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	01/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to ensure the resident's care plans were comprehensive, patent-centered and individualized for transfers. This was found true for five(5) of 31 care plans reviewed during the Long Term Care Survey process. Resident Identifiers: #2, #9, #84, #85, and #105. Facility Census: 117.Findings included: a) The facility's policy and procedure stated, the Center must develop and implement a person-centered care plan for each patient/resident (hereinafter patient) consistent with patient rights measurable objectives and timeframes to meet a patient's medical, nursing and mental and psychosocial needs and all services that meet professional standards of quality. b) On 01/20/2026 at 3:53 PM , the following resident's records were reviewed: Residents #2, #9, #84, #85 and #105. All five (5) care plans reviewed listed the intervention for transfers as Lift per assessment. The care plans were not individualized for each resident. On 01/20/2026 at 04:36 PM, the Minimum Data Set (MDS) Coordinator confirmed the care plans were the same for transfers and reported they only update the actual assessment with changes, not the care plan. When asked by the state surveyor how they identify a resident's change in transfer status for staff, the MDS Coordinator reported, they follow the assessment and a sticker on the resident' door was used to identify how the resident transfer for staff. On 01/20/2025 at 04:40 PM, the Director of Nursing (DON) reported transfer changes are on the door by the resident's name and if there is a change in transfer they usually put a change in transfer/lift under a different section of the care plan. The DON stated, I understand. when discussing how the care plans were not individualized for each resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, staff interview and resident interview, the facility failed to ensure a resident's call light was adapted to a resident's individual physical needs. This failed practice was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #84. Facility census: 117. Findings included: a) Resident #84 On 01/19/2026 at 10:10 AM, Resident #84's call light was out of reach and attached to the bed. Registered Nurse (RN) #78 confirmed the call light was out of reach and stated, it was hooked around the bed. RN # 78 re-attached the call light in reach of the resident. The resident reported they could reach it and the resident stated, but no one answers it. RN #78 requested the resident to push the call light. The resident attempted to push the call light, but it did not come on. The resident was physically unable to activate the regular, standard call light button on the call light device. The state surveyor pushed the call light button, and it came on immediately. After surveyor intervention, an adaptive touch pad call light was placed, and the resident was able to activate the call system for assistance as needed. On 01/21/2026, the resident continued to be able to activate the call light system with the new touch pad call light upon request by the surveyor. b) The facility's policy and procedure for Activities of Daily Living (ADL's) stated, Assistive devices and adaptive equipment are provided, as needed. The facility's policy and procedure for Call Lights stated, Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the patient to use the call system.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and staff interview, the facility failed to ensure a comprehensive assessment of resident preferences for customary routine and activities was completed and documented in the annual Minimum Data Set (MDS) for one (1) of two (2) residents. This was true for Resident #15. Resident identifier: #15. Facility census: 117.Findings include:a) Resident #15On 01/20/25, a review of Resident #15's annual Minimum Data Set (MDS) completed on 07/06/25 revealed that Section F (Preferences for Customary Routine and Activities) was not completed. The MDS reflected Not assessed for all required items, including:F0300 - Should the resident be interviewed regarding daily and activity preferencesF0400 - Interview for daily preferencesF0500 - Interview for activity preferencesF0600 - Primary respondent for daily and activity preferencesF0700 - Should a staff assessment be conductedF0800 - Staff assessment of daily and activity preferencesThis demonstrated that the facility failed to conduct and document an assessment of Resident #15's customary routine and activity preferences as required for the annual MDS.On 01/20/25 at approximately 1:00 PM, an interview was conducted with the Activity Director, in the presence of the Assistant Administrator. During the interview, the Activity Director stated, I completed a recreation quarterly progress note and care plan evaluation assessment instead of the annual. This statement confirmed that Section F of the annual MDS for Resident #15 was not assessed or completed.Resident Assessment Instrument guidance indicates if information is unavailable use the appropriate non responsive or dashed code.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based upon record review and staff interview, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program when a new mental health diagnosis or change in condition is presented. This was found to be true for one (1) of six (6) residents during the long term care survey process. Resident identifier #87. Facility census: 117. Resident #87 a) On 01/20/26 reviewed Resident #87 PASARR dated 09/17/24. It was observed that the only diagnosis on the form was Delusional Disorder. According to the medical diagnosis listed for Resident #87 was diagnosed with conversion disorder with seizures or convulsions and anxiety disorder unspecified on 02/05/25. On 01/21/26 at approximately 9:00 a.m., interview with the facility's Social Worker verified the missed diagnosis and that a new PASARR should have been completed (Social Worker did submit a new PASARR on 01/21/26).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review , observation, staff interview and resident interview, the facility failed to ensure a resident received food that accommodated the resident's intolerances and preferencesfor one (1) of two (2) residents reviewed for choices. Resident Identifier: #84. Facility Census: 17. Findings included: a) The facility's policy and procedure for Person-Centered Choices stated, Patients/Residents (hereinafter resident) are offered a choice of nourishing, palatable, well-balanced food and beverage options that meet their daily nutritional needs, taking into consideration the preferences of each resident. b) On 01/20/2026, Resident #84's tray card was reviewed by the state surveyor. The resident received the following items on her tray: Fish on a bun, Potato Wedges and Sliced Peaches. Resident #84 reported they had told staff they did not like fish. The DON asked the resident if she wanted the rice or an alternate from the always available menu. The resident declined the rice and alternates from the always available menu. According to Resident #84's food preference list, baked fish was listed as a dislike.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to ensure a resident was provided a physician ordered assistive device during mealtime in the dining room. This failed practice was a random opportunity for discovery, and had the potential to affect a limited number of residents residing in the long term care facility. Resident Identifier: #6. Facility Census: 117. Findings included:a) Resident #6The facility's policy and procedure for Activities of Daily Living (ADL's) stated, Assistive devices and adaptive equipment are provided, as needed. The facility's policy and procedure for Dining Service Standards 6.6 Assistance - adaptive devices are provided, as indicated on the resident plan of care. The resident 's diet order stated, Regular Liberalized diet Regular Texture, Standard Thin Liquids consistency, Scoop plate with meals, large portions, [NAME] Cup. The resident's care plan interventions stated, Scoop plate with all meals, large portions, Kennedy cup. The resident's tray card listed [NAME] Cup in bold print. On 01/19/2026 at 11:34 AM, Registered Nurse (RN) #78 confirmed the resident did not have a Kennedy cup and reported she would talk to Occupational Therapy (OT) about the cup. RN #78 stated, He does good. without the [NAME] Cup.The state surveyor reported the findings to the Assistant Administrator on 01/19/2026 at 12:36 PM.

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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. Based on records review and staff interviews, the facility failed to ensure a complete and accurate medical records. This failed practice was found true for one (1) out of (31) residents reviewed. Resident identifier: #61. Facility Census: 117 a) Resident #61 Documentation review of the medical record revealed a note by a medical provider reflected that resident has capacity and the assessment sheet scanned into the medical record demonstrated resident lacks capacity. Interview with the facility's Assistant Administrator on 01/18/26 at approximately 3:08 p.m., verified the inaccuracy of Resident #61's medical record.

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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 record review, staff interview, resident interview and observation, the facility failed to ensure call lights were operational and within the resident's reach. This failed practice had the potential to affect a limited number of residents. Resident identifiers: #9 and #84. Facility Census: 117.Findings included: a) Resident #9 On 01/18/2026, during the initial interview process, Resident #9 was observed requesting to lay down. The resident's call light was behind him on his bed. The resident was unable to reach his call light upon two observed attempts. Assistance was obtained by the state surveyors. Nursing Assistant (NA) #25 confirmed the call light was out of reach. The NA reported the resident was care planned to be out of bed for meals. The patient's call light did not turn on when activated by the surveyor. At 11:20 AM, NA # 25 confirmed the call light did not turn on and stated, Maybe it got unplugged a little bit. On 01/18/2026 at11:40 AM, the Administrator reported the broken call light was put into the TELS system to be repaired and maintenance was coming in to fix it. b) Resident #84 On 01/8/2026 at 01:20 PM, Resident #84 was unable to reach her call light while sitting in her wheelchair. Nursing Assistant (NA) #96 confirmed the call light was not in reach of the resident and stated, I moved stuff to put the tray down. On 01/19/2026 at 10:10 AM, Resident #84's call light was out of reach and attached to the bed. Registered Nurse (RN) #78 confirmed the call light was out of reach and stated, it was hooked around the bed. Registered Nurse (RN) #78 re-attached the call light in reach of the resident.