STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, NC 28139

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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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, (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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 accurately documented medication orders in the medical record.

2. Resident #8 was admitted to the facility on [DATE].

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been performed. She reported there was a code for refusal and that is what she expected to be used when a treatment was refused.