongoing compliance. All licensed nursing staff were re-educated by 3/31/2026 by the DON or designee on requirements including: (1) labeling all insulin with the date opened upon first use, (2) adhering to manufacturer-defined shortened expiration times, (3) verifying medication integrity prior to each administration, and (4) proper disposal of expired medications. A standardized visual cue has been implemented on all medication carts to prompt nurses to verify open dates prior to administration. Newly hired licensed nurses and staff not educated by 3/31/2026 will be educated upon hire or prior to working their next shift. To ensure sustained compliance, the facility will implement ongoing audits of medication carts and insulin supplies. The Unit Manager/Designee will complete medication storage audits 3 times a week x 4 weeks, then weekly for 8 weeks. Audits will include verification of open dates, expiration dates, and proper storage. The data from audits will be brought to the facilities Quality Assurance Performance Improvement (QAPI) by the DON. Findings will reviewed through the facility's QAPI program for 3 months, with corrective action taken for any identified variances. Any identified non-compliance will trigger immediate re-education and follow-up audit. The administrator is responsible for ensuring the plan of correction is completed. 5. Completion Date: 4/1/2026	

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F0761 SS = D	Continued from page 2 be clearly labeled with date dispensed and expiration date." - An observation of Medication Cart #1 with Nurse #1 on 03/09/26 at 4:15 PM revealed the following: - One Novolog insulin injector pen for Resident #5 was opened with 12 units remaining. The insulin injector pen contained a blank label without an open date or an expiration date documented, - One Lantus insulin injector pen for Resident #45 was opened with 80 units remaining. The insulin injector pen contained a blank label without an open date or an expiration date documented, - One Novolog insulin injector pen for Resident #6 was opened with 100 units remaining. The insulin injector pen contained a blank label without an open date or an expiration date documented, - One Aspart insulin injector pen for Resident #59 opened on 01/08/26 with an expiration date of 02/04/26. A review of the manufacturer's directions September 2025 for insulin Aspart pens stated they should be discarded 28 days after opening. - One Liraglutide injection pen for Resident #69 opened on 01/10/26 with an expiration date of 02/06/26. A review of the manufacturer's directions January 30, 2026, for Liraglutide (a GLP 1 medication used for diabetes) stated it should be discarded 30 days after opening. Nurse #1 was interviewed on 03/09/26 at 4:48 PM. Nurse #1 stated she did not know why the insulin injector pen for Resident #5 and Resident #45 were not dated, and she verbalized she did not know how long the insulin had been opened in the medication cart. Nurse #1 stated she had opened the insulin injector pen for Resident #6 at 12:00 PM on 03/09/26 and administered 4 units at that time. Nurse #1 verbalized she forgot to date it when she opened the insulin injector pen. Nurse #1 indicated she was aware she should have dated it at the time it was opened. Nurse #1 stated she did not know why the insulin injector pen for Resident #59 was still in the medication cart. She verbalized insulins should be discarded after 28 days. Nurse #1 stated she did not know why the Liraglutide injector pen for Resident #69 was still in the medication cart. She verbalized she thought it should be discarded after 28 days.	F0761		

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F0761 SS = D	Continued from page 3 During an interview conducted with the Director of Nursing (DON) on 03/12/26 at 10:42 AM, she stated all nursing staff should be attentive during medication administration to ensure no medications were left unattended within reach of residents or visitors. The DON verbalized the nurse opening an injector pen was responsible for labeling all medications with the opened date and expiration date at the time it was opened. Labeled injector pens ensured that nurses did not use expired medications. The DON stated that insulin expired 28 days after opening, and GLP 1 medications expired 30 days after opening per manufacturer's and pharmacy recommendations. Expired medications were required to be removed from the medication cart, discarded, and replaced with new ones. An interview conducted with the Administrator on 03/12/26 at 11:06 PM. The Administrator stated all nursing staff should ensure no medications were left unattended during medication administration. The facility should remain free of unsecured medications. Also, all nursing staff should label medication with the date and expiration date when it was opened. Nursing staff should not use expired medication and should dispose of and replace expired medication.	F0761		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842	F842 1.Based on record review, and staff and Nurse Practitioner interviews, the facility failed to ensure an accurate medical record when medications were ordered by mouth instead of via gastrostomy tube (g-tube) for Resident #4. The facility also failed to accurately document the refusal of Resident #8's compression hose on the Treatment Administration Record (TAR). This was for 2 of 2 residents reviewed for accuracy of the medical record (Resident #4 and Resident #8). For Resident #4, all active medication orders were immediately reviewed and corrected to accurately reflect the prescribed route of administration (gastrostomy tube versus oral) by the Vice President of Clinical Operations (VPCO). The Medication Administration Record (MAR) was updated to ensure alignment with the physician's orders, and licensed nursing staff were educated to verify route prior to administration. For Resident #8, documentation related to the refusal of compression hose was corrected on the TAR to accurately reflect the resident's refusal. The physician was notified of the refusal and the order was discontinued, and the care plan was reviewed and updated as appropriate to reflect the resident's preferences and clinical needs by the VPCO. No adverse outcomes were identified for either resident.	04/01/2026

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F0842 SS = D	Continued from page 4 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and	F0842	Continued from page 4 2.Current facility residents are at risk of being affected by the deficient practice. 3/26/2026 a 100% audit of current residents with enteral feeding tubes was conducted to verify that all medication orders accurately reflected the correct route of administration and that the MAR matched physician orders by the VPCO. 4 additional orders had to have administration route corrected. Additionally, a 100% audit of compression hose orders was conducted to ensure that refusals were consistently and accurately documented by the unit manager (UM). Any discrepancies identified were immediately corrected, including updating orders, MAR/TAR entries, and ensuring physician notification where indicated. Results of the audit were reviewed by the Director of Nursing (DON)/designee with corrective actions implemented at the time of discovery. No further issues were noted during the compression hose audit. 3.To ensure the deficient practice does not recur the facility has reinforced and standardized processes to ensure accuracy of medical record documentation. Licensed nursing staff were re-educated on: (1) verification of medication orders including route prior to transcription and administration, (2) accurate documentation of treatments including refusals on the TAR, and (3) requirements for physician notification and care plan updates related to refusals. The education was completed by the DON or designee by 3/31/2026. A secondary verification process has been implemented where the nurse managers will review the order listing reports each morning during clinical and ensure the correct route is indicated on new orders. Newly hired licensed nurses and treatment aides and staff not educated by 3/31/2026 will be educated upon hire or prior to working their next scheduled shift by the DON or designee. 4.The DON/designee will conduct audits to ensure ongoing compliance with accurate documentation practices. Audits will include review of residents with enteral feeding tubes for correct route documentation and review of compression hose orders for accurate documentation of refusals. Audits will be conducted 3x a week x 4 weeks, then weekly x4 weeks and then monthly x1 month. Audit findings will be brought by the DON to the facilities monthly Quality Assurance Performance Improvement meeting and reviewed to ensure compliance for 3 months. The administrator is responsible for ensuring the plan of correction is completed. 5. Completion Date: 4/1/2026	

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F0842 SS = D	Continued from page 5 resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Nurse Practitioner interviews, the facility failed to ensure an accurate medical record when medications were ordered by mouth instead of via gastrostomy tube (g-tube) for Resident #4. The facility also failed to accurately document the refusal of Resident #8's compression hose on the Treatment Administration Record (TAR). This was for 2 of 2 residents reviewed for accuracy of the medical record (Resident #4 and Resident #8). Findings included: 1. Resident #4 was initially admitted to the facility on 04/11/24 with a readmission date of 10/02/24. A review of Resident #4's physician orders revealed an order dated 10/13/24 Diet: NPO-nothing by mouth. An order dated 08/27/25 read: lorazepam (a benzodiazepine medication used for anxiety) 0.5 milligram one (1) tablet by mouth twice daily for anxiety. An order dated 09/26/25 read: sertraline (an antidepressant medication) 100 milligrams by mouth daily for depression. An order dated 11/17/25 read: geri-tussin DM (cough syrup containing a cough suppressant dextromethorphan) 100 milligrams/milliliter give 10 milliliters (200 milligrams) by mouth twice daily for congestion. A review of Resident #4's March 2026 Medication Administration Record (MAR) revealed Resident #4's lorazepam, sertraline, and geri-tussin were documented as administered as ordered on the MAR every shift from 03/01/26 through 03/11/26. An interview was conducted on 03/09/26 at 4:43 PM with Nurse #1. Nurse #1 revealed she worked with Resident #4 on a regular basis and was assigned to him on 03/09/26. Nurse #1 stated that Resident #4 was NPO and he always	F0842		

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F0842 SS = D	Continued from page 6 received all his medications crushed through his gastrostomy tube (g-tube). Nurse #1 indicated she had not noticed that some of his medications were ordered by mouth and not via g-tube on the MAR. Nurse #1 stated that she had never administered his medication by mouth but had always administered it all through his g-tube. An interview was conducted on 03/11/26 at 1:52 PM with Nurse #2 who was assigned to Resident #4 on 03/11/26. Nurse #2 stated that she worked with Resident #4 on a regular basis. Nurse #2 explained that Resident #4 was NPO due to dysphagia from a previous stroke and all his medications were crushed and administered through his g-tube. Nurse #2 stated that when orders were put into the electronic medical record (EMR), the route of administration defaulted to “by mouth” and had to be manually changed to g-tube. Nurse #2 verbalized she had noticed that some of Resident #4’s medications were ordered by mouth on the MAR but failed to correct it due to time constraints. Nurse #2 stated that Resident #4 had not received his medication by mouth and stated he would have refused it because he was aware that he could not have anything by mouth. An interview with the Nurse Practitioner (NP) was conducted 03/11/26 at 2:54 PM. The NP stated that Resident #4 had severe dysphagia from a previous stroke and was unable to take medication, liquid, or food by mouth. Resident #4 was at risk for aspiration pneumonia (pneumonia caused by inhalation of food or liquid) because of his dysphagia. The NP verbalized that she entered the orders for Resident #4 in the EMR and the administration route was entered as “by mouth” in error. The NP explained that the EMR defaulted to by mouth and had to be manually changed, which she had not done when the orders were entered. The NP stated that Resident #4 had not received his medications by mouth to her knowledge but had received them via G-tube as he should have. The NP explained that if he had received them by mouth, he may have developed aspiration pneumonia but Resident #4 had not had any respiratory concerns. An interview was conducted on 03/12/26 at 10:42 PM with the Director of Nursing (DON). The DON stated Resident #4's medication orders should have been entered into the EMR with the correct route of administration. The DON stated nursing staff should correct any inaccurate orders on the MAR immediately. The DON stated that to her knowledge, no medication had been administered to Resident #4 by mouth. An interview conducted on 03/12/26 at 11:06 PM with the Administrator revealed the nursing staff should have	F0842		

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F0842 SS = D	Continued from page 7 accurately documented medication orders in the medical record. 2. Resident #8 was admitted to the facility on 3/7/2021. A physician order written on 11/16/23 revealed an order for knee high compression hose to be put on in the morning and removed in the evening before bedtime. Review of the March 2026 Treatment Administration Record (TAR) revealed compression hose had been initialed by staff each day indicating that the compression hose had been put on the resident every morning and removed every evening except the evening of March 4, 2026. Further review of the March 2026 TAR revealed that Nurse Aide (NA) #1 had initialed the compression hose 7 out of 11 days as being put on. An observation of Resident #8 was made on 3/11/26 at 1:16 PM and there were no compression hose in place at that time. An interview was conducted with NA #1 on 3/11/26 at 3:19 PM. NA #1 was responsible for treatments of Resident #8. NA #1 revealed that Resident #8 did not wear compression hose. Nurse aide #1 stated she was not sure why she had marked on the TAR that her compression hose were being put on. An interview was conducted with Nurse #2 on 3/11/26 at 3:30 PM who frequently cared for Resident #8. Nurse #2 stated that Resident #8 refused her compression hose frequently and she could not remember the last time she had worn them. She reported that if a resident refused treatment, it should have been marked as a refusal on the TAR and not initialed as being done on the TAR. An interview was conducted with the Assistant Director of Nursing (ADON) on 3/11/26 at 3:22 PM. She indicated that Resident #8 refused her compression hose a lot. She reported that she could not remember the last time Resident #8 had worn the compression hose. The ADON stated that if a resident refused a treatment, then it should have been marked on the TAR as a refusal and should not have been initialed as being done. An interview was conducted with the Director of Nursing on 3/11/26 at 4:30 PM. The Director of Nursing stated she would have expected her nursing staff to not mark a treatment on the TAR had it not been performed. She reported there was a code for refusal and that is what she expected to be used when a treatment was refused.	F0842		

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