STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure one (1) of two (2) residents reivewed for pressure ulcers were not neglected. Resident #1 entered the facility without a pressure ulcer. He was discharged to another facility (nursing home). An assessment completed within 40 minutes after his discharge from the facility revealed a deep foul smelling wound to the coccyx. Resident #1 sustained actual harm. Resident identifier: #1. Facility Census: 118 Findings Include: a) Resident #1 Resident #1 was admitted to the facility on [DATE] from a critical illness recovery hospital. He had been at that facility from 01/22/25 - 02/18/25. He had previously been at another acute care hospital from [DATE] - 01/22/25. He was sent to the acute care hospital on [DATE] after his percutaneous endoscopic gastrostomy tube malfunctioned. While hospitalized he had two (2) surgeries and left the hospital on [DATE] with a surgical wound to the left and right abdomen. Due to postoperative complications a wound vac was placed for healing purposes. Upon admission to Facility #1, there was an admission progress note, and skin check performed. Documentation shows the resident arrived on 02/18/25 at 10:30 PM. Observation of the skin assessment was documented as (absent of any related wounds to coccyx). New skin Issue. Location: Left Lower Quadrant Midline. Issue type: Surgical wound. Wound was present on admission. Length (cm): 3.5 Width (cm): 0.6 Depth (cm): 0.1#002: New skin Issue. Location: Right Lower Quadrant Midline. Issue type: Surgical wound. Wound was present on admission. Length (cm): 9.8 Width (cm): 4.8 Depth (cm): 0.2#003: New skin Issue. Location: Left heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstagable pressure injuries presenting as deep tissue injury. Wound was present on admission. Length (cm): 5.6 Width (cm): 4.4 Depth (cm): 0#004: New skin Issue. Location: Right heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstagable pressure injuries presenting as deep tissue injury. Wound was present on admission. Length (cm): 1.9 Width (cm): 1.3 Depth (cm): 0 (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
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	Additional skin checks were performed weekly on 02/25/25, 03/05/25, 03/12/25, 03/19/25, 03/26/25, 04/02/25 and 04/09/25. Random dated copies were provided for review for the following dates: 02/18/25 (admission), 02/26/25, 03/19/25, 04/02/25, 04/09/25. (absent of any related wounds to coccyx). In addition, the facility provided the latest skin and wound evaluations. 04/02/25 documented surgical wound to left lower quadrant abdomen 04/02/25 documented surgical wound to right lower quadrant abdomen 04/02/25 documented surgical wound, dehiscence to right lower quadrant abdomen 04/02/25 documented pressure deep tissue injury to left heel 04/02/25 documented pressure deep tissue injury to left heel On 05/12/25 Residents #1s medical records were reviewed. A Braden scale for predicting pressure risk was completed on the following days resulting in the following scores: 02/29/25 - 10 which indicated the resident was at a high risk of developing pressure ulcers. 02/25/25 - 10 which indicated the resident was at a high risk of developing pressure ulcers 03/05/25 - 11 which indicated the resident was at a high risk of developing pressure ulcers 03/12/25 -11 which indicated the resident was at a high risk of developing pressure ulcers Resident #1's care plan was reviewed and showed a focus area for the resident being at risk for skin breakdown due to decreased activity, frail fragile skin, impaired condition, incontinence, limited mobility, recent surgery and pressure areas to the left and right heel, a surgical site to the left and right lower abdomen. The goal associated with this focus area was for the pressure areas and surgical sites to heal upon review and for the resident's wound/skin impairment to heal as evidenced by a decrease in size, absence of erythema and drainage and/or pressure ulcer: Interventions related to his goal included: - Enhanced Barrier Precautions - Heels up device while in bed as resident will allow - Low air loss mattress to bed, weekly hand checks to monitor settings - Negative pressure wound therapy to right lower ABD per orders - pro mattress to bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	- Pad side rails/wheelchair or other equipment as necessary - Pat (do not rub) skin when drying - Provide patient and/healthcare decision maker education regarding risk factors and interventions - Provide preventative skin care i.e. lotions, barrier creams as ordered. - Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanch easily. - Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation. - Observe skin condition daily with ADL care and report abnormalities. - Observe for verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered. - Obtain dietitian consult as needed/ordered - Obtain skilled PT/OT evaluation to improve functional mobility. - Provide wound treatment as ordered - Provide supplements as ordered. - Weekly skin check by license nurse - Weekly wound assessment to include measurements and description of wound status. The care plan also indicated the following related to Activities of Daily Living (ADL) assistance required by Resident #1. Resident requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, - dressing, eating, bed mobility, transfer, locomotion, toileting related to hx (history) of Cerebrovascular Accident (CVA) VA with paraplegia affecting both sides. Resident is incontinent of bladder and bowel and is unable to cognitively and physically participate in a retaining program due to total lift status, neurocognitive disorder. During an interview on 05/13/25 with the Director of Nursing, she stated Nurse Aides do not document each time they turn the residents, they only document if they turn the resident during that shift. Medical Record documentation on the following days showed the resident was not turned for each of the three (3) shifts. 03/11/25, 03/16/25, 03/18/25, 03/25/25, 03/30/25, 04/08/25. When asked why all three shifts were not documented, she could not provide an answer. A review of the physician's orders for Resident #1 from the time of admission until the time discharged found no orders related to pressure ulcer treatment and/or prevention for his coccyx. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #1s discharge progress note completed by Licensed Practical Nurse #8 states a skin check was completed, however there is no skin check or skin, and wound evaluations documented for 04/10/25 (discharge date). There was no written discharge skin and wound evaluation documentation noted. Treatment Administration Records (TAR) for February, March and April 2025 found no wound treatments were missing. (absent of any related wounds to coccyx) On 05/12/25 at 1 PM during an interview with Licensed Practical Nurse (LPN) #6 she states she does 99% of all wound care. She said she was responsible for weekly skin checks and skin and wound evaluations. LPN #6 said if there is a new wound identified by an LPN or Nurse Aid, she also assessed that wound if she was in the facility. If not, the LPN assesses it, and LPN #6 follows up when LPN #6 returned. When asked to identify wounds that Resident #1 had upon discharge, she stated He had two abdominal surgical wounds, one on each side, bilateral DTI's (deep tissue injuries) to his heels. She denied any knowledge of a wound to his coccyx. When asked if there was ever a time when a dressing would be in place without a physicians order, she stated no. On 05/13/25 at 12:55 PM during a telephone interview with the Medical Director for the facility, he said he did not perform skin checks on residents. He said he depended on documentation from the staff. On 05/12/25 at 4:20 PM the surveyor went to the facility where the resident was discharged to. LPN #3 took report from the facility on 04/10/25. She stated the report consisted of when his last bowel movement was, his vital signs, his tube feeding details. She states the only report obtained concerning skin status, was that there were no new issues. LPN #4 was the nurse on duty on 04/10/25 at 5:45 PM when the resident arrived at the facility. She stated Resident #1 arrived at 5:45 PM via stretcher by ambulance. She stated she performed a body audit at 6:00 PM and documented it at that time on paper. She described the wound on the coccyx as deep, maybe bone exposed, foul odor, dressing in tack dated 4/10/25, there were initials on the dressing, but she did not remember what they were. Once she removed the dressing, which was a Mepilex, was removed, there was a blue foam dressing in place, it was not packed in the wound, only laid across it. LPN #4 said, Our facility calls it hydrofera blue. It smelled terrible. The body audit drawing showed the following: dated 04/10/25 6:00 PM 160.8 weight, vital signs, BP (blood pressure) 106/74 P (pulse) 76, T (temperature) 97.7, R (respirations) 20, 02 Sat 99% on 2 liters of oxygen. Front view: Head: dry, flaky skin. Feet: dry, flaky skin. Right arm: scab. Bilateral lower extremities: dry, flaky skin. Right abdominal wound, left abdominal healing scar. lower left abdomen: feeding tube. Rear view: Back: redness. Bilateral heels: redness. Wound on coccyx. Note on the back of the body audit stated: Resident has dry skin on his head and face. Small scab on right upper arm. Large abdominal wound middle of upper abdomen cover by Allevyn. Healing scar on the left side of mid abdomen. Feeding tube site on left lower abdomen. Bilateral lower legs and feet are dry and flaky. Redness on middle of back towards right side. Wound on coccyx covered with a dressing. Both heels are red. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	LPN #4 also documented an electronical assessment once the resident was admitted , comfortable in bed and time allowed. The electronic documentation on 04/10/25 at 8:40 PM identifies vital signs as noted above. Integumentary assessment: Deficits noted: Color: normal flesh tone appropriate to complexion Moisture: Dry Temperature: Warm Turgor: Fair Skin intact: No Comments: Abdominal wound to middle of abdomen, wound on coccyx, feeding tube on left lower abdomen, redness on heels, dry skin, scab on right arm. On 04/11/25 at 9:40 AM a wound and ulcer assessment was completed and documented by the RN as follows: Wound #1 Wound type: Pressure Ulcer Wound location: Coccyx Dressing present: Yes Dressing intact: yes Dressing changed Yes Incision present: no Sutures/staples present: No Size length 2.5 width 1.5 depth: 05 Has wound be staged by Registered Nurse? Yes Unstagable, necrotic slough/eschar tissues obscure base of ulcer, unable to determine whether ulcer is III or IV. Odor: Yes extensive malodorous purulent smell to wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	Drainage: Yes Drainage color: black. Drainage amount: moderate Signs of infection: Hot, reddened Additional comments: black drainage coming from wound tissue and soaking removed dressing, gray necrotic tissues surrounding wound bed with tunneling noted at the left upper side of wound measuring 0.5 cm Are there significant changes in would or signs of infection since last assessment? Yes. Physician notified. Photos taken of the wound: Yes Wound #2 Wound type: surgical wound Wound location: Abdomen Dressing present: Yes Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no Size: length: 6/9 width 3.3 depth 0 cm Not staged, no odor, no drainage Signs of infection: reddened Additional comments: healing surgical wound to left abdomen with scab formation, no drainage Physician notified Wound #3 Wound type: pressure ulcer Wound location: right heel Dressing present: yes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no Size length 3 width 3 depth 0 cm No odor, no drainage, Signs of infection: swollen, hot and reddened Physician notified Wound #4 Wound type: pressure ulcer Wound location: left heel Dressing present: yes Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no Size length 3 width 3 depth 0 cm No odor, no drainage, Signs of infection: reddened Additional comments: 2 small areas of dry flaking skin beginning to peel with new tissue. Physician notified (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0600 Level of Harm - Actual harm Residents Affected - Few	A registered nursing note stated, Resident returned 4/10/25 in late evening, wounds present with dressings intact completed on 4/10/25 at (name of facility) Wounds reviewed today per this Registered Nurse (RN) and Unit Manager for staging. Resident noted to be 100.3 degrees temp., with pain noted to turning and touch of coccyx. Coccyx wound is infected, necrotic, unstagable and requires debridement and support not available in house. No treatment orders or notification received on this wound condition; Wound not included on PASR preadmission screening and resident review). Resident condition reported to Family Nurse Practitioner (FNP) and Medical Director with orders to send to ER for further treatment. Social Services informed of wound findings to coccyx. DON/Administrator informed. Health care surrogate (HCS) informed of findings per RN unit manager and gave preference of (local hospital name) for hospital. According to the discharge summary from the local hospital with admission date of 4/11/25, the resident was admitted with the following admitting diagnosis: Decubitus ulcer State 3 present on admission. Infected with osteomyelitis. Post obstructive pneumonia. Mucus plugging. General surgery and infectious disease was consulted for care. While inpatient a debridement of the wound on his coccyx was complete with discharge orders to pack wound daily with normal saline moistened kerlix gauze. Cover with 4 X 4 and ABD (abdominal pad). Clean wound daily with wound cleanser. Per the surgical team the resident was transferred to another local hospital for a course of intravenous antibiotics. On 4/22/25 the resident was transferred to another skilled nursing facility where he was admitted because of a decubitus ulcer, sacral region, State III. He received a ten (10) day course of Daptomycin in 0.9% sodium chloride 500mg/50 ml piggyback, give 400 mg daily per IV and Piperacillin-Tazobactam 3.375 gram reconstituted solution IV every 6 hours. On 05/12/25 at 2:10 PM the Resident #1's wound was observed by this surveyor accompanied by the floor nurse and unit manager. There was a dressing in place. The wound was clean and dressed. The necrotic tissue had been removed. The RN Unit Manager states he had an appointment on 05/13/25 with the wound center to see if he is a candidate for a wound vacuum to his coccyx. . During an interview on 05/13/25 at 9:00 AM the Administrator, wound nurse and DON, said they were aware of the DON from the facility he was discharged to coming into their facility however they did not accompany her to the resident's room and are unaware if she did a skin assessment. It was their understanding that she was only there to confirm that the wound vac had been removed prior to him being sent to her facility. During this interview the wound nurse was asked for a list of wound care supplies they typically use in their facility, the list consisted of blue classic foam. On 5/13/25 at 9:10 AM the Administrator, wound nurse and DON at Facility #1 were shown the body audit, skin assessment and pictures of Resident #1 upon returning to the facility. The discussion included that the resident left their facility at 5:20 PM and arrived at the other facility at 5:45 PM. They were informed Resident #1 had a dressing to his coccyx dated 4/10/25. They all agreed. When asked how they think the dressing got applied at their facility, they had no explanation. They expressed their shock and concern for Resident #1 but denied knowing anything about the Stage III pressure ulcer to Resident #1's coccyx.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview the facility failed to provide accurate information to the receiving facility regarding skin condition. This failed practice was found true for (1) one of (3) three residents reviewed for transfer/discharge during the complaint survey. Resident identifier #1. Facility census: 118. Findings Include: a) Resident #1 A record review on 05/12/25 at 9:55 AM, revealed that Resident #1 was transferred from this facility to a different nursing home on [DATE] at approximately 5:20 PM. Further record review revealed the following general note dated 04/10/25 at 5:20 PM, that read as follows: Resident discharging from the facility at this time via ambulance transport to (Local State Nursing Home Named). Vital signs obtained and within normal limits. Skin check completed and no new issues identified. All discharge paperwork reviewed with MPOA (via phone) and with the Nurse during the report called to (Local State Nursing Home Named). Medication list reviewed and sent with the resident as well. No questions or concerns. Further record review revealed a Skin and wound assessment dated [DATE] that indicates Resident #1 had the following skin/wound issues: Deep tissue injury to Right heal Deep tissue injury to left heal Surgical wound to abdomen A review of the Pre-admission Screening and Resident Review (PASRR'S) for admission and discharge from the facility dated 02/18/25 and 04/07/25 were marked no for decubitus. Further review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/25 was marked no for stage 2, 3, 4, and unstageable pressure ulcers. During an interview on 05/12/25 at 12:30 AM, Nursing Assistant (NA) #5 He had a place on his butt. It was a little one. I did not really see it after that because it was always covered with a bandage of some sort that was dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/12/25 at 4:00 PM, Licensed Practical Nurse (LPN) #4 stated, I was one of the admitting nurses. He came to us on April 10th. When he came in had a square bandage on a wound on his belly which we knew about. He also had a clean dressing on his coccyx that had the date of 04/10/24 and initials on it. I do not remember what the initials were. The dressing was blue foam like you use to pack a wound but it wasn't packed it was just laid on top, and then the covering to secure it. The wound on his coccyx looked like it was to the bone. It smelled awful. It was red and brown down there and was really deep. He would kind of groan when we rolled him to look at it. The discharge that they sent us did not say anything about the wound on his coccyx. A record review on 05/12/25 at 4:15 PM, of the admission Body Audit dated 04/10/25 reads as follows: Resident has dry skin and his head and face. Small scab on right upper arm. Large abdominal wound middle of upper abdomen covered by Allevyn. Healing scar on the left side of mid abdomen. Bilateral lower legs and feet are dry and flaky. Redness on middle of back towards right side. Wound on coccyx covered with a dressing. Both heels are red. On 5/13/25 at 9:10 AM the Administrator, wound nurse and DON at Facility #1 were shown the body audit, skin assessment and pictures of Resident #1 upon returning to the facility. The discussion included that the resident left their facility at 5:20 PM and arrived at the other facility at 5:45 PM. They were informed Resident #1 had a dressing to his coccyx dated 4/10/25. They all agreed. When asked how they think the dressing got applied at their facility, they had no explanation. They expressed their shock and concern for Resident #1 but denied knowing anything about the Stage III pressure ulcer to Resident #1's coccyx.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure one (1) of two (2) residents reivewed for pressure ulcers received the apprpirate care to treat a wound to the coccyx. Resident #1 entered the facility without a pressure ulcer to the coccyx . He was discharged to another facility (nursing home). An assessment completed within 40 minutes after his discharge from the facility revealed a deep foul smelling wound to the coccyx. Resident #1 sustained actual harm. Resident identifier: #1. Facility Census: 118 Findings Include: a) Resident #1 Resident #1 was admitted to the facility on [DATE] from a critical illness recovery hospital. He had been at that facility from 01/22/25 - 02/18/25. He had previously been at another acute care hospital from [DATE] - 01/22/25. He was sent to the acute care hospital on [DATE] after his percutaneous endoscopic gastrostomy tube malfunctioned. While hospitalized he had two (2) surgeries and left the hospital on [DATE] with a surgical wound to the left and right abdomen. Due to postoperative complications a wound vac was placed for healing purposes. Upon admission to Facility #1, there was an admission progress note, and skin check performed. Documentation shows the resident arrived on 02/18/25 at 10:30 PM. Observation of the skin assessment was documented as (absent of any related wounds to coccyx). New skin Issue. Location: Left Lower Quadrant Midline. Issue type: Surgical wound. Wound was present on admission. Length (cm): 3.5 Width (cm): 0.6 Depth (cm): 0.1#002: New skin Issue. Location: Right Lower Quadrant Midline. Issue type: Surgical wound. Wound was present on admission. Length (cm): 9.8 Width (cm): 4.8 Depth (cm): 0.2#003: New skin Issue. Location: Left heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstagable pressure injuries presenting as deep tissue injury. Wound was present on admission. Length (cm): 5.6 Width (cm): 4.4 Depth (cm): 0#004: New skin Issue. Location: Right heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstagable pressure injuries presenting as deep tissue injury. Wound was present on admission. Length (cm): 1.9 Width (cm): 1.3 Depth (cm): 0 Additional skin checks were performed weekly on 02/25/25, 03/05/25, 03/12/25, 03/19/25, 03/26/25, 04/02/25 and 04/09/25. Random dated copies were provided for review for the following dates: 02/18/25 (admission), 02/26/25, 03/19/25, 04/02/25, 04/09/25. (absent of any related wounds to coccyx). In addition, the facility provided the latest skin and wound evaluations. 04/02/25 documented surgical wound to left lower quadrant abdomen 04/02/25 documented surgical wound to right lower quadrant abdomen (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	04/02/25 documented surgical wound, dehiscence to right lower quadrant abdomen 04/02/25 documented pressure deep tissue injury to left heel 04/02/25 documented pressure deep tissue injury to left heel On 05/12/25 Residents #1s medical records were reviewed. A Braden scale for predicting pressure risk was completed on the following days resulting in the following scores: 02/29/25 - 10 which indicated the resident was at a high risk of developing pressure ulcers. 02/25/25 - 10 which indicated the resident was at a high risk of developing pressure ulcers 03/05/25 - 11 which indicated the resident was at a high risk of developing pressure ulcers 03/12/25 -11 which indicated the resident was at a high risk of developing pressure ulcers Resident #1's care plan was reviewed and showed a focus area for the resident being at risk for skin breakdown due to decreased activity, frail fragile skin, impaired condition, incontinence, limited mobility, recent surgery and pressure areas to the left and right heel, a surgical site to the left and right lower abdomen. The goal associated with this focus area was for the pressure areas and surgical sites to heal upon review and for the resident's wound/skin impairment to heal as evidenced by a decrease in size, absence of erythema and drainage and/or pressure ulcer: Interventions related to his goal included: - Enhanced Barrier Precautions - Heels up device while in bed as resident will allow - Low air loss mattress to bed, weekly hand checks to monitor settings - Negative pressure wound therapy to right lower ABD per orders - pro mattress to bed - Pad side rails/wheelchair or other equipment as necessary - Pat (do not rub) skin when drying - Provide patient and/healthcare decision maker education regarding risk factors and interventions - Provide preventative skin care i.e. lotions, barrier creams as ordered. - Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanch easily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	- Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation. - Observe skin condition daily with ADL care and report abnormalities. - Observe for verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered. - Obtain dietitian consult as needed/ordered - Obtain skilled PT/OT evaluation to improve functional mobility. - Provide wound treatment as ordered - Provide supplements as ordered. - Weekly skin check by license nurse - Weekly wound assessment to include measurements and description of wound status. The care plan also indicated the following related to Activities of Daily Living (ADL) assistance required by Resident #1. Resident requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, - dressing, eating, bed mobility, transfer, locomotion, toileting related to hx (history) of Cerebrovascular Accident (CVA) VA with paraplegia affecting both sides. Resident is incontinent of bladder and bowel and is unable to cognitively and physically participate in a retaining program due to total lift status, neurocognitive disorder. During an interview on 05/13/25 with the Director of Nursing, she stated Nurse Aides do not document each time they turn the residents, they only document if they turn the resident during that shift. Medical Record documentation on the following days showed the resident was not turned for each of the three (3) shifts. 03/11/25, 03/16/25, 03/18/25, 03/25/25, 03/30/25, 04/08/25. When asked why all three shifts were not documented, she could not provide an answer. A review of the physician's orders for Resident #1 from the time of admission until the time discharged found no orders related to pressure ulcer treatment and/or prevention for his coccyx. A review of Resident #1s discharge progress note completed by Licensed Practical Nurse #8 states a skin check was completed, however there is no skin check or skin, and wound evaluations documented for 04/10/25 (discharge date). There was no written discharge skin and wound evaluation documentation noted. Treatment Administration Records (TAR) for February, March and April 2025 found no wound treatments were missing. (absent of any related wounds to coccyx) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/12/25 at 1 PM during an interview with Licensed Practical Nurse (LPN) #6 she states she does 99% of all wound care. She said she was responsible for weekly skin checks and skin and wound evaluations. LPN #6 said if there is a new wound identified by an LPN or Nurse Aid, she also assessed that wound if she was in the facility. If not, the LPN assesses it, and LPN #6 follows up when LPN #6 returned. When asked to identify wounds that Resident #1 had upon discharge, she stated He had two abdominal surgical wounds, one on each side, bilateral DTI's (deep tissue injuries) to his heels. She denied any knowledge of a wound to his coccyx. When asked if there was ever a time when a dressing would be in place without a physicians order, she stated no. On 05/13/25 at 12:55 PM during a telephone interview with the Medical Director for the facility, he said he did not perform skin checks on residents. He said he depended on documentation from the staff. On 05/12/25 at 4:20 PM the surveyor went to the facility where the resident was discharged to. LPN #3 took report from the facility on 04/10/25. She stated the report consisted of when his last bowel movement was, his vital signs, his tube feeding details. She states the only report obtained concerning skin status, was that there were no new issues. LPN #4 was the nurse on duty on 04/10/25 at 5:45 PM when the resident arrived at the facility. She stated Resident #1 arrived at 5:45 PM via stretcher by ambulance. She stated she performed a body audit at 6:00 PM and documented it at that time on paper. She described the wound on the coccyx as deep, maybe bone exposed, foul odor, dressing in tack dated 4/10/25, there were initials on the dressing, but she did not remember what they were. Once she removed the dressing, which was a Mepilex, was removed, there was a blue foam dressing in place, it was not packed in the wound, only laid across it. LPN #4 said, Our facility calls it hydrofera blue. It smelled terrible. The body audit drawing showed the following: dated 04/10/25 6:00 PM 160.8 weight, vital signs, BP (blood pressure) 106/74 P (pulse) 76, T (temperature) 97.7, R (respirations) 20, 02 Sat 99% on 2 liters of oxygen. Front view: Head: dry, flaky skin. Feet: dry, flaky skin. Right arm: scab. Bilateral lower extremities: dry, flaky skin. Right abdominal wound, left abdominal healing scar. lower left abdomen: feeding tube. Rear view: Back: redness. Bilateral heels: redness. Wound on coccyx. Note on the back of the body audit stated: Resident has dry skin on his head and face. Small scab on right upper arm. Large abdominal wound middle of upper abdomen cover by Allevyn. Healing scar on the left side of mid abdomen. Feeding tube site on left lower abdomen. Bilateral lower legs and feet are dry and flaky. Redness on middle of back towards right side. Wound on coccyx covered with a dressing. Both heels are red. LPN #4 also documented an electronical assessment once the resident was admitted , comfortable in bed and time allowed. The electronic documentation on 04/10/25 at 8:40 PM identifies vital signs as noted above. Integumentary assessment: Deficits noted: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	Color: normal flesh tone appropriate to complexion Moisture: Dry Temperature: Warm Turgor: Fair Skin intact: No Comments: Abdominal wound to middle of abdomen, wound on coccyx, feeding tube on left lower abdomen, redness on heels, dry skin, scab on right arm. On 04/11/25 at 9:40 AM a wound and ulcer assessment was completed and documented by the RN as follows: Wound #1 Wound type: Pressure Ulcer Wound location: Coccyx Dressing present: Yes Dressing intact: yes Dressing changed Yes Incision present: no Sutures/staples present: No Size length 2.5 width 1.5 depth: 05 Has wound be staged by Registered Nurse? Yes Unstagable, necrotic slough/eschar tissues obscure base of ulcer, unable to determine whether ulcer is III or IV. Odor: Yes extensive malodorous purulent smell to wound Drainage: Yes Drainage color: black. Drainage amount: moderate Signs of infection: Hot, reddened Additional comments: black drainage coming from wound tissue and soaking removed dressing, gray necrotic tissues surrounding wound bed with tunneling noted at the left upper side of wound measuring 0.5 cm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	Are there significant changes in would or signs of infection since last assessment? Yes. Physician notified. Photos taken of the wound: Yes Wound #2 Wound type: surgical wound Wound location: Abdomen Dressing present: Yes Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no Size: length: 6/9 width 3.3 depth 0 cm Not staged, no odor, no drainage Signs of infection: reddened Additional comments: healing surgical wound to left abdomen with scab formation, no drainage Physician notified Wound #3 Wound type: pressure ulcer Wound location: right heel Dressing present: yes Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	Size length 3 width 3 depth 0 cm No odor, no drainage, Signs of infection: swollen, hot and reddened Physician notified Wound #4 Wound type: pressure ulcer Wound location: left heel Dressing present: yes Dressing intact: yes Dressing changed: yes Incision present: no Sutures/staples present: no Size length 3 width 3 depth 0 cm No odor, no drainage, Signs of infection: reddened Additional comments: 2 small areas of dry flaking skin beginning to peel with new tissue. Physician notified A registered nursing note stated, Resident returned 4/10/25 in late evening, wounds present with dressings intact completed on 4/10/25 at (name of facility) Wounds reviewed today per this Registered Nurse (RN) and Unit Manager for staging. Resident noted to be 100.3 degrees temp., with pain noted to turning and touch of coccyx. Coccyx wound is infected, necrotic, unstagable and requires debridement and support not available in house. No treatment orders or notification received on this wound condition; Wound not included on PASR preadmission screening and resident review). Resident condition reported to Family Nurse Practitioner (FNP) and Medical Director with orders to send to ER for further treatment. Social Services informed of wound findings to coccyx. DON/Administrator informed. Health care surrogate (HCS) informed of findings per RN unit manager and gave preference of (local hospital name) for hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515061	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Center	152 Saddleshop Road Hilltop, WV 25855

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 0686 Level of Harm - Actual harm Residents Affected - Few	According to the discharge summary from the local hospital with admission date of 4/11/25, the resident was admitted with the following admitting diagnosis: Decubitus ulcer State 3 present on admission. Infected with osteomyelitis. Post obstructive pneumonia. Mucus plugging. General surgery and infectious disease was consulted for care. While inpatient a debridement of the wound on his coccyx was complete with discharge orders to pack wound daily with normal saline moistened kerlix gauze. Cover with 4 X 4 and ABD (abdominal pad). Clean wound daily with wound cleanser. Per the surgical team the resident was transferred to another local hospital for a course of intravenous antibiotics. On 4/22/25 the resident was transferred to another skilled nursing facility where he was admitted because of a decubitus ulcer, sacral region, State III. He received a ten (10) day course of Daptomycin in 0.9% sodium chloride 500mg/50 ml piggyback, give 400 mg daily per IV and Piperacillin-Tazobactam 3.375 gram reconstituted solution IV every 6 hours. On 05/12/25 at 2:10 PM the Resident #1's wound was observed by this surveyor accompanied by the floor nurse and unit manager. There was a dressing in place. The wound was clean and dressed. The necrotic tissue had been removed. The RN Unit Manager states he had an appointment on 05/13/25 with the wound center to see if he is a candidate for a wound vacuum to his coccyx. . During an interview on 05/13/25 at 9:00 AM the Administrator, wound nurse and DON, said they were aware of the DON from the facility he was discharged to coming into their facility however they did not accompany her to the resident's room and are unaware if she did a skin assessment. It was their understanding that she was only there to confirm that the wound vac had been removed prior to him being sent to her facility. During this interview the wound nurse was asked for a list of wound care supplies they typically use in their facility, the list consisted of blue classic foam. On 5/13/25 at 9:10 AM the Administrator, wound nurse and DON at Facility #1 were shown the body audit, skin assessment and pictures of Resident #1 upon returning to the facility. The discussion included that the resident left their facility at 5:20 PM and arrived at the other facility at 5:45 PM. They were informed Resident #1 had a dressing to his coccyx dated 4/10/25. They all agreed. When asked how they think the dressing got applied at their facility, they had no explanation. They expressed their shock and concern for Resident #1 but denied knowing anything about the Stage III pressure ulcer to Resident #1's coccyx.