STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #15) of 21 residents reviewed for resident rights.The facility failed to ensure Resident #15 was not sleeping on a couch in view of the hallway in a t-shirt and brief and later in just the t-shirt the night of 04/19/2026.This failure could place residents at risk of lack of personal privacy and dignity.Findings Included:Record review of Resident #15's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy, muscle weakness, difficulty in walking, insomnia (problems falling and staying asleep), unsteadiness on feet, and frequency of micturition (needing to urinate more often than once every 3-4 hours).Record review of Resident #15's quarterly MDS completed on 03/17/26 revealed a BIMS of 5 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #15 used a wheelchair and was dependent for toileting. She required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for transferring from chair/bed-to-chair.Record review of Resident #15's care plan last reviewed/revised on 04/01/26 revealed Resident #15 was a wanderer and at increased risk of falling. One of the interventions was [Resident #15]'s physical needs will be met; . toileting. She was to use a fall mat next to her bed as well as a scoop mattress and be monitored at least every 2 hours while in bed. Resident #15 was noted to be receiving hospice care and one of the interventions was [Resident #15] will be kept clean and comfortable. She was noted to require extensive assistance with toileting and transfers by one staff member. The goal was [Resident #15 will maintain a sense of dignity by being clean, dry, . One of the interventions included, Monitor appearance. Resident #15 was at risk for incontinence. Staff were to, Provide incontinent care after each episode of incontinence. She was at risk for skin breakdown due to incontinence. Staff were to, Keep clean and dray as possible. Minimize skin exposure to moisture. Staff were also to Provide toileting assistance every 2 hours and prn.Record review of Resident #15's active orders dated 04/27/26 revealed the following orders with corresponding start dates:11/19/25 Brief Check and document wet or dry every 3 hours02/26/26 BED MOBILITY with assist of 1-202/26/26 TRANSFER with assist of 1-2During an interview on 04/27/26 at 04:37 AM LVN C stated she was working on 100 hall on the night of 04/19/26 when LVN D, who was working on 400 hall (Resident #22's hall), asked her for assistance. LVN C stated she walked with LVN D to Resident #22's suite and noted Resident #15 asleep on the couch in view of the hall wearing only a t-shirt and a soaked brief. LVN C stated she told LVN D, This is not cool. She stated LVN D told her, Wherever she (Resident #15) wants sleep; she's gonna sleep. LVN C stated LVN D told her she did not have time to baby talk 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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. LVN C stated she assisted LVN D with another resident in the suite, returned to her hall, and called the on-call phone to let ADON A know she was worried about the residents on hall 400. She stated she told ADON A about Resident #15 lying on the couch wearing only a soaked brief and T-shirt.During an interview and observation on 04/27/26 at 05:07 AM LVN C was asked what time she called ADON A. LVN C sent a text screen shot showing the time of her call to ADON A on the on-call phone was 04:35 AM on 04/20/26.During an interview on 04/27/26 at 05:47 AM LVN E stated leaving residents in wet and soiled briefs was an example of neglect.During an observation on 04/27/26 at 05:52 AM Resident #15 was lying in her bed on her right side with her eyes closed. Her bed was in the lowest position, and a fall mat was on the floor next to her bed.During an interview on 04/27/26 at 05:57 AM RN F stated she came to work on the morning of 04/20/26 and LVN C asked her to check on the residents on hall 400. RN F stated she joined LVN H on hall 400 and the two of them found Resident #15 asleep on the couch in the entryway to her suite in view of the hall wearing only a t-shirt with a soaked brief on the floor next to the couch RN F stated the couch was soaked with urine around Resident #15. She stated, I called ADM and let her know my serious concerns. I don't like to throw the word neglect around, but I could say I have serious concerns about the care on that hall overnight or the lack of care on that hall overnight.During an interview on 04/27/26 at 06:05 AM ADM stated she interviewed LVN D and was told Resident #15 said the couch was her bed and refused to get off of the couch. She stated LVN D told her she (LVN D) was overwhelmed and struggled through the night but did the best she could.During an interview on 04/27/26 at 07:11 AM LVN D stated 04/19/26 was her first time working in the facility. She stated she was shocked when she picked up the night shift to find she was responsible for total care for 6 residents and did not have a CNA to help her. She stated she had a back injury that made it impossible for her transfer residents alone. LVN D said of the residents on hall 400, Everybody was confused, dead weight, couldn't stand by themselves. She stated one resident was on a sofa and had taken her brief off. She refused to get up and go to bed and told me she was in her bed. Apparently, she had taken her brief off and dropped it on the floor. LVN D stated she was capable of assisting with brief changes but I can't solo due to her back injury. She stated of Resident #15, She had taken her brief off and denied care. I had been warned she might refuse care and not take her medications.During an interview on 04/27/26 at 07:41 AM LVN D stated, If you need to be lifted up out of a wheelchair and transferred to the bed and I am the only one there I can't do it.During an observation on 04/27/26 at 08:16 AM Resident #15 was lying in bed on her left side with her eyes closed. Her bed was in lowest position and fall mat was on the floor next to the bed. The couch in the entryway of her suite was visible from the hallway.During an interview on 04/27/26 at 09:08 AM ADON A stated LVN C called her on the morning of 04/20/26 and told her she was concerned about the residents on hall 400. ADON A stated LVN C told her about a resident with a soaked brief.During an interview on 04/27/26 at 09:47 AM LVN H stated she came to work on the morning of 04/20/26 and she and RN F found Resident #15 asleep on the couch with her soaked brief on the floor next to the couch. LVN H stated Resident #15's wheelchair was next to her, and she (LVN H) assumed Resident #15 put herself on the couch. She stated Resident #15's bed was not made, and she thought that was probably why Resident #15 put herself on the couch.During an observation and interview on 04/27/26 at 10:09 AM Resident #15 was in her bed with HOB raised to seated position. She did not remember a night when she slept on the sofa.During an observation and interview on 04/27/26 at 12:00 PM ADM, MS, and this surveyor entered a closet in the facility to watch recorded camera footage of LVN D on hall 400 the night of 04/19/26. According to camera footage, LVN D did not enter a resident room until after 10 PM on the night of 04/19/26. ADM stated it was nice to know you pay so much money for agency staff to sit around on their phones. LVN D did enter resident rooms after 10:00 PM but did not remain in any of the rooms for more than 2 minutes except for the instance she and LVN C entered the suite of Resident #15 and Resident #22. The two LVNs remained in the suite for 3 minutes at approximately 4:30 AM on 04/20/26.During an interview on 04/28/26 at 08:26 AM LVN K stated leaving residents in unchanged, wet briefs was an example of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect of residents. He stated this could result in skin breakdown, decreased self-esteem, possible UTI, and psychologically cause residents not to trust care givers.During an interview on 04/28/26 at 08:30 AM CMA L stated not changing a resident's wet brief was an example of neglect. She stated residents might feel embarrassed or isolate themselves if their wet briefs were not changed.During an interview on 04/28/26 at 08:32 AM CNA M stated not changing a resident's brief was an example of neglect and could result in infection.During an interview on 04/28/26 at 08:35 AM CMA G stated leaving residents in wet briefs was an example of neglect and could lead to UTIs, rashes, odor, and decreased self-esteem.During an interview on 04/28/26 at 08:36 AM SC stated leaving residents in wet briefs was an example of neglect and could cause skin breakdown.During an interview on 04/28/26 at 08:39 AM DT stated not checking on resident every 2 hours was an example of neglect and could lead to pressure sores, UTIs, and indecency.During an observation on 04/28/26 at 01:38 PM Resident #15's skin showed no redness or breakdown.During an interview on 04/29/26 at 07:33 AM LVN J stated not changing a resident's brief was an example of neglect. She stated leaving a resident on a couch in a soaked brief and t-shirt overnight was not acceptable because the resident might fall and was not supposed to be out in public undressed. She stated, Another resident can go by and see somebody naked. LVN J stated a possible negative outcome of leaving a resident in an unchanged brief was skin breakdown or sores.During an interview on 04/29/26 at 09:02 AM SC stated all staff were responsible to ensure residents were not left sleeping overnight on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. She stated this could negatively impact the dignity of the resident. SC stated, She has a bed she needs to be in.During an interview on 04/29/26 at 09:06 AM LVN K stated it was not okay for a resident to be left overnight sleeping on a couch in just a t-shirt and brief or just a t-shirt. He stated, For one, other patients can see them; invades their privacy and their dignity, self-esteem. We have to advocate for the patient. He stated all facility staff were responsible for ensuring this did not happen to a resident. He stated even if housekeeping walked by and noticed a resident in that position, they were responsible to let the nurse know.During an interview on 04/29/26 at 09:18 AM RN S stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt for dignity and privacy reasons. She stated the nurse was ultimately responsible to ensure this did not happen to a resident.During an interview on 04/29/26 at 09:24 AM LVN T stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt. She stated, It is a dignity issue for one and plus they need to be able to sleep in their bed and get a good night's sleep. She stated the charge nurse was responsible for ensuring this did not happen to a resident. She stated if the resident insisted on sleeping on the couch the charge nurse should make sure they are clothed and have a blanket and pillow.During an interview on 04/29/26 at 09:30 AM ADON A stated if staff found a resident asleep on the couch in view of the hallway wearing just a t-shirt and brief or just a t-shirt she expected them to get the resident in the room, dressed, and covered. She stated if the resident wanted to sleep on the couch staff should redirect the resident and educate them on safety and comfort. She stated all staff were responsible for ensuring residents did not sleep as described above. ADON A stated it could negatively impact a resident's privacy and/or dignity. She stated a resident staying all night in a wet brief could lead to skin breakdown and lead the resident to think no one cares about them. ADON A stated leaving residents in their beds soaked in urine or feces was an example of neglect.During an interview on 04/29/26 at 09:38 AM ADON B stated he would expect staff to get a resident dressed and into their bed if they were found sleeping on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. He stated all staff were responsible for making sure this did not happen. He stated if the resident insisted on sleeping on the couch staff should cover them and shut the door, so they were not visible from the hallway. He stated otherwise a resident could get really cold and their dignity might be negatively impacted. ADON B stated leaving a resident on the couch as described above was an example of neglect. He stated residents could get UTIs and skin breakdown if left in wet briefs. He stated their (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity could be insulted.During an interview on 04/29/26 at 09:44 AM DON stated if her staff saw a resident sleeping in view of the hallway on a couch in just a t-shirt and brief or just a t-shirt she expected her staff to, Wake patient, take to room, and if they refuse to go to their room at least get them a blanket and pillow. She stated the resident could get too cold or end up getting sick if left as described above. DON stated the resident could fall off of the couch. She stated leaving a resident as described above was an example of neglect. She stated leaving residents in wet or soiled briefs could lead to skin breakdown or infection.During an interview on 04/29/26 at 10:23 AM ADM stated she would hope her staff would assist a resident who was sleeping on the couch in view of the hallway in just a t-shirt and brief or just a t-shirt to make sure that resident was appropriately dressed and clean. She stated any staff member with knowledge of the condition of the resident mentioned above was responsible to intervene. ADM stated leaving the resident as described above would be a dignity issue. She stated leaving residents in wet or soiled briefs could lead to skin breakdown.Record review of facility admission packet page titled Texas Department of Aging and Disability Services revealed the following: You, the resident do not give up any rights when you enter a nursing facility. If anyone . violates your dignity, you have the right file a complaint. You have a right to: . 2. safe, decent and clean conditions; . 4. be treated with courtesy, consideration, and respect; . 6. privacy, .Record review of the facility admission packet page 14-21 titled Resident Rights revealed the following: . The facility protects and promotes the rights of each resident in our care. 1. Basic Rights. Each resident has the right to a dignified existence . 15. Privacy. Each resident has the right to privacy with regard to accommodations, treatment, communications, personal care . 49. Resident Dignity. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that maintains or enhances his/her quality of life .Record review of facility policy titled Patient/Resident Rights and dated 10/01/20 revealed the following: . The Facility employs measures to ensure patient and resident personal dignity, well-being, and self-determination are maintained . The Facility treats each resident with respect and dignity. The Facility provides care for each resident in a manner that promotes, maintains, or enhances quality of life .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, for 6 residents (Resident #1, Resident #5, Resident #15, Resident #17, Resident #22, and Resident #41) of 83 residents reviewed for abuse and neglect.The facility failed to ensure Resident #1, Resident #5, Resident #15, Resident #17, Resident #22, and Resident #41 were not neglected during the 06:00 PM to 06:00 AM shift beginning on 04/19/26.The facility failed to ensure Resident #1 was not lying in a bed covered in feces.The facility failed to ensure Resident #5 was not lying in a bed soaked in urine.The facility failed to ensure Resident #15 was not lying asleep on a couch in just a soaked brief and t-shirt and later on a soaked couch in just a brief.The facility failed to ensure Resident #17 was not lying in a bed soaked in urine.The facility failed to ensure Resident #22 was assessed upon reporting a fall and was not lying in her bed upside down.The facility failed to ensure Resident #41 was not lying in a bed soaked in urine.These failures could place residents at risk of injury, infection, and/or negatively impacted self-esteem.Findings Included:Record review of Resident #1's admission record dated 04/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, muscle wasting and atrophy, muscle weakness, difficulty in walking, altered mental status, and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning).Record review of Resident #1's admission MDS completed 04/20/26 revealed a BIMS of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #1 required substantial maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort with toileting and all transfers.Record review of Resident #1's care plan last reviewed/revised on 04/20/26 revealed he had cognitive loss especially with short term recall. He experienced occasional bladder incontinence related to age. One of the interventions was, Provide incontinent care after each incontinent episode. Resident #1 was at risk for skin breakdown. Interventions included keeping him as clean and dry as possible, minimizing skin exposure to moisture, and keeping his linens clean, dry, and wrinkle free.Record review of Resident #1's active orders dated 04/27/26 revealed the following orders with corresponding start dates:04/09/26 BED MOBILITY with assist of 1-204/09/26 TOILETING with assist of 1-204/09/26 TRANSFER with assist of 1-2During an observation and interview on 04/27/26 at 05:37 AM Resident #1 was lying in bed on his back. When asked if staff took good care of him, he stated, That depends. When asked if there was a time staff did not take good care of him, he did not answer the question.During an observation and interview on 04/27/26 at 10:02 AM Resident #1 was lying in bed on his back. He stated he did not remember a night when the nurse did not check on him, and he ended up in a bed covered in feces. When asked if staff took good care of him on the night shift he looked down and away and stated, I don't want to answer the question.During an interview and observation on 04/27/26 at 10:06 AM Resident #1's skin showed no issues, redness, or irritation. Resident #1 denied any issues and stated he was pleased with his care.Record review of Resident #5's admission record dated 04/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, diarrhea, difficulty in walking, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), infectious gastroenteritis and colitis (inflammation of stomach and large intestine often resulting in bloody diarrhea, abdominal pain, and cramping.), benign prostatic hyperplasia with lower urinary tract symptoms (the flow of urine is blocked due to the enlargement of prostate the gland; symptoms include increased frequency of urination at night and difficulty in urinating), and muscle wasting and atrophy.Record review of Resident #5's admission MDS completed on 04/15/26 revealed a BIMS of 14 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which indicated intact cognition. Section GG Functional Abilities revealed Resident #5 used a wheelchair and had impairment of both lower extremities. He required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for toileting and all transfers.Record review of Resident #5's care plan last reviewed/revised on 04/21/26 revealed he had behavioral symptoms and as an intervention staff were to ensure his physical needs including toileting were met. Resident #5 was noted to have gastroenteritis with frequent diarrhea. He was noted to be incontinent of bowel and bladder, and staff were to provide incontinent care after each incontinent episode. Resident #5 was at risk of falling and staff were to keep his call light in reach at all times. Record review of Resident #5's active orders dated 04/27/26 revealed the following orders and corresponding start dates:04/07/26 AMBULATION with assist of 1-204/07/26 BED MOBILITY with assist of 1-204/07/26 TOILETING with assist of 1-204/07/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:51 AM Resident #5 was lying in his bed with his eyes closed under a blanket.During an observation and interview on 04/27/26 at 08:15 AM Resident #5 was lying in bed on his back with the head of the bed raised slightly. He stated staff took good care of him.During an observation and interview on 04/27/26 at 10:09 AM Resident #5's skin showed no redness or irritation, and he stated he was pleased with his care.During an observation and interview on 04/27/26 at 10:12 AM Resident #5 was lying in his bed on his back. He did not seem to understand when asked about a night when staff did not check on him and he woke up in a soaked brief and bed.Record review of Resident #15's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy, muscle weakness, difficulty in walking, insomnia (problems falling and staying asleep), unsteadiness on feet, and frequency of micturition (needing to urinate more often than once every 3-4 hours).Record review of Resident #15's quarterly MDS completed on 03/17/26 revealed a BIMS of 5 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #15 used a wheelchair and was dependent for toileting. She required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for transferring from chair/bed-to-chair.Record review of Resident #15's care plan last reviewed/revised on 04/01/26 revealed Resident #15 was a wanderer and at increased risk of falling. One of the interventions was [Resident #15]'s physical needs will be met; . toileting. She was to use a fall mat next to her bed as well as a scoop mattress and be monitored at least every 2 hours while in bed. Resident #15 was noted to be receiving hospice care and one of the interventions was [Resident #15] will be kept clean and comfortable. She was noted to require extensive assistance with toileting and transfers by one staff member. The goal was [Resident #15 will maintain a sense of dignity by being clean, dry, . One of the interventions included, Monitor appearance. Resident #15 was at risk for incontinence. Staff were to, Provide incontinent care after each episode of incontinence. She was at risk for skin breakdown due to incontinence. Staff were to, Keep clean and dray as possible. Minimize skin exposure to moisture. Staff were also to Provide toileting assistance every 2 hours and prn.Record review of Resident #15's active orders dated 04/27/26 revealed the following orders with corresponding start dates:11/19/25 Brief Check and document wet or dry every 3 hours02/26/26 BED MOBILITY with assist of 1-202/26/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:52 AM Resident #15 was lying in her bed on her right side with her eyes closed. Her bed was in the lowest position, and a fall mat was on the floor next to her bed.During an observation on 04/27/26 at 08:16 AM Resident #15 was lying in bed on her left side with her eyes closed. Her bed was in lowest position and fall mat was on the floor next to the bed. The couch in the entryway of her suite was visible from the hallway.During an observation and interview on 04/27/26 at 10:09 AM (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15 was in her bed with HOB raised to seated position. She did not remember a night when she slept on the sofa. She stated staff were kind and took good care of her.During an observation on 04/28/26 at 01:35 PM Resident #15's skin showed no breakdown or redness.Record review of Resident #17's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, muscle wasting and atrophy, muscle weakness, overactive bladder, difficulty walking, repeated falls, and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning).Record review of Resident #17's admission MDS completed 03/31/26 revealed a BIMS of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #17 used a walker and required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for toileting. She required partial/moderate assistance defined as Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports truck or limbs but provides less than half the effort for all transfers.Record review of Resident #17's care plan revealed she experienced occasional bladder incontinence due to age. Staff were to provide incontinence care after each incontinent episode. She was noted to have cognitive loss especially in relation to short term recall.Record review of Resident #17's active orders dated 04/27/26 revealed the following orders and corresponding start dates:03/24/26 AMBULATION with assist of 1-203/24/26 BED MOBILITY with assist of 1-203/24/26 TOILETING with assist of 1-203/24/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:41 AM Resident #17 was lying in bed on her left side in the fetal position. She stated staff took good care of her and no one had been unkind to her during her stay in the facility.During an observation on 04/27/26 at 10:13 AM Resident #17's skin showed no redness or irritation. She stated she had no issues and was pleased with her care.Record review of Resident #22's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified lack of coordination, altered mental status, muscle weakness, difficulty in walking, and muscle wasting and atrophy.Record review of Resident #22's quarterly MDS completed on 01/29/26 revealed a BIMS of 9 which indicated moderately impaired cognition. Section GG Functional Abilities revealed she used a manual wheelchair and was dependent for chair/bed-to-chair transfers. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.Record review of Resident #22's care plan last reviewed/revised on 04/21/2026 revealed she had a history of falling. An intervention to address this issue was to place her in her bed or recliner while she was in her room and not to leave her in her wheelchair. Another intervention was to observe her frequently and place her in a supervised area when out of bed.Record review of Resident #22's orders dated 04/27/26 revealed the following orders and order start dates: 05/24/24 1-2 person assist for ambulation 05/24/24 1-2 person assist for transfer05/24/24 1-2 person assist for toileting dated 05/24/24.05/24/24 at risk for falls02/26/26 1-2 person assist for bed mobilityRecord review of Resident #22's progress notes revealed the following notes:A note by LVN H on 04/20/26 at 09:39 AM This nurse and another nurse entered resident's room at approx 0615 (06:15 AM) and discovered resident laying on right side on the floor beside bed. Blanket was underneath resident and pillow was under left leg. This nurse asked resident what happened? Resident stated ?I guess I fell out of bed' Resident c/o pain to left hip and knee. Assessed for other injuries. Vital signs taken. None noted. Notified on call and administrator. Resident sent to [hospital initials] hospital for eval and treat due to guarding of left hip.A note by LVN H on 04/20/26 at 12:31 PM Returned from hospital via facility transport at approx 1200 (12:00 PM). In wheelchair with no new orders. Hip contusion. Smiling and conversating with no new c/o pain or discomfort at this time.During an observation and interview on 04/27/26 at 10:07 AM Resident #22 was seated in her wheelchair in her room. She stated she remembered the night LVN D worked and would not help her into bed. She stated, She (LVN D) was (continued on next page)

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	675498	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	just hateful. I don't think she was really interested in doing anything. I was very stressed out that night because she had such an attitude. Resident #22 stated she fell out of her bed that night onto the fall mat next to her bed. She did not remember a fall prior to that one.During an observation on 04/28/26 at 01:23 PM Resident #22's skin showed no breakdown or redness.Record review of Resident 41's admission record dated 04/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, reduced mobility, need for assistance with personal care, difficulty in walking, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), benign hyperplasia without lower urinary tract symptoms (the flow of urine is blocked due to the enlargement of prostate the gland; symptoms include increased frequency of urination at night and difficulty in urinating), muscle wasting and atrophy, and muscle weakness.Record review of Resident #41's quarterly MDS completed 02/25/26 revealed a BIMS of 9 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #41 used a wheelchair was required partial/moderate assistance defined as Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports truck or limbs, but provides less than half the effort for toileting and all transfers.Record review of Resident #41's care plan last reviewed/revised 04/13/26 revealed he could use the sit to stand lift for transfers. One of the interventions was, 2 staff members will use the sit to stand lift to ensure safety. Resident #41 was care planned for having a diagnosis of benign prostatic hyperplasia. One of the interventions was, Keep perineal area clean and dry. Resident #41 was noted to be frequently incontinent of bowel and bladder and to be at risk for skin breakdown, recurrent UTIs, and dignity problem (being embarrassed). The interventions included offering toileting every two hours while awake, assisting with toilet transfers, provide perineal care and provide incontinent care as indicated. Resident #41 was noted to have cognitive loss especially in the area of short-term recall. He was noted to be at risk of skin breakdown related to decreased mobility. Interventions included keeping him as clean and dry as possible and keeping his linens clean, dry, and wrinkle free.Record review of Resident #41's active orders dated 04/27/26 revealed the following orders and corresponding start dates:12/19/24 AMBULATION with assist of 1-2 persons12/19/24 TOILETING with assist of 1-2 persons12/19/24 TRANSFER with assist of 1-2 personsDuring an observation on 04/27/26 at 05:54 AM Resident # 41 was lying on his back in bed with his eyes closed. The head of his bed was slightly raised, and he had 3 pillows under his head.During an observation and interview on 04/27/26 at 10:05 AM Resident #41 was seated in his wheelchair in the doorway of his room. He stated he did not remember a night when staff did not change his brief, and he ended up soaking wet the next morning.During an interview on 04/27/26 at 04:37 AM LVN C stated she was working on 100 hall on the night of 04/19/26 when LVN D, who was working on 400 hall (Resident #22's hall), asked her for assistance. LVN C stated she walked with LVN D to Resident #22's suite and noted Resident #15 asleep on the couch in view of the hall wearing only a t-shirt and a soaked brief. LVN C stated she told LVN D, This is not cool. She stated LVN D told her, Wherever she (Resident #15) wants sleep; she's gonna sleep. LVN C stated LVN D told her she did not have time to baby talk the residents. LVN C stated she assisted LVN D with Resident #22 who stated she had fallen and her knee hurt as a result and she was in her bed upside down to take the pressure off of her knee. LVN C asked if she could assess her knee, and Resident #22 stated she just wanted to sleep. LVN C stated she put a pillow between Resident #22's legs and Resident #22 said the pillow relieved the knee pain. LVN C stated this happened at approximately 04:30 AM. She stated she returned to her hall and called the on-call phone to let ADON A know she was worried about the residents on hall 400. She stated she told ADON A about Resident #15 lying on the couch wearing only a soaked brief and T-shirt and about Resident #22 seeming to be afraid of LVN D and saying she had a fall and her knee hurt as a result. She stated ADON A told her she would let ADM know in the morning.During an interview and observation on 04/27/26 at 05:07 AM LVN C sent a text screen shot showing the time of her call to ADON A on the on-call phone was 04:35 AM on 04/20/26.During an (continued on next page)

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	675498	A. Building B. Wing	04/29/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 04/27/26 at 05:47 AM LVN E stated leaving residents in wet and soiled briefs was an example of neglect.During an interview on 04/27/26 at 05:57 AM RN F stated she came to work on the morning of 04/20/26 and LVN C asked her to check on the residents on hall 400. RN F stated she joined LVN H on hall 400 and the two of them found Resident #15 asleep on the couch in the entryway to her suite in view of the hall wearing only a t-shirt with a soaked brief on the floor next to the couch RN F stated the couch was soaked with urine around Resident #15. RN F stated Resident #41 was lying bed soaked from the back of his neck down to his knees. She stated Resident #22 was on the floor of her room next to the bed with the head at the foot of the bed and her feet toward the head of the bed. She stated Resident #22 was complaining of pain, so she was sent to the hospital for evaluation. She stated Resident #1 was lying in a bed covered in feces. RN F stated all of the residents on hall 400 required a full bed change due to soaked linens. She stated, I called ADM and let her know my serious concerns. I don't like to throw the word neglect around, but I could say I have serious concerns about the care on that hall overnight or the lack of care on that hall overnight. She stated of hall 400 on the morning of 04/20/26, There was major concerns.During an interview on 04/27/26 at 06:05 AM ADM stated LVN C called in a complaint to the company hotline regarding LVN D's care of residents on the night shift of 04/19/26. She interviewed LVN D and was told Resident #15 said the couch was her bed and refused to get off of the couch. She stated LVN D told her she (LVN D) was overwhelmed and struggled through the night but did the best she could. ADM stated, My day shift nurses were upset because people were wet.During an interview on 04/27/26 at 07:11 AM LVN D stated 04/19/26 was her first time working in the facility. She stated she was shocked when she picked up the night shift to find she was responsible for total care for 6 residents and did not have a CNA to help her. She stated she had a back injury that made it impossible for her transfer residents alone. LVN D said of the residents on hall 400, Everybody was confused, dead weight, couldn't stand by themselves. She stated one resident was on a sofa and had taken her brief off. She refused to get up and go to bed and told me she was in her bed. Apparently, she had taken her brief off and dropped it on the floor. LVN D stated she was capable of assisting with brief changes but I can't solo due to her back injury. She stated of Resident #15, She had taken her brief off and denied care. I had been warned she might refuse care and not take her medications. LVN D stated Resident #41 was too big for her to provide a brief change to him. She stated some residents needed brief changes, but she was unable to change them due to being unable to stay bent over.During an interview on 04/27/26 at 06:50 AM ADM stated LVN D told her she had had 2 back surgeries and was [AGE] years old. ADM stated staff did skin sweeps on all residents on hall 400 on 04/20/26 because the day shift coming on that morning reported all the beds on hall 400 were soaked. She stated the skin sweeps revealed no redness or injury. She stated none of the residents on hall 400 were interviewable.During an interview on 04/27/26 at 07:41 AM LVN D stated, I do want to emphasize that I feel facility management was completely neglectful for not providing adequate staff and support for staff. Been told they are notorious for understaffing and leaving a nurse to do total care without the assistance of a CNA. In the past I would have immediately called the state line and reported them. They figure out who said what and then you get blackballed. She stated she did not tell the facility she could not do the job of nurse and CNA because she did not want to be blacklisted with her agency. When asked if she thought the residents on her hall on the night shift of 04/19/26 were neglected due to no CNA being assigned to assist her, she replied, I'm hoping this isn't a catch 22 scenario. I feel there was a lot more that could have been done and I did all I could do under the circumstances and the conditions. If your life is in jeopardy, I am the one you want there. If you need to be lifted up out of a w/c and transferred to the bed and I am the only one there I can't do it. And I looked down the halls and couldn't find anyone to help. She stated, If your life is in jeopardy, I am the one you want there. If you need to be lifted up out of a wheelchair and transferred to the bed and I am the only one there I can't do it. LVN D stated Resident #22 told her she wanted to go to bed and LVN D told her she (LVN D) was not able to put her to bed alone and would try to find someone to help. LVN (continued on next page)

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	675498	A. Building B. Wing	04/29/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D stated she went down halls and could not find CNAs to help her. She stated she found one CNA who told her she would be there shortly to help but did not show up. She stated Resident #22 must have put herself on her bed upside down. She stated of Resident #41, I'm quite certain he needed to be changed (brief), but I told him I could not push and lift and roll. Multiple times I went looking for CNAs to help make rounds and check on him and they would say, ?When I get time I'll come over. LVN D stated no CNA ever came to her hall to assist her.During an interview on 04/27/26 at 08:17 AM CMA G stated if she saw a resident in a soaked brief and t-shirt asleep on a couch in view of the hall, she would take care of the resident and then let the charge nurse know how she found the resident. She stated leaving residents in wet or soiled briefs was a form of neglect.During an interview on 04/27/26 at 09:08 AM ADON A stated LVN C called her on the morning of 04/20/26 to say she had concerns about the residents on hall 400. ADON A stated LVN C told her she saw a resident in a soaked brief but did not say anything else. She stated LVN C did not tell her anything about a resident who was in pain and said she fell. ADON A stated she sent a text to the two other nurses in the facility (LVN I and LVN J) asking them to send one of their CNAs to help LVN D. She stated she did not follow up to see if that was done or further check on the residents on hall 400.During an interview on 04/27/26 at 09:47 AM LVN H stated when she came to work on the morning of 04/20/26 LVN D did not give report, just said, Good luck and left the facility. She stated she and RN F found Resident #22 on the floor of her room and sent her to the hospital because she was complaining of pain in her left hip and knee. She stated she found Resident #15 sleeping in just a t-shirt on the couch visible from the hallway. LVN H stated Resident #15's soaked brief was on the floor next to the couch and the couch was also soaked where Resident #15 was seated. She stated Resident #41 was soaking wet from his ankles to his neck. She stated he was begging to get up and saying, I'm wet, I'm wet, I'm wet. She stated he was complaining about being cold. LVN H stated she and RN F let ADM know about the condition of the residents of hall 400 right away. She stated Resident #17 had a brown ring on her bottom and her bed was soaked. She stated Resident #1 had feces all over his bed. LVN H stated Resident #5 was wearing a soaked brief and his bedding was soaked as well. She stated she was in complete shock that morning as she had never come to work to find her residents in the condition they were in. She stated as she was getting all of her residents cleaned up, she did a skin sweep on them and found no redness or irritation. She stated of the residents' skin, There wasn't any extra or new redness or anything like that. Nothing out of the ordinary on them. LVN H stated none of her residents complained about the care they received overnight. She stated for the most part her residents were not interviewable with the occasional exception of Resident #22.During an interview and observation on 04/27/26 at 11:57 AM ADM was asked for the times of the text messages between the on call phone and LVN I and LVN J. ADM showed this surveyor a text exchange on the on-call phone dated 04/20/26 between ADON A, LVN I, and LVN J. At 04:45 AM ADON A asked the two LVNs to send their CNAs to hall 400 if they got the chance.During an observation and interview on 04/27/26 at 12:00 PM ADM, MS, and this surveyor entered a closet in the facility to watch recorded camera footage of LVN D on hall 400 the night of 04/19/26. According to camera footage, LVN D did not enter a resident room until after 10 PM on the night of 04/19/26. ADM stated it was nice to know you pay so much money for agency staff to sit around on their phones. LVN D did enter resident rooms after 10:00 PM but did not remain in any of the rooms for more than 2 minutes except for the instance she and LVN C entered the suite of Resident #15 and Resident #22. The two LVNs remained in the suite for 3 minutes at approximately 4:30 AM on 04/20/26.During an interview on 04/28/26 at 08:26 AM LVN K stated an example of neglect was leaving residents alone when they needed to have their briefs changed. He stated this could lead to skin breakdown and psychologically the residents would be hesitant to trust. He stated it could negatively impact their self esteem as well as cause UTIs.During an interview on 04/28/26 at 08:30 AM CMA L stated not changing a resident's wet brief was an example of neglect. She stated residents might feel embarrassed or isolate themselves if their wet briefs were not changed.During an interview on 04/28/26 at 08:32 AM CNA M stated not changing a resident's brief (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was an example of neglect and could result in infection.During an interview on 04/28/26 at 08:35 AM CMA G stated leaving residents in wet briefs was an example of neglect and could lead to UTIs, rashes, odor, and decreased self-esteem.During an interview on 04/28/26 at 08:36 AM SC stated leaving residents in wet briefs was an example of neglect and could cause skin breakdown.During an interview on 04/28/26 at 08:39 AM DT stated not checking on resident every 2 hours was an example of neglect and could lead to pressure sores, UTIs, and indecency.During an interview on 04/29/26 at 07:33 AM LVN J stated not changing a resident's brief was an example of neglect. She stated leaving a resident on a couch in a soaked brief and t-shirt overnight was not acceptable because the resident might fall and was not supposed to be out in public undressed. She stated, Another resident can go by and see somebody naked. LVN J stated a possible negative outcome of leaving a resident in an unchanged brief was skin breakdown or sores. She stated she remembered working on the night of 04/19/26 and ADON A asking her to send her CNAs to hall 400 to help LVN D. She stated her CNAs did not go as they had just enough time to finish their last round on her hall. LVN J stated she answered a call light for LVN D because it had been going off for a long time. She stated she was not sure how long but that she had administered a medication and charted and it was still going off. She described the location of Resident #1's room. She stated he was confused and asking about his car. LVN D stated she noticed several of the call lights for hall 400 went off for long periods of time that evening. She stated not answering a call light within 15 minutes, not changing resident briefs, and not dressing residents were examples of neglect. LVN J stated, That is inhumane. You don't do that to anybody.During an interview on 04/29/26 at 09:02 AM SC stated staff were responsible to ensure residents were not left sleeping overnight on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. She stated this could negatively impact the dignity of the resident. SC stated, She has a bed she needs to be in. She stated not assessing a resident for injury after a professed fall could be a form of neglect. SC stated sitting in wet or soiled briefs all night was a form of neglect and resident skin could breakdown.During an interview on 04/29/26 at 09:06 AM LVN K stated it was not okay for a resident to be left overnight sleeping on a couch in just a t-shirt and brief or just a t-shirt. He stated, For one, other patients can see them; invades their privacy and their dignity, self-esteem. We have to advocate for the patient. He stated all facility staff were responsible for ensuring this did not happen to a resident. He stated even if housekeeping walked by and noticed a resident in that position, they were responsible to let the nurse know. He stated not assessing a resident who said they fell could lead to pain, compartment syndrome, and death. LVN K stated the nurse on duty was responsible for assessing the resident.During an interview on 04/29/26 at 09:18 AM RN S stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt for dignity and privacy reasons. She stated the nurse was ultimately responsible to ensure this did not happen to a resident. RN S stated the nurse on duty was responsible for assessing a resident who said they fell. She stated not assessing the resident could lead to the resident having an injury staff did not know about. She stated leaving residents in wet or soiled briefs was a form of neglect.During an interview on 04/29/26 at 09:24 AM LVN T stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt. She stated, It is a dignity issue for one and plus they need to be able to sleep in their bed and g

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides jurisdiction) in accordance with State law through established procedures for 1 (Resident #9) of 21 residents reviewed for reporting of alleged violations. The facility failed to report to the State within 2 hours when Resident #9 was allegedly abused by a staff member. This failure could place residents at risk of ongoing abuse.Findings included: Record review of the intake investigation report for Intake ID#1084554 revealed the following:Incident date and time: 04/18/2026 at 12:35 PM Date facility first learned of Incident: 04/20/26 at 11:00 AM Record review of TULIP Intake Information for Case # 1084554, revealed the following:Case Type: IncidentDate received: 04/20/26 at 12:42 PM Narrative of Incident: Resident #9 alleged that CNA N slapped her while another CNA was assisting her with turning her in bed. Resident #9 reported that CNA N entered the room to and slapped her hip during care. Actions and Notifications:CNA N was suspended pending investigationSkin assessment completed with no injuries notedAbuse/neglect in-service provided Record review of Resident #9's face sheet, printed 04/28/26 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including, but not limited to, bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), history of opioid abuse, altered mental status, unspecified psychosis, depression (a mood disorder that causes a persistence feeling of sadness and loss of interest), heart failure (a chronic condition in which the heart dose not pump blood as well as it should), rheumatoid arthritis (autoimmune inflammation of the joints), pain, muscle weakness, and muscle wasting and atrophy (breakdown of muscles). Record review of Resident #9's most recent MDS, a quarterly assessment completed 02/23/26, revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident #9 required substantial to maximal assistance with bed mobility, toileting, and transfers. Record review of Resident #9's care plan revealed:-Problem start date 4/20/26: Resident made false accusations regarding staff treatment.Approach: redirect resident when false accusations were made.- Problem start date 1/14/26: Behavioral symptoms related to history of opioid abuse.Approach: monitor for behavioral or physical indicators of substance abuse. Record review of Resident #9's active orders revealed: Use mechanical Lift for all transfers every shift, start date of 04/06/26. Record review of Resident #9's progress notes revealed:04/19/26 at 02:58 AM: Resident refused brief change in bed and requested sit-to-stand transfer despite Hoyer lift orders.04/19/26 at 02:59 AM: On call notified of disagreement at this time. During an interview on 04/27/26 at 5:49 AM, CNA O stated that she was present with CNA N the night of the incident and Resident #9 was irritated. CNA O stated that CNA N asked Resident #9 to roll during brief change and that Resident #9 became aggressive with CNA N. CNA O stated she went back into Resident #9's room later with another CNA to transfer her, Resident #9 stated, you saw CNA N hit me, right?. CNA O replied, no I did not. CNA O stated she did not witness a slap by CNA N to Resident #9. CNA O stated she reported the incident immediately to the charge nurse and she further stated Resident #9 tends to make a lot of false claims resulting in 2 CNA's always being present to do resident care with her. During an interview on 04/27/26 at 5:58 AM, Resident #9 stated that CNA N no longer worked with her due to the incident that was reported. During an interview on 04/29/26 at 8:09 AM, CNA N stated she was suspended pending investigation and returned to work on 04/22/26. She denied striking Resident #9 and stated she was unaware of the allegation until the investigation began. During an interview on 04/29/26 at 9:20 AM, ADON A stated she was on call the night of the incident but does not remember hearing about it. She stated the (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident occurred on 04/19/26, while she was on call, and was reported to the State on 04/20/26, which was not timely. She stated delayed reporting could result in continued abuse and could give the appearance of failure to report.During an interview on 04/29/26 at 9:21 AM, the DON stated the ADM was responsible for reporting abuse allegations to the State. She confirmed the incident occurred on 04/19/26, ADON A was on call during that time, and it was not reported until 04/20/26. She stated the delay was not timely and could result in harm to the residents. The DON stated she felt the breakdown happened with on-call weekend staff. During an interview on 04/29/26 at 9:37 AM, the ADM stated she was responsible for ensuring reports to the state were made. She stated the incident was reported to the on-call nurse on 04/19/26 but was not reported to her until 04/20/26. She identified a breakdown in communication and stated delayed reporting could allow abuse to continue. Record review of facility provided policy titled Abuse, Neglect, Exploitation or Mistreatment revised March 2026, revealed the following in part.The facility's leadership prohibits neglect, mental, physical and/or verbal abuse and are reported immediately. 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency in accordance with state law though established procedures. Record review of facility provided policy titled Resident Rights, from admissions handbook revision date of September 2020 revealed the following in part .#47. Protection from Abuse. The facility must develop and implement written policies and procedures and training that prohibit and prevent the mistreatment, neglect, and exploitation and abuse of residents. The facility must ensure that all alleged violations involving exploitation, mistreatment, neglect or abuse, are reported immediately. All alleged violations-immediately but not later than 1) 2 hours if the alleged violation involves abuse or results in serious bodily injury and 2) 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury, to the administrator of the facility and to other officials including state survey agency and adult protective services here state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures.