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	05/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, resident interview, and observation, the facility failed to ensure physician orders were followed for residents receiving oxygen therapy. This failed practice had the potential to affect a limited number of residents. Resident Identifiers: #54 and #87. Facility Census: 117. Findings included:a) Resident #54 On 05/11/26 at 12:45 PM, Resident #54's oxygen concentrator was set on 1.5 liters and the resident reported he felt he was short of breath. The resident reported he was supposed to be on two (2) liters of oxygen. Review of Resident #54's electronic medical record revealed:-The resident's physician order stated, Oxygen at 2L/min via Nasal Cannula continuously every day and night shift. -The resident's care plan stated, Oxygen per order. On 05/11/25 at 2:26 PM, the resident's care plan was updated following surveyor intervention to include: Resident is non-compliant with use of oxygen since admission on [DATE]. Resident will at times refuse to wear oxygen, throw tubing in the floor, self-adjust concentrator settings. Unit Manager Licensed Practical Nurse #115 observed the oxygen concentrator and stated, Let me check the order. The unit manager returned to the resident's room and reported the order was for two (2) liters and stated, It's slightly off. b) Resident #87 On 05/11/26 at 1:00 PM, Resident #87's concentrator was set on 3.5 liters. The concentrator was out of the resident's reach at the time of the observation. The resident reported he was supposed to be on four (4) liters of oxygen. Review of Resident #87's electronic medical record revealed:-The resident's care plan stated, Oxygen as ordered. -The resident's physician order stated, Oxygen at 4L via NC [nasal canula] every day and night shift. Unit Manager Licensed Practical Nurse #94 confirmed the oxygen concentrator was on 3.5 liters and stated, Let me go check. The unit manager returned and reported the concentrator was to be set on four (4) liters and that the resident was care planned to sometimes mess with it. c) Policy and Procedure for Oxygen Concentrator The facility's policy and procedure for Oxygen Concentrator stated, 10. Set liter flow per order.

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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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, resident interview, and staff interview, the facility failed to provide adequate hydration for Residents #55, #107, and #68. These were random opportunities for discovery. Resident Identifiers: #55, #107 and #68. Facility Census: 117.Findings Included:a) Resident #55On 05/11/26 at 12:25 PM, an initial interview was held with Resident #55. The resident stated, I would like some ice water. The resident was asked, Did you get any fresh ice water today? Resident #55 stated, No, I haven't. An observation was made at this time of a 12-ounce Styrofoam cup, which was undated, that had a small amount of water and no ice inside the cup.On 05/11/26 at 12:30 PM, Activities Director #55 was asked to come into the resident's room. The Activities Director confirmed the cup was not dated and there was a small amount of water and no ice inside the cup.b) Resident #107On 05/11/26 at 12:35, an initial interview was held with Resident #107. Resident #107 is roommates with Resident #68. The resident was asked, Did you receive fresh ice water today? The resident stated, No, we haven't been given any ice water today. An observation of a 12-ounce Styrofoam cup, undated, was sitting on the over-the-bed table with no water or ice inside of the cup. On 05/11/26 at 12:45 PM, Licensed Practical Nurse (LPN) #71 was asked to come into the room. LPN #71 confirmed no water or ice was inside of the Styrofoam cup.c) Resident #68On 05/11/26 at 12:35, an initial interview was held with Resident #68. Resident #68 is roommates with Resident #107. The resident was asked, Did you receive fresh ice water today? The resident stated, No, not today. An observation of a 12-ounce Styrofoam cup, undated, was sitting on the over-the-bed table with no water or ice inside of the cup. On 05/11/26 at 12:45 PM, LPN #71 was asked to come into the room. LPN #71 confirmed no water or ice was inside the Styrofoam cup.On 05/11/26 at approximately 1:20 PM, the Administrator was notified. The Administrator confirmed the staff should be passing ice and water to the residents. The Administrator stated, We will get education started immediately with staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, the facility failed to maintain an effective infection control program related to the placement of urinary catheter drainage bags for Resident #72 and #78, and storage of a granulated cylinder for Resident #54. These were random opportunities for discovery. Resident Identifiers: #72, #78 and #54. Facility Census: 117. Findings Included:a) Resident #72On 05/11/26 at 12:19 PM, an initial interview was held with Resident #72. The urinary catheter drainage bag was observed behind the wheelchair hanging and touching the floor. On 05/11/26 at 12:23 PM, the Activities Director #55 was asked to come to the resident's room. The Activities Director #55 confirmed the urinary catheter drainage bag should not be touching the floor. The Activities Director #55 raised the bag and the urinary catheter drainage bag was not touching the floor.On 05/11/26 at approximately 12:40 PM, the Administrator was notified and confirmed the urinary catheter drainage bag should not be touching the floor. The Administrator stated, We will talk to the staff.b) Resident #78On 05/11/26 at 12:35 PM, an initial interview was held with Resident #78. The urinary catheter drainage bag was observed laying in the floor. Nurse Aide (NA) #45 entered the room and moved the urinary catheter foley bag on the bed rail.On 05/11/26 at approximately 12:40 PM, the Administrator was notified and confirmed the urinary catheter drainage bag should not be touching the floor. The Administrator stated, We will talk to the staff.c) Resident #54On 05/11/26 at 12:44 PM, an initial interview was attempted with Resident #54. A granulated cylinder was observed sitting on the back of the commode. The granulated cylinder did not have any identifying information located on it, and was not properly stored in a storage bag.On 05/11/26 at 12:48 PM, Unit Manager (UM) #115 was asked to enter the resident's room. UM #115 confirmed the granulated cylinder did not have any identifying information and was not stored properly. The UM stated, I'll remove it.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, staff interview, and record review, the facility failed to ensure call systems were within the resident's reach. This failed practice had the potential to affect a limited number of residents. Resident Identifiers: #69 and #85. Facility Census: 117.Findings included:a) Resident #69On 05/11/26 at 12:30 PM, Resident #69's call light was attached to her nightstand. The resident was sitting in her wheelchair near the bottom of her bed. The resident stated, I want it close as I can. The resident's call light was not within reach.On 05/11/26, Activity Director #140 confirmed the call light was out of reach. The activity director attached the call light to the resident's blanket on the bed within the resident's reach.b) Resident #85 On 05/11/26 at 12:29 PM, Resident #85's call light was observed on the floor behind the resident's wheelchair. The resident was sitting in his wheelchair at the time. On 05/12/26, Activity Director #140 confirmed the resident's call light was in the floor and placed the call light within the resident's reach.c) Policy for Call LightsThe facility's policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed.