

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  Hilltop Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  336 Edgewood Drive Pineville, LA 71360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure a resident's right to be free from neglect by failing to provide the necessary care and services to 1 (Resident #1) of 3 (Resident #1, Resident #2 and Resident #3) sampled residents. Findings:The deficient practice resulted in an Immediate Jeopardy situation for Resident #1 on 07/24/2025 at approximately 2:30 a.m. when Resident #1 was found on the floor by S3 LPN and complained of neck pain. Resident #1 was placed back into bed and S3 LPN failed to notify the Physician of Resident #1's fall and failed to medicate Resident #1 for complaints of pain. Resident #1 sustained a second fall on 07/24/2025 at 4:30 a.m. and then complained of neck, back, and head pain at that time. Resident #1 was transported to the hospital on [DATE] at 7:40 a.m. and was diagnosed with a fracture of his C-4, C-5 and C-6. Pain medications that were ordered and available for Resident #1 were not administered.S1 Administrator was notified of the Immediate Jeopardy situation on 08/27/2025 at 2:45 p.m.This deficient practice continued at a potential for more than minimal harm for all residents in the facility that had the potential to fall or required the need for pain medications. The census was 89.Findings: On 08/25/2025, a review of the facility's policy titled Abuse-Neglect Prevention Manual with a revision date of 04/03/2025, revealed in part., Definitions: (G). Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. On 08/25/2025, a review of the facility's policy titled Falls, with no revision date, revealed in part.Procedure: 3. Ascertain extent and type of injury.4. Make resident as comfortable as condition permits.5. Notify physician for further orders. Follow nursing interventions if required.6. Notify family or guardian.7. Document details in nurses' notes. (All shifts will complete a follow-up note for at least 72 hours.)8. Fill out incident/accident formReview of Resident #1's medical record revealed an admit date of 07/21/2025 with diagnoses that included in part.Heart Disease Unspecified, Dementia in other Diseases, Mood Disturbance, Anxiety and Type II Diabetes Mellitus. Review of Resident #1's Discharge MDS with an ARD of 07/26/2025 revealed a BIMS score of 5 indicating severe cognitive impairment. Review of Resident #1's MDS revealed he required supervision or touching assistance with oral hygiene, personal hygiene; partial/moderate assistance with toileting hygiene, bathing and set-up or clean up assistance with eating. Resident #1 used a manual wheelchair for mobility had no impairments to upper/lower extremities. Review of Resident #1's care plan with a target date of 10/19/2025 revealed in part.1. Physical mobility impaired with interventions that included to assist with bed mobility, transfers, locomotion as necessary or requested, monitor for decline in mobility and notify physician of changes.2. Self-care deficit with interventions that included for resident to receive person-centered care; needs with assist with bathing, hygiene, dressing, and grooming.3. High Risk for falls related to Cerebrovascular Accident and Heart Disease with interventions that included turn bars on bed times two to assist with mobility, assist with transfers as needed, keep assistive devices in reach, keep bed in lowest position with wheels locked, and keep call light in reach. Review of an incident report dated 07/24/2025 at 4:30 a.m. by S4 LPN revealed in part .Nursing Description: This nurse was notified by CNA that resident was lying on the floor. As this nurse entered the room this nurse observed resident lying on the floor on his back between the bed and the air conditioner. Resident stated he didn't know what happened or how he got on the floor. No injuries noted anywhere to residents body upon full body assessment. Range of Motion within normal limits. Resident stated he was having some back, head and neck pain. Daughter notified of incident and transfer of resident to ER to be evaluated and treated. Immediate Action Taken: Full body assessment, Vital signs taken, pain assessment, assisted back into bed x 3 person assist to wait on ambulance to transfer to hospital. Level of Pain-10. Review of Resident #1's Medication Administration Record and Narcotic Log revealed no documentation of pain medicine administered on 07/24/2025. Review of Resident #1's nursing progress notes dated 07/24/2025 at 7:40 a.m. by S2 DON revealed in part. ambulance here to transport resident to the hospital per stretcher due to pain from fall. Nursing progress note dated 07/24/2025 at 1:20 p.m. revealed in part. report received from the hospital regarding resident. Nurse reports CT of the head clear but neck shows C-4 and C-5 fracture and resident will be coming back to the nursing home in a C-collar and to follow up with neurosurgery in 2 weeks. Family aware and has been at the hospital with resident. Review of Resident #1's x-ray dated 07/24/2025 revealed in part.CT of Cervical Spine without contrast. History: Neck pain, fall. Impression: Osteoporosis, mild anterior subluxation C4-C5 and prior anterior and posterior bony fusion C5-C7 Transverse fracture through the body of C5 with additional</p>		

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview the facility failed to provide care and services that met professional standards of quality for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents, by failing to ensure physician orders were followed timely for the management of pain, and timely hospital transfer after a fall. Findings: The deficient practice resulted in an Immediate Jeopardy situation for Resident #1 on 07/24/2025 at approximately 2:30 a.m. when Resident #1 complained of neck pain after being found on the floor by S3 LPN. S3 LPN failed to notify the physician of the fall and failed to administer pain medications that were ordered and available to give. Resident #1 sustained a second fall on 07/24/2025 at 4:30 a.m. and complained of neck, back, and head pain at a 10 out of 10 on the pain scale at that time. Resident #1 was not transferred to the hospital for evaluation until 3 hours after transfer orders had been given to S3 LPN. On 07/24/2025 at 1:20 p.m. the hospital notified the facility that Resident #1 had a fracture of his C-4, C-5 and C-6. S1 Administrator was notified of the Immediate Jeopardy situation on 08/27/2025 at 2:45 p.m. This deficient practice continued at a potential for more than minimal harm for all residents in the facility. The census was 89. Findings: Review of a facility's policy titled Code of Ethics with no revision date, revealed in part. 2. Facility maintains accurate and reliable clinical documentation to insure that all patient care services are medically necessary and conform with all requirements for the delivery of quality patient care services. Review of a facility's policy titled Code of Conduct, with no revision date, revealed in part. The Code of Conduct is in effect at this facility to protect the rights and safety of all employees and patients. Any employee guilty of any of the following will be subject to immediate dismissal: (21). Inefficiency, inability and/or gross or repeated negligence in the performance of assigned duties. Review of Resident #1's medical record revealed an admit date of 07/21/2025 with diagnoses that included in part. Heart Disease Unspecified, Dementia in other Diseases, Mood Disturbance, Anxiety and Type II Diabetes Mellitus. Review of Resident #1's Discharge MDS with an ARD of 07/26/2025 revealed a BIMS score of 5 indicating severe cognitive impairment. Review of Resident #1's MDS revealed he required supervision or touching assistance with oral hygiene, personal hygiene; partial/moderate assistance with toileting hygiene, bathing and set-up or clean up assistance with eating. Resident #1 used a manual wheelchair for mobility had no impairments to upper/lower extremities. Review of Resident #1's care plan with a target date of 10/19/2025 revealed in part. 1. Physical mobility impaired with interventions that included to assist with bed mobility, transfers, locomotion as necessary or requested, monitor for decline in mobility and notify physician of changes. 2. Self-care deficit with interventions that included for resident to receive person-centered care; needs with assist with bathing, hygiene, dressing, and grooming. 3. High Risk for falls related to Cerebrovascular Accident and Heart Disease with interventions that included turn bars on bed times two to assist with mobility, assist with transfers as needed, keep assistive devices in reach, keep bed in lowest position with wheels locked, and keep call light in reach. Review of an incident report dated 07/24/2025 at 4:30 a.m. by S4 LPN revealed in part. Nursing Description: This nurse was notified by CNA that resident was lying on the floor. As this nurse entered the room this nurse observed resident lying on the floor on his back between the bed and the air conditioner. Resident stated he didn't know what happened or how he got on the floor. No injuries noted anywhere to residents body upon full body assessment. Range of Motion within normal limits. Resident stated he was having some back, head and neck pain. Daughter notified of incident and transfer of resident to ER to be evaluated and treated. Immediate Action Taken: Full body assessment, Vital signs taken, pain assessment, assisted back into bed x 3 person assist to wait on ambulance to transfer to hospital. Level of Pain-10. Review of Resident #1's Medication Administration Record and Narcotic Log revealed no documentation of pain medicine administered on 07/24/2025. Resident #1 had Tramadol HCL 50 Milligrams by mouth every 12 hours as needed for moderate to severe pain ordered and available. Review of Resident #1's nursing progress notes dated 07/24/2025 at 7:40 a.m. by S2 DON revealed in part. ambulance here to transport resident to the hospital per stretcher due to pain from fall. Nursing progress note dated 07/24/2025 at 1:20 p.m. revealed in part. report received from the hospital regarding resident. Nurse reports CT of the head clear but neck shows C-4 and C-5 fracture and resident will be coming back to the nursing home in a C-collar and to follow up with neurosurgery in 2 weeks. Family aware and has been at the hospital with resident. Review of Resident #1's x-ray dated 07/24/2025 revealed in part. CT of Cervical Spine without contrast History: Neck pain, fall Impression: Osteoporosis, mild anterior subluxation C4-C5 and prior</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview the facility failed to ensure that the nurse staffing pattern was posted daily. The facility census was 89. Findings: Observation on 08/25/2025 at 11:00 a.m. of the posted facility staffing pattern revealed a date of 08/13/2025. Observation and interview on 08/25/2025 at 2:35 p.m. with S2 DON and S10 RN/Charge Nurse stated the [NAME] Clerk had quit abruptly and she was responsible for the daily posting of the facility's staffing pattern. S2 DON confirmed the posted facility staffing sheet was dated 08/13/2025 and did not reflect the current date or staffing, and it should.</p>