

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  The Hilltop on Main		STREET ADDRESS, CITY, STATE, ZIP CODE  1015 N Main Meridian, TX 76665	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</b></p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for the facility's only kitchen reviewed for food service safety.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure food was labeled with a product name and use by date in the facility's only walk-in freezer, walk-in cooler, and side-by-side refrigerator.</li> <li>The facility failed to clean, and sanitize, the kitchen's only industrial can opener.</li> <li>The facility failed to ensure the sanitizer in the facility's only dishwasher was at 50 PPM.</li> </ol> <p>These failures placed residents at the facility at risk for ingesting food borne pathogens.</p> <p>Findings included:</p> <p>Observation and interview on [DATE] at 10:08 AM revealed the kitchen's only industrial can opener (a metal can opener attached to a table/counter to open large metal cans.) The industrial can opener had a 6-inch-long handle which rotated a metal gear (like the size and shape of a hockey puck,) which in turn rotated a metal can. On the underside of the 6-inch-long handle mechanism, was a 1-inch piece of sharp metal, which ended at a point, which pierced the top of the can. Inside the metal gear, and on the 1-inch piece of sharp metal, was a black sticky substance. The black sticky substance was easily removed with gloved fingers. The black sticky substance was easy to roll between two fingers and produce 1 pea-sized amount of contamination.</p> <p>Observations on [DATE] at 10:11 AM of the facility's only walk-in freezer revealed 3 bags of frozen chicken in 3 individual bags. Two bags contained frozen chicken; neither plastic bag had a label for the product name, or a label with a date to use by. The third bag of chicken was not sealed, open to air, and did not have a label for the product name or a label with a date to use by. All three bags had frost and ice built up inside the bag.</p> <p>(continued on next page)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on [DATE] at 10:12 AM of the facility's only walk-in cooler revealed a large cardboard box on the middle shelf. The large cardboard box contained 12 small bags of green beans. The outside of the cardboard box did not have a label for the product name or a label with a date to use by. The small individual bags of green beans did not have a label for the product name or a label with a date to use by.</p> <p>Observations on [DATE] at 10:13 AM of the facility's only side-by-side refrigerator revealed a large sealable bag of cooked bread. The bag of cooked bread did not have a label for the product name or a label with a date to use by.</p> <p>Interview and observation on [DATE] at 10:20 AM with the KM revealed the industrial can opener was supposed to have been swapped out yesterday, [DATE], but a lot was going on. She messaged the MD to come to the kitchen. He presented promptly; he was observed having removed the old industrial can opener and installing a new one.</p> <p>Interview and observation on [DATE] at 10:28 AM of the facility's only dishwasher revealed the KM operating the dishwasher to check the amount of liquid sanitizer in the rinse cycle. The dishwashing machine had an information plate that reflected the appropriate chemical concentration was 50 PPM. To check the amount of the liquid sanitizer in the rinse cycle, the KM utilized a small piece of test paper provided by the company that serviced the machine. The KM was observed taking a small piece of test paper (about the size of a fortune from a fortune cookie) and rested it across an item that just exited from the dishwashing machine. After placing the test paper on the item, the test paper was supposed to react to the sanitizing chemical and darken to correspond with a color chart on the test strip container, representing an acceptable amount of sanitizer. The observation revealed the test strip, which was originally off-white, did not change color. The amount of sanitizer in the rinse cycle was not sufficient to cause a chemical change on the test paper, nor sufficient to sanitize the dishes run through the machine. The KM stated she would not run any more dishes through the machine until it was fixed. She stated she was going to call the dishwashing company to come out and look at the machine.</p> <p>Record review of a photo of the information plate on the facility's only dishwasher reflected the chemical sanitizing concentration was supposed to be 50 PPM.</p> <p>Interview on [DATE] at 11:18 AM with the KA revealed staff had to put a used by date and labeled all the food. She stated staff had to put a used by date so they would know when food went bad. She stated when the food expired, they would throw it out. She stated if residents were served expired food, they could have gotten food poisoning, diarrhea, and dehydrated. She stated before the staff used the can opener, they should have made sure it was clean so it would not grow bacteria. She demonstrated how she checked the dishwasher temperatures.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 11:33 AM with the KM revealed food storage could not have food out of date. She stated they used the first-in, first-out method which involved using the older food first. She stated when food had reached the used by date, they would throw it out. She stated they should have checked the dates before they send the food out and food was thrown out after 72 hours. She stated if a resident would have eaten food that had sat for a long period of time, the residents could have gotten a sickness such as food poisoning. She stated the equipment had to be kept clean so bacteria would not transfer. She stated they should have sanitized the equipment before and after use. She stated the dishwasher was used to kill all the germs and bacteria. She stated if a resident ingested bacteria they could get sick. She stated most of the residents were more susceptible to getting sick. She stated they had to make sure the dishwasher had the right temperature and sanitizer. She stated for training, she took notes, spot checked, and redirected.</p> <p>Interview on [DATE] at 11:47 AM with the DON revealed, regarding the food borne pathogens, if temperatures were not checked or food was stored too long, the residents could get illnesses.</p> <p>She stated the residents could get stomach viruses such as nausea, vomiting, or dehydration. She stated there had not been any residents in the three-week period that she had worked at the facility with outbreaks of food borne pathogens that she was aware of. She stated they should have a safeguard in place and should have had a policy in place that they dated and checked the food. She stated the kitchen supervisor should have checked and made sure staff had cleaned the equipment.</p> <p>Interview on [DATE] at 11:55 AM with the ADM revealed they should have labeled and dated all foods that were opened. She stated food should be discarded after 72 hours. She stated they should not keep expired food and it could cause stomach issues such as diarrhea. She stated schedules should have been made by the KM, so everyone knew what needed to be cleaned. She stated they should have checked the dishwasher temperatures during a wash. She stated she checked the temperature once a week. She stated the staff had been trained and she went in the kitchen weekly and followed up with manager. She stated she also checked everything in the kitchen to make sure staff were complying.</p> <p>Record review of the facility's Food Receiving and Storage Policy, dated [DATE], reflected that all food in the freezer of refrigerator will be covered, labeled, and dated with a use by date.</p> <p>Record review of the facility's Dishwasher Machine Use Policy, dated [DATE], reflected the dishwasher chemical sanitizer concentration was ,d+[DATE] PPM. Corrective action would be taken immediately if sanitizer concentration was too low. If chemical concentration did not meet requirements, use of the machine would cease immediately until PPM were adjusted.</p> <p>Record review of the facility's Sanitization Policy, dated [DATE], reflected all equipment was supposed to be kept clean, maintained in good repair. All equipment was supposed to have been washed to remove or completely loosen soils by manual or mechanical means necessary and sanitized with hot water or chemical sanitization.</p> <p>Record review of the Food and Drugs Administration 2022 Food Code, [DATE] Edition, reflected guidance for Ware-washing Machine, Data Plate Operating Specifications. Section ,d+[DATE].113 reflected the data plate provides the operator with the fundamental information needed to ensure that the machine is effectively washing, rinsing, and sanitizing equipment and utensils. The ware-washing machine has been tested , and the information on the data plate represents the parameters that ensure effective operation and sanitization and that need to be monitored.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 (Resident #1) of 6 residents reviewed for infection control.</p> <p>The DON failed to use enhanced barrier precautions during a gastrostomy feeding for Resident #1 on 01/22/2025 by not donning a gown prior to administering the feeding.</p> <p>This failure could place residents at risk of cross contamination which could result in infections or illness.</p> <p>Findings included:</p> <p>Record review of Resident #1 face sheet dated 1/22/2025 reflected she was a [AGE] year-old female with diagnoses of unspecified dementia (a loss of thinking, remembering, and reasoning skills), type 2 diabetes mellitus (elevated blood sugars), dysphagia (difficulty swallowing), and encounter for attention to gastrostomy (care of gastrostomy tube).</p> <p>Record review of Resident #1s annual MDS assessment dated [DATE] reflected she had a BIMS score of 6 indicating Resident #1 had severe cognitive impairment. The MDS reflected Resident #1 was Dependent for eating (indicating the helper does all the effort and the resident does none of the effort to complete the activity). The MDS reflected Resident #1 received 51% of her total calories through parenteral or tube feeding.</p> <p>Record review of Resident #1's care plan dated 07/09/2023 and updated 08/22/2024 reflected Resident #1 had a diagnosis of severe oropharyngeal dysphagia. She had a history of aspiration pneumonia, and a feeding tube was recommended and placed. The goal was that Resident #1 would be free of aspiration pneumonia through the review date. Interventions included that Resident #1 was dependent with tube feeding and water flushes. Interventions also included to Monitor/document/report PRN any signs and symptoms of: Aspiration- fever, SOB, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration.</p> <p>Record review of Resident #1's Physicians Order summary report dated 01/22/2025 reflected give Glucerna 1.5 237 ml five times a day for Nutrition. Flush tube with 60mL water before and after every feeding and/or meds dated 01/15/2025.</p> <p>In an observation of a gastric tube bolus feeding on 1/22/25 at 11:00 am, the DON failed to don her gown</p> <p>Prior to entering the room and the administration of the gastrostomy feeding for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/23/25 at 10:49, the [NAME] stated she had been employed at the facility for 3 weeks as the Director of Nursing Services. She stated she was curious why enhanced barrier precautions were not in place, but she had been working the floor as charge nurse and had not had time to address the issue. She stated her administrator was the certified infection preventionist. The DON stated the administrator or infection preventionist was responsible for educating the staff and ensuring proper enhanced barrier precautions were in place for residents that required them. The DON stated some of the negative effects related to not having enhanced barrier precautions in place for residents with g-tubes could be the spreading of infection.</p> <p>In an interview on 1/23/25 at 11:15am with the ADM, she stated all staff should have monitored for the needs for enhanced barrier precaution for the residents. She stated the DON was new; she just started on the January 6th, 2025. The ADM stated she was responsible for infection preventionist monitoring. She stated she was responsible for educating the staff on enhanced barrier precautions. She stated the previous DON made rounds daily and monitored for the need of enhanced barrier precautions. She stated gown and gloves should be used during those high contact resident care activities to prevent the spread of infection.</p> <p>Record review of facility policy titled Enhanced Barrier Precautions dated August 2022 reflected Enhanced barrier precautions are utilized to prevent spread of multi-drug-resistant organisms to residents.</p> <ol style="list-style-type: none"> <li>1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to the resident.</li> <li>2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.             <ol style="list-style-type: none"> <li>a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).</li> <li>b. Personal protective equipment (PPE) is changed before caring for another resident.</li> <li>c. Face protection may be used if there is also a risk of splash or spray.</li> </ol> </li> <li>3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:             <ol style="list-style-type: none"> <li>g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.)</li> </ol> </li> </ol>		