STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675518	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hilltop on Main	1015 N Main Meridian, TX 76665

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to have licensed nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans, in thatThe facility failed to have a 24 hour licensed nursing service on 7/19/25, 7/20/25, 08/02/25 and 09/27/25This failure placed all residents at risk for unmet needs and/or injury.Findings included: Record review of the PBJ staffing data report for the fourth quarter of the financial year 2025 reflected that there was no licensed nursing coverage for 24 hours/day on 07/09/25, 07/20/25, 08/02/25 and 09/27/25.During an interview on 03/03/26 at 10:42 a.m., LVN B reported that she had worked at the facility approximately 2.5 years prior to the interview date. She stated that her work hours were from 6:00 AM to 2:00 PM, Monday through Friday. LVN B indicated that she did not recall any days during her tenure when the facility lacked licensed nurses. She emphasized the importance of 24/7 licensed nurse coverage in ensuring resident safety, noting that such staffing supports staff in effectively implementing interventions. Additionally, LVN B highlighted the critical role of licensed nurses in coordinating residents' care, asserting that their presence is essential because many nursing tasks can only be performed by licensed professionals.During an interview on 03/03/26 at 1:40 p.m., LVN C stated that she had previously worked at the facility, with her second term beginning in October 2025 after a hiatus. She reported working on a rotating schedule from Monday through Sunday, from 2:00 PM to 10:00 PM, with additional hours when necessary and take-off days only when required. LVN C indicated that she had never experienced a day without 24-hour licensed nurse coverage during her shifts. She emphasized that the presence of a licensed nurse was mandatory, given the limited scope of practice for CNAs and the numerous tasks that could only be performed by a licensed nurse.During a telephone interview on 03/03/26 at 1:10 p.m., the MD, who has been affiliated with the facility for approximately two years, noted that while many DONs had come and gone, he was unaware of any lapses in 24/7 licensed nurse staffing. The MD expressed concern that such gaps could pose significant risks, particularly because licensed nurses are responsible for performing tasks that only they are qualified to carry out. He emphasized that the absence of licensed staff during these times could compromise resident safety.During an interview on 03/03/26 at 3:17 p.m., the DON stated that she officially assumed her responsibilities on 02/28/2026. She reported that she was not aware of any days at the facility without licensed nurses, whether fully or partially, but committed to preventing such situations in the future while serving as the DON. She emphasized that even a few hours without a licensed nurse could put residents' lives at risk, given their age and health conditions.During an interview on 03/03/26 at 3:27 p.m., the ADM stated that she had been employed at the facility since August 2025. She acknowledged occasional shortages of LVN coverage until October 2025 but confirmed that, since that time, there have been no days without licensed nurse coverage, whether LVN or RN. The ADM emphasized that the facility maintained sufficient skilled LVNs on payroll, many of whom were dedicated and willing to work beyond their scheduled hours when needed.Record review of the facility's policy staffing, Sufficient and competent Nursing revised in August 2022 reflected: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competence necessary to provide nursing and related care and services for all residents in (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	accordance with resident care plans and the facility assessment.Licensed nurses and certified assistants are available 24 hours a day, seven days a week to provide competent care services . 2. A licensed nurse is designated as a charge nurse on each shift .

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week and designate a registered nurse to serve as the director of nursing on a full-time basis for 1 of 1 DON (DON) and 1 of 1 RN (RN) reviewed for DON and RN coverage.The facility failed to have an RN on a regular basis in the facility since August 2025.The facility failed to have a full-time DON on regular basis from 10/01/25 to 02/28/26.This failure could place residents at risk of harm due to being left without supervisory coverage for coordination of events such as emergency care, disasters and providing quality care.Findings included:Record review of the facility timecard report revealed the facility did not have a DON from 10/01/25 to 11/30/25 and 12/26/25 to 02/28/26.Record review of the facility time card report revealed the facility did not have RN coverage in year 2025 on 09/01, 09/02, 09/05 to 09/07 , 09/10 to 09/13, 09/15 to 10/05, 10/07 to 10/10, 10/13 to 10/23, 10/25 to 11/14, 11/17 to 11/21 , 11/24 to 12/3 , 12/5, 12/9 , 12/10, 12/12 to 12/15, 12/17 to 12/19, 12/21, 12/24 to 12/26, 12/29 to 12/31 and there were no RN coverages as on 03/03/26 since 01/01/26.During an interview on 03/03/26, at 10:42 AM, LVN B reported that she had previously worked at the facility and, after a period of absence, resumed employment approximately 2.5 years prior to the interview. She stated she had felt the lack of RN and DON as a concern during her new tenure as LVN and on certain occasions posed significant challenges. She said, although the facility occasionally employed RNs and DONs, there were periods when neither was present. In such instances, LVN B indicated that she would seek supervisory guidance by consulting physicians, RNs, or DONs from sister facilities. LVN B mentioned that, when appropriate, she would seek advice from the pharmacy or dietitian as well.During an interview on 03/03/26 at 1:40 p.m., LVN C, who had a longstanding history with the facility and returned to work in October 2025 after a hiatus, stated that there had been no consistent RN or DON coverage since her reemployment. She noted that the DONs employed at the facility had short tenures and frequently resigned. LVN C reported that managing without a regular RN or DON was consistently difficult; nevertheless, she managed these gaps by reaching out to RNs and DONs at sister facilities to obtain their expertise when needed.During a telephone interview on 03/03/26 at 1:10 PM, the MD, who had been with the facility for approximately two years, observed that many DONs had come and gone, resulting in periods during which the facility lacked a DON. The MD said , he was unaware of the absence of RNs but expressed concern regarding the lack of DON services. He stated that the absence of a DON compromised the continuity of care and negatively impacted overall quality. The MD further noted that, in the past, the facility had conducted numerous QAPI meetings without the presence of a DON on the QAPI committee, which he considered problematic with respect to maintaining high standards of nursing care.During an interview on 03/03/26 at 3:17p.m., the DON stated that she was appointed on 01/29/2026 but was unable to commence her duties immediately due to her RN license being overdue for renewal. She said she officially assumed her responsibilities on 02/28/2026, following the renewal of her license. She stated the DON had a critical role in a nursing facility, noting that the DON was responsible for overseeing nursing staff, providing guidance as needed, and ensuring compliance with regulations, policies, and procedures to maintain quality of care. She also mentioned the importance of RNs in such settings, as they provided guidance, support, and performed nursing tasks beyond the scope of CNAs and LVNs. The DON further stated, the role of a DON on the QAPI committee was vital, as the DON was best positioned to articulate nursing-related issues and facilitate discussions aimed at improving the quality of care and residents' quality of life.During an interview on 03/03/26 at 3:27 p.m., the ADM stated that she had been employed at the facility since August 2025. She stated the recurring shortage of RNs and DONs had been an ongoing issue, prompting her to bring this matter to the attention of the director of operations and business partners. She said she had requested the assignment of an RN from sister facilities to serve as an interim DON, given that sister facilities had (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	available RNs and DONs without any outcome. She stated that a registered nurse was currently on the facility's payroll but required clinical supervision for a period of time as per the Board of Nursing due to compromised competency issue in the past. The ADM stated this RN had been working as an RN whenever a DON was present and was expected to resume his duties now that a DON was appointed. The ADM also stated that the corporate office had advertised RNs; however, recruitment was challenging because the facility's remote location limited access to main towns and cities. She further indicated that there were no reported quality concerns attributable to the lack of RNs or DONs, citing the experience of the LVNs and CNAs employed at the facility, as well as the low resident census and the absence of residents with complex health conditions during this period.Record review of the facility's policy staffing, Sufficient and competent Nursing revised in August 2022 reflected: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competence necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.A register nurse provides services at least eight consecutive hours every 24 hours, seven days a week. RNs may be scheduled more than eight hours depending on the acuity needs of the resident.Inquiries or concerns related to our facility's staffing should be directed to the director of nursing services (DNS) or his/her designee .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to assess the resident for risk of entrapment from bed rails prior to installation and review the risk and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 5 (Resident #2, #7, #12, #18, #26) of 14 residents reviewed for bedrails. The facility failed to properly assess the risk of entrapment, or obtain documentation of informed consents for Resident #2, #7, #12, #18, and #26 prior to the installation and use of bed rails. This failure could place residents at risk of entrapment, restraint, and injury. Findings included: Record review on 3/3/2026 of Resident #2's admission record and 5-day scheduled MDS assessment, dated 1/23/2026, reflected an [AGE] year-old female admitted [DATE] and readmitted on [DATE]. Resident #2 was shown to be her own decision maker with no other RP listed. The resident's diagnoses included cerebral infarction (stroke), contracture of right hand (condition in which one or more fingers bend toward the palm), muscle weakness, and other lack of coordination (inability to perform smooth and precise movements due to a breakdown in communication between the brain, muscles, and nerves). The resident's BIMS score was 12, which indicated moderate cognitive impairment. Section J of the MDS assessment regarding Fall History, reflected the resident had no falls or fractures in the six months prior to admission/entry or reentry. Section P of the MDS assessment regarding restraints and alarms reflected physical restraints were not used, including bed rails. Record review on 3/3/2026 of Resident #2's physical restraint assessment, signed and locked on 12/26/2025, reflected that the resident did not use any form of physical restraint. Record review on 3/3/2026 of Resident #2's care plan reflected an intervention/task initiated and revised on 1/2/2026 that stated, The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working reachable call light, the bed in low position at night; [Slide fails] as ordered, handrails on walls. Personal items within reach. Record review on 3/3/2026 of Resident #2's physical restraint assessment, signed and locked on 1/17/2026, reflected that the resident did not use any form of physical restraint. Record review on 3/3/2026 of Resident #2's Visual/Bedside EHR Report with an admission date on 1/17/2026 reflected, BED MOBILITY: The resident uses positioning bar to maximize independence with turning and repositioning. Record review on 3/3/2026 of Resident #2's MDS EHR Report with an admission date of 1/17/2026 and a review date of 2/8/2026 reflected no physical restraints used in bed including bed rail. Record review on 3/3/2026 of Resident #2's order summary report reflected an active verbal order dated 3/2/2026 that stated, Positioning bar for bed mobility per resident request with no start or end date. Record review on 3/3/2026 of Resident #2's undated Clinical Miscellaneous documents did not reveal any consent form related to bed rail/grab bar usage or the risks and advantages of the use of bed rail/grab bar. Record review on 3/3/2026 of Resident #7's admission record and comprehensive MDS assessment, dated 1/2/2026, reflected a [AGE] year-old female admitted t 6/22/2017 and readmitted [DATE]. Resident #7 was shown to be her own decision maker with the responsible party listed as self. The resident's diagnoses included: chronic respiratory failure (long term condition where the lungs cannot maintain adequate oxygen levels or remove carbon dioxide effectively), chronic obstructive pulmonary disease (progressive lung disease making it hard to breathe), morbid (severe) obesity due to excess calories (BMI of 40 or higher due to the intake of calories in excess of what is used for energy), acquired absence of left leg above knee (loss of the left leg above the knee due to trauma or medical condition), and acquired absence of right leg above knee (loss of the right leg above the knee due to trauma or medical condition). The resident's BIMS score was 12, indicating moderate cognitive impairment. Section P of the MDS assessment regarding restraints and alarms reflected bed rail not in use. Record review on (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/3/2026 of Resident #7's CAA worksheet, dated 1/2/2026, reflected the use of physical restraints was not checked or indicated. Record review on 3/3/2026 of Resident #7's care plan, initiated on 4/10/2018 and revised on 12/14/2023, reflected, SIDE RAILS: Half rails up as per [Dr.s] order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition at least every 2 hours and as necessary to avoid injury. Record review on 3/3/2026 of Resident #7's undated order summary report reflected no order for bed rails or side rails. Record review on 3/3/2026 of Resident #7's undated Clinical Miscellaneous documents did not reveal any form related to bed rail/grab bar/side rail usage or the risks and advantages of the use of bed rail/grab bar/side rail. Record review on 3/3/2026 of Resident #7's Assessments in the EHR did not show an assessment for the safe use of bed rails/grab bars/side rails. Record review on 3/2/2026 of Resident #12's admission record and quarterly MDS assessment, dated 12/19/2025, reflected a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #12 was shown to have a guardian as her RP. Resident #12's diagnoses included cerebral palsy (group of conditions that affect movement and posture caused by brain damage before birth), severe intellectual disability (disorder that causes difficulties with reasoning, problem-solving, abstract thinking, and learning), muscle weakness, and pain the right hip and left knee. A BIMS was not conducted due to the resident being rarely/never understood. Section P of the MDS assessment regarding restraints and alarms reflected bed rail not in use. Record review on 3/2/2026 of Resident #12's care plan, initiated on 11/3/2016, reflected no focus, goal, or intervention/tasks listed involving the usage of bed rail/grab bar/side rail. The care plan reflected an entry for ADL Self Care Performance Deficit r/t Aggressive Behavior, Confusion, Impaired Balance with intervention/tasks for bed mobility as I require assistance from staff with bed mobility care at times, Level of assistance may vary depending on my condition. Record review on 3/2/2026 of Resident #12's undated order summary report reflected no order for bed rails or side rails. Record review on 3/2/2026 of Resident #12's undated Clinical Miscellaneous documents did not reveal any form related to bed rail/grab bar/side rail usage or the risks and advantages of the use of bed rail/grab bar/side rail. Record review on 3/2/2026 of Resident #12's Assessments in the EHR did not show an assessment for the safe use of bed rails/grab bars/side rails. Record review on 3/3/2026 of Resident #18's admission record and comprehensive MDS assessment, dated 10/31/2025, reflected a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #18 was shown to have a RP listed. Resident #18's diagnoses included type 2 diabetes with diabetic peripheral angiopathy (disorder that occurs when the body becomes resistant to insulin or the pancreas fails to produce insulin leading to high blood sugar that damages blood vessels and reduces blood flow to the limbs), chronic obstructive pulmonary disease (progressive lung disease making it hard to breathe), traumatic hemorrhage of cerebrum (brain bleed caused by trauma), and muscle weakness. The resident's BIMS score was 15, indicating normal cognitive functioning with minimal or no impairment. Section P of the MDS assessment regarding restraints and alarms reflected bed rail not in use. Record review on 3/3/2026 of Resident #18's care plan, initiated on 12/9/2022, reflected no focus, goal, or intervention/tasks listed involving the usage of bed rail/grab bar/side rail. The care plan reflected resident had an ADL self-care performance deficit with interventions/tasks initiated on 2/20/2025 and revised on 5/5/2025 related to bed mobility listed as, I require setup assistance from staff with bed mobility care at times, Level of assistance may vary depending on my condition. Record review on 3/3/2026 of Resident #18's order summary report reflected no order for bed rails or side rails. Record review on 3/3/2026 of Resident #18's undated Clinical Miscellaneous documents did not reveal any form related to bed rail/grab bar/side rail usage or the risks and advantages of the use of bed rail/grab bar/side rail. Record review on 3/3/2026 of Resident #18's Assessments in the EHR did not show an assessment for the safe use of bed rails/grab bars/side rails. Record review on 3/3/2026 of Resident #26's admission record and quarterly MDS assessment, dated 12/26/2025, reflected an [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #26 was listed as her own RP. The resident's diagnoses included (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic obstructive pulmonary disease (progressive lung disease making it hard to breathe), type 2 diabetes mellitus with diabetic neuropathy (disorder that occurs when the body becomes resistant to insulin or the pancreas fails to produce insulin leading to nerve damage), morbid (severe) obesity due to excess calories (BMI of 40 or higher due to the intake of calories in excess of what is used for energy), and muscle weakness. The resident's BIMS score was 13, indicating normal cognitive functioning with minimal or no impairment. Section P of the MDS assessment regarding restraints and alarms reflected bed rail not in use. Record review on 3/3/2026 of Resident #26's care plan, initiated on 1/9/2020 and revised 12/30/2025, reflected no focus, goal, or intervention/tasks listed involving the usage of bed rail/grab bar/side rail. Record review on 3/3/2026 of Resident #26's undated order summary report reflected no order for bed rails or side rails. Record review on 3/3/2026 of Resident #26's Clinical Miscellaneous documents did not reveal any form related to bed rail/grab bar/side rail usage or the risks and advantages of the use of bed rail/grab bar/side rail. Record review on 3/3/2026 of Resident #26's Assessments in the EHR did not show an assessment for the safe use of bed rails/grab bars/side rails. During an observation of Resident #12's bed area on 3/1/2026 at 1:19 p.m. revealed bed rails attached to the resident's bed. During an observation of Resident #7's bed area on 3/1/2026 at 1:48 PM revealed bed rails attached to the resident's bed. Observation of Resident #2's bed area on 3/3/2026 at 11:00 a.m. revealed bed rails attached to the resident's bed. During an observation of Resident #18's bed area on 3/3/2026 at 2:30 p.m. revealed bed rails attached to the resident's bed. During an observation of Resident #26's bed area on 3/3/2026 at 2:33 p.m. revealed bed rails attached to the resident's bed. During an interview on 3/2/2026 at 4:15 p.m., MD A stated that he was the MD for the facility for approximately the last 1.5 years. MD A stated that he does not recall being consulted for the use of bed rails of any resident at the facility. MD A stated that he would strongly prefer the facility consult with him prior to use or installation, MD A said he did not recall writing an order for bed rails for any resident at the facility. MD A stated the use of bed rails posed a risk for entrapment and restraint. MD A stated he did not prefer the use of bed rails for that reason. MD A stated that he would ensure that he followed up with the facility and ensure the use of bed rails is discontinued. In an interview on 3/3/2026 at 10:41 AM, LVN B stated that she was employed with the facility for 2.5 years as a LVN LVN B confirmed the use of bed rails within the facility. LVN B stated that bed rails were used for positioning and bed mobility purposes. She did not know when bed rails were implemented for those in use. She stated that use of bed rails would require the MDS assessment to reflect their use, an order for use, their use be documented in the care plan, and consent forms to have been obtained from residents or their representatives. LVN B stated that consultation with therapy services, the doctor, the ADM, and the DON should be done for alternative options before bed rails are utilized to determine if they're appropriate. LVN B stated that she was sure a safety assessment should be completed for each resident before bed rail use was implemented. She said there were no problems or accidents related to bed rails or grab bars that she knew of. LVN B stated that the possible negative outcomes related to the use of bed rails or side rails could be injury or accidents such as skin tears if the resident's arm gets caught in the rail. LVN B stated failure to follow the proper process for bed rail use could pose a threat to the residents' safety. Interview on 3/3/2026 at 1:08 p.m. revealed RP #1 stated she was the assigned court appointed guardian case manager for Resident #12 for two yrs, but the agency in which she worked was the assigned guardian for some time. RP #1 stated that she had no concerns or issues related to the care or supervision provided to Resident #12 at the facility. RP #1 stated Resident #12 had no accidents or injuries at the facilit. RP #1 said Resident #12 was very happy at the facility and RP #1 was very satisfied with the facility, too. RP #1 stated she was not aware of the use of bed rails for Resident #12 and she did not sign a consent for their use. RP #1 stated that consent could have been provided by the prior case manager. RP #1 said she had not noticed bed rails were being used. She said she was not opposed to their use if their use was recommended and ordered due to an identified need. RP #1 said she was included in care plan meetings and care plan developments and never had concerns (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for abuse, neglect, or exploitation of the resident in the facility. During an interview on 3/3/2026 at 2:30 p.m., Resident #18 stated that it was her preference to have bed rails installed on her bed for mobility purposes. During an interview on 3/3/2026 at 2:33 p.m., Resident #26 stated that it was her preference to have bed rails installed on her bed for mobility purposes. During an interview on 3/3/2026 at 3:27 p.m., the ADM revealed she was employed at the facility since August 2025. She stated that in-service and training were regularly provided to staff regarding resident care and needs topics. The ADM stated that her expectation regarding the use of bed rails was to follow their policy. She said the use of bed rails should be documented and ensure residents were restraint free. She said she expected each resident using bed rails to have a care plan in which the use was documented and orders were obtained prior to their use. The ADM stated she believed consents were required as well. The ADM stated there were benefits and risks when bed rails were used such as keeping resident safe, but she stated, a lot could go wrong mentally and physically and they could cause harm. The ADM stated the MDS should reflect residents' status and needs accurately. The ADM stated this could negatively impact the safety of the residents. Record review of the facility's policy titled, Restraint-Free Care: Upholding Dignity and Safety at The Hilltop on Main, reflected the following: The Hilltop on Main is committed to maintaining a restraint-free environment in all areas of care. Restraints are any physical or mechanical device, material, or equipment attached to or adjacent to a resident's body that the individual cannot easily remove and that restricts freedom of movement or normal access to one's body. A restraint free environment protects the physical, emotional, and psychological health of residents. Restraints can cause harm, agitation, confusion, or loss of function. Federal and state standards uphold the right of every resident to live free from unnecessary restraints.restraints are only used as a last resort in cases where immediate harm is imminent and no other safe alternatives exist Staff are trained to utilize alternative interventions such as.scheduled toileting, hydration, and mobility routines. Each staff member plays a vital role in maintaining a restraint free culture. Record review of the facility's policy and procedures regarding Bed Safety and Bed Rails reflected the following: The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The resident sleeping environment is evaluated by the interdisciplinary team.Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.) Use of Bed Rails .bed rails include:Side railsSafety rails; and Grab/assist bars2. a. The definition of restraints is based on the functional status of the resident and not on the device.3. The use of bed rails or side rails.is prohibited unless the criteria for use of bed rails have been met, including attempts to use other alternatives, interdisciplinary evaluation, resident assessment, and informed consent.5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. The interdisciplinary evaluation includes: a. an evaluation of alternatives to bed rails that were attempted. b. the resident's risk associated with the use of bed rails. c. input from the resident and/or representative. d. consultation with the attending physician.6. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis b. size and weight c. sleep habits d. medication(s) e. acute medical and surgical interventions f. underlying medical conditions g. existence of delirium h. ability to toilet self safely i. cognition j. communication k. mobility (in and out of bed; and l. risk of falling.8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hilltop on Main	1015 N Main Meridian, TX 76665

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post daily information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 3 days (03/01/26, 03/02/26 and 03/03/26) of 3 days reviewed for posted nurse staffing information.The facility did not post the required current nurse staffing information from 03/01/26 through 03/03/26.This failure could place residents at risk of not having access to information regarding staffing data and the facility census.Findings included:During an observation on 03/01/26 at 10:00 a.m., it was revealed that there was no staffing posting present at the facility with facility name and date containing the total number of staff and actual hours worked by RNs, LPNs and LVNs or CNAs who are directly responsible for resident care.During an observation and interview on 03/03/26 at 1:25 p.m., LVN C searched the nursing station and surrounding area for the daily staffing postings. She stated that there was no staffing posting present. She also searched various folders for previous days' postings but was unable to locate any. LVN C indicated that there were no staffing postings for 03/01/16 and 03/02/26. She stated that it was the responsibility of the DON to ensure the daily staffing information was posted.During an interview on 03/03/26 at 1:40 p.m., the DON stated that she was new to the facility, having started on 02/28/26, and was not aware that it was her duty to post the daily staffing information. The DON stated that staffing postings were important for residents, their families, and visitors, as they provided information regarding the number of staff members in various roles available for nursing-related tasks. She stated she would post the staffing information as soon as possible.Record review of the facility's policy, Staffing, sufficient and competent nursing, revised in August 2022, reflected: .Direct care daily staffing numbers (the number of nursing professional responsible for providing direct care to residents) are posted in the facility for every shift.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 13 residents (Resident #8) reviewed for accuracy of assessments. The facility failed to accurately indicate Resident #8's receipt of injections and insulin injections on the resident's quarterly MDS assessment completed on 12/10/2025. This failure could place residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review on 3/2/2026 of Resident #8's quarterly MDS assessment, dated 12/19/2025, reflected a [AGE] year-old male admitted [DATE]. His diagnoses included neurocognitive disorder with Lewy bodies (protein deposits that develop in nerve cells of the brain that affect thinking, memory and movement), Type 2 Diabetes with moderate non-proliferative retinopathy without macular edema, right eye (a condition characterized by insulin resistance and high blood sugar that has caused right eye damage), neuroleptic induced parkinsonism (movement disorder caused by the use of antipsychotic medications), and acquired absence of right foot (loss of the right foot due to a condition not present at birth). Resident #8's BIMS score was 10, indicating moderate cognitive impairment. Section N of the assessment regarding medications showed Resident #8 received 0 injections of any type during the prior seven days or since admission/entry or reentry if less than seven days. Section N of the assessment regarding insulin had no entries for the number of days that insulin injections were received during the prior seven days or since admission/entry. Record review on 3/2/2026 of Resident #8's care plan reflected dated 8/5/2024, The resident has Diabetes Mellitus On NCS diet (dietary approach that eliminates extra sugar in the diet;diet, No Concentrated Sweets. Trulicity, Jardiance, Metformin and regular insulin administered on a sliding scale every am and hs. Record review on 3/2/2026 of Resident #8's Order Summary Report revealed an active order for Insulin Regular Human Injection Solution Injection.Inject as per sliding scale.and call MD for another further orders if above 400, subcutaneously (method of delivering medication into the fatty tissue just beneath the skin, allowing slow and steady absorption into the bloodstream. in the morning related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA ordered on 8/31/2024, started on 9/1/2024, with no end date listed, and an active order for Trulicity Subcutaneous Solution Auto-injector 1.5MG/.5ML (Dulaglutide) Inject 1 dose subcutaneously (under the skin) in the morning every Mon related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA ordered on 1/24/2025, started on 1/27/2025, with no end date listed. Record review on 3/2/2025 of Resident #8's Medication Administration Record, dated December 2025, revealed Insulin and Trulicity injections were administered to Resident #8 as ordered and in the 7 days prior to the completion of the MDS quarterly assessment completed on 12/19/2025. During an observation and interview on 3/1/2026 at 1:39 p.m., Resident #8 stated was diabetic and received insulin to manage his blood sugar. During an interview on 3/2/2026 at 2:54 p.m., MDS A stated that she had 30 years of experience conducting MDS assessments. She stated that she was a Clinical Reimbursement Specialist for the company that operated the facility. MDS A stated she conducted MDS assessments for this facility and was employed with the company for five yrs. She stated that she had the proper training and skills to conduct MDS assessments and received ongoing education, inservice, and support to do her job well. During record review of MDS A Resident #8's quarterly MDS assessment, dated 12/19/2025, physician orders, and Medication Administration Record for December 2025 during the interview and confirmed Resident #8 did receive insulin and injections during the seven days prior to the completion of the quarterly MDS assessment completed by MDS A on 12/19/2025. MDS A stated this was a mistake and oversight on her part. MDS A stated that there would be no negative outcome to the resident due to her mistake, but it would have a negative effect on the reimbursement amount the facility received for services. During an interview on 3/3/2026 at 10:41 a.m., LVN B stated that she was employed with the facility for 2.5 years as a Licensed Vocational Nurse. LVN B (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that MDS assessments should accurately reflect the needs and characteristics of the residents, LVN B stated that the MDS assessment should accurately reflect the needs and characteristics of the residents, including the use of insulin and receipt of injections. LVN B stated an inaccurate MDS assessment could have a negative impact on residents' health and safety because it is the basis of the creation of the plan of care and the use of insulin and injections needed to be monitored. LVN B stated it would also not provide a clear clinical picture. During an interview on 3/3/2026 at 3:27 p.m., the ADM stated that she was employed at the facility since 8/13/2025 as the administrator. She stated that she oversaw staff and resident care at the facility. She reported no observed concerns with the care provided to the residents. The ADM stated that her expectation was that the MDS assessments completed on residents would accurately reflect the status and needs of the residents. She stated that inaccurate MDS assessments could negatively impact the safety of the residents. The ADM stated, specifically regarding insulin, an inaccurate assessment could lead to their blood sugar being off and negatively impact the resident's health. Record review on 3/2/2026 of the facility's Electronic Transmission of the MDS policy revised September 2010 reflectedAll staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual, before being permitted to use the MDS Information System. A copy of the MDS RAI Instruction Manual is maintained by the Resident Assessment Coordinator. Record Review on 3/2/2026, of the Long-Term Care Facility RAI 3.0 User's Manual revised October 2025 reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs safely and in a manner that promoted each resident's rights, physical, mental, and psychosocial well-being for 2 of 2 (Resident #22 and #24) reviewed for competent nursing staff. The facility failed to ensure CNA A utilized appropriate communication, intervention, and redirection methods with Resident #24 which led to an escalation of conflict between Resident #22 and Resident #24 resulting in Resident #22 making threatening gestures and a threat of harm to Resident #24. This failure could place the residents at risk of serious injury or harm. Findings included: Record review on 3/1/2026 of Resident #22's admission record and modified quarterly MDS assessment, dated 2/13/2026, reflected an [AGE] year-old male admitted on /2022 and readmitted [DATE]. Resident #22 was his own RP. Resident #22's diagnoses included chronic obstructive pulmonary disease (trouble breathing), Alzheimer's disease with late onset dementia, (condition causing confused thinking) and major depressive disorder (sadness, lack of interest or pleasure in doing things that does not resolve on it's own) The resident's BIMS score was 11, indicating moderate cognitive impairment. Record review on 3/1/2026 of Resident #22's care plan reflected an intervention/task initiated on 3/16/2022 stated, Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Record review reflected this intervention/task was the responsibility of the CNA. Record review on 3/1/2026 of Resident #24s admission record and modified quarterly MDS assessment, dated 2/13/2026, reflected a [AGE] year-old male admitted [DATE] and 1/30/2021. Resident #26 had a responsible party/POA listed. Resident #26's diagnoses included type 2 diabetes mellitus with hyperglycemia ((a condition characterized by insulin resistance and high blood sugar), chronic obstructive pulmonary disease (progressive lung disease making it hard to breathe), vascular dementia, moderate, with other behavioral disturbance (cognitive decline due to reduced blood flow to the brain, leading to various behavioral changes), personality change due to known physiological condition (alterations in behavior, mood, and interpersonal interactions), psychotic disorder with delusions, and major depressive disorder, without psychotic features (depression that significantly impairs daily functioning with symptoms including sadness, loss of interest in activities and a decrease in daily functioning). Resident #26's BIM score was 01, indicating severe cognitive impairment. Resident #26's MDS assessment reflected the resident had unclear speech, his ability to express his ideas and wants was limited to making concrete requests, and he sometimes made himself understood with simple, direct communication only. The MDS assessment reflected Resident #26 had no behavioral symptoms, including physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and other behaviors. Record review on 3/1/2026 of Resident #26's care plan focus task initiated on 7/31/2015 and revised on 4/28/2022 stated, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs[)]Disease process. Care Conference Resident only [involves] in activities with food, occasionally church, [watch] tv and resident shopping[)]. The intervention for this focus task stated, Modify daily schedule, treatment plan PRN to accommodate activity participation as requested by the resident. This focus task, goal and intervention was the responsibility and duty of the CNA. Resident #26's care plan included a focus task initiated 7/29/2015 and revised on 5/20/2025 which stated, The resident has a communication problem r/t stroke, expressive aphasia sometimes understands and sometimes understood and speech unclear SHAKES HEAD YES/NO OR USES HAND GESTURES. and an interventions initiated 7/29/2015 which stated, Anticipate and meet needs, and Speak on an adult level, speaking clearly and slower than normal initiated on 11/6/2022, which were the responsibility of and duty of the CNA. During an observation on 3/1/2026 at 12:10 p.m. during dining (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nods. He indicated that he was doing well and had no problems. He indicated that he was enjoying his lunch. No signs of distress or negative psycho social outcomes observed. In an interview on 3/3/2026 at 12:58 p.m. with RP #2, Resident #26's RP, stated there were no concerns with the resident's care or supervision voiced. RP #2 stated she had no concerns for the resident's safety or well being. She stated she was notified of the incident between Resident #26 and #22. She stated that the resident had no prior incidents with other residents. RP #2 said she Resident #26 has had no negative occurrences with staff to her knowledge. RP #2 said she visits Resident #26 a couple of times a month and has not had any concerns. During an interview on 3/3/2026 at 1:51 p.m., LVN A stated that there aren't usually problems between Resident #22 and #26. She said Resident #26 has a history of screaming out but Resident #22 doesn't. LVN A stated that CNA A was the problem because she does not appropriately interact or intervene with residents. LVN A stated that CNA A is demanding and controlling of the residents and didn't utilize appropriate deescalation techniques. LVN A said CNA communicated with residents in a disrespectful manner. LVN A stated that CNA A often disappeared and didn't help with resident care. LVN A stated that she had reported her concerns and observations to management in the past and the issue continued. She stated that the staff turnover and the lack of consistent management staff had made reporting all concerns difficult. During an interview on 3/3/2026 at 2:16 p.m., CNA A stated she was employed at the facility for 18 months. She stated she was educated, trained and regularly in serviced on resident care, meeting resident needs, and resident interventions. CNA A stated the facility is understaffed and she felt unsupported in that manner. She said she had made staffing concerns known to the charge nurse. She said the facility had only had a DON for 2 weeks so she had not made a report to the DON. CNA A stated that she is often tired because of the amount of hours and work she had to complete. In regards to the incident between the residents observed, CNA A stated Resident #22 wanted the TV off and Resident #26 wanted the TV on so she told Resident #26 they couldn't turn the TV on. CNA A said the AD hid the remote. CNA A stated she overheard #22 tell other residents he did not want the TV on so she honored that. CNA A stated that she left the dining room to go help elsewhere. CNA A stated she thought it was appropriate to tell the residents to keep the TV off. CNA A stated that she usually told the residents what to do to keep peace and maintain order and talked in a tone to make them understand. Record review on 3/3/2026 at approximately 2:30 p.m of CNA A's personnel file revealed an orientation list for CNA regarding relevant resident care, dementia care and relevant resident related topics but no indication that CNA reviewed this list and no indication of a skills check-off. The file reflected two prior disciplinary actions in approximately February and August 2025 related to refusal to provide resident care and inappropriate resident interaction and response. In an interview on 3/3/2026 at 3 PM, the DON stated that she was made aware of the incident between Resident #22 and #26 on 3/1/2026 by LVN B. The DON stated that she gave LVN B instructions on what to do and who to notify. She said she read the nurses notes to make sure all necessary tasks were done. The DON said she interviewed staff to ensure resident safety. DON said she hadn't observed CNA A's interactions with the residents much but had no concerns from her limited observations. DON said she wasn't fully aware of how the incident was handled until this day but once she learned, CNA A was terminated. DON said CNA A's interventions and actions were inappropriate and no consistent with her duties and responsibilities. DON stated that she didn't know CNA had been previously disciplined but if she did she would've taken her off of the floor immediately and made sure she was held to the proper standards and ensured her competency. DON said any refusal of care would've been a problem because that was the basis of CNA A's job. DON stated that potential negative outcomes of the situation could have been hurt feelings of the residents and residents feeling disrespected in their own home. DON said it could have also led to residents' needs not being met. DON stated that it was possible that this situation might not have occurred if CNA A didn't engage in an argument with residents about the TV in the first place. In an interview on 3/3/2026 at 3:27 p.m., the ADM stated she was employed at the facility since August 2025 and regular in-service education and training on (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relevant resident care topics had been provided to staff during her time at the facility. The ADM stated she made regular rounds to observe staff to resident interactions and had no concerns. She stated no concerns were reported to her by anyone else. The ADM stated if she learned of staff failures, she would provide specific in-service education and provide counseling or coaching. The ADM stated that she expected staff to treat residents with respect and dignity and provide care they are trained to provide.