STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675988	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Rehabilitation and Care Center	970 Hilltop Dr Weatherford, TX 76086

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be informed in advance by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he/ she preferred for 1 of 6 residents (Resident #3) reviewed for antipsychotic consents. The facility failed to ensure Resident #3, or her representative signed consent for the antipsychotic medication Seroquel (quetiapine) (an antipsychotic medication used to treat mental health disorders, such as schizophrenia) prior to administering the medication, and after the dosage was increased prior to administering the new dosage ordered by physician. These failures could affect residents by placing them at risk of not being informed the risks and possible side effects of their medication to make informed decisions regarding their care. Findings included: Record review of Resident #3's electronic face sheet, not dated revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease (progressive mental deterioration that can occur in middle age or old age due to degeneration of the brain), Vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), stroke (a medical emergency occurring when blood flow to the brain is blocked or a vessel bursts causing rapid brain cell death). Record review of Resident #3's quarterly MDS dated [DATE] revealed: BIMS score of 00 which indicated the resident was unable to complete the BIMS test. Further review of the MDS Section N-Medications revealed Resident #3 was taking an antipsychotic medication. Record review of Resident #3's physician order dated 11/10/2025 revealed: Quetiapine tablet 50 mg 1 tablet to be administered daily at bedtime. Record review of Resident #3's physician order dated 11/23/2025 revealed: Quetiapine tablet 50 mg 2 tablets to be administered at bedtime. Record review of Resident #3's MAR dated November 2025 revealed Resident #3 received Seroquel (quetiapine) 50 mg 1 tablet at bedtime starting the night of 11/10/2025 - 11/22/2025, and two 50 mg tablets at bedtime starting 11/23/25 - 11/26/25. Record review of Resident #3's EMR revealed there was not a HHSC Form 3713 Consent for Antipsychotic or Neuroleptic Medication Treatment. A facility form used for consent Seroquel revealed no evidence of a signature by Resident or their representative. Further review revealed a verbal consent obtained by the prior ADON on 11/27/2025 for dosage of Quetiapine (Seroquel) 50mg at bedtime. There was no evidence that side effects were discussed with Resident #3s representative and that she acknowledged understanding of the side effects listed on the form. Record review of Resident #3's electronic medical chart revealed no evidence Resident #3, or her representative consented to or was aware of an increased dosage of Seroquel on or before 11/23/2025. Record review of an Inservice dated 03/11/2026 signed by 10 members of the nursing staff reflected All Antipsychotics must have a signature on the 3713 prior to administration. During a telephone interview on 03/12/2026 at 8:00 a.m., Resident #3's representative stated she did not give verbal consent for Quetiapine and would not have given the consent if she had been aware that the medication was not recommended for use in the elderly. During an interview on 03/12/2026 at 2:45 p.m., LVN A stated the process for giving an antipsychotic medication began with the nurse getting an order from the physician and then calling the family to get consent from 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family. She stated there are two papers for them to sign, the HHSC form 3713 and a Consent for use of psychotropic medications. She stated the medication cannot be given until both of these consents are signed by the resident or resident representative. During an interview on 03/13/2026 at 1:08 p.m., with the Interim DON present, the CCN stated it was the nurse's responsibility for getting consents signed for psychoactive medications. She stated those consents should have been obtained prior to giving psychoactive medication to the resident. She stated she was not able to find a consent for Quetiapine (Seroquel) medication on Resident #3. She stated she was unaware that verbal consents were not appropriate for Quetiapine on Resident #3. She stated she could not find a consent with updated dosage for Resident #3. She verified that the consent for Seroquel on Resident #3 did not have a physical signature on the form. She stated what might have contributed to Resident #3 not having a consent on file could be that the facility had changed in Nursing administration over the past several months and them not being familiar with the consent requirements for antipsychotics. The CCN stated not obtaining consent prior to medication administration could have caused residents or their representatives to not be provided with information of the side effects of the medication or not being notified that the resident was ordered that medication. She stated DON and ADONs were responsible for monitoring that the appropriate medications had consents. She stated she had just started monitoring the consents and had conducted an in-service on consents on 3/11/2026. Record review of facility policy titled Antipsychotic Medication Use dated March, 2025 revealed: Antipsychotic medications will be prescribed at the lowest possible dosage, for the shortest period of time and are subject to gradual dose reductions and re-review. Requirements for consents: If a resident is currently on an antipsychotic or Neuroleptic medication, a consent will be obtained by the resident, or a resident's legally authorized representative providing consent to prescribe this medication, HHSC (consent) form, which is form 3713, the form 3713 either the original version or a copy, will be added to the resident's clinical record. This form is completed if the antipsychotic or Neuroleptic medication is prescribed to a resident for the first time and will be completed prior to the first dose is administered. Review of LTCR Provider letter titled Consent for Antipsychotic and Neuroleptic Medications dated May 5, 2022, accessed on 03/19/2026 at https://www.hhs.texas.gov/sites/default/files/documents/pl2022-11.pdf, revealed The prescriber of the medication, the prescriber's designee, or the NF' s medical director must complete Section I of Form 3713. HHSC cannot specify who can be the designee for the prescriber. Prescribers should consult their own board, such as the Texas Medical Board, to determine who can act as their designee. A prescriber can delegate the completion of Form 3713, Section I, if the prescriber's license permits it . The resident or the resident's legally authorized representative must sign Section II of Form 3713 (Consent for Antipsychotic or Neuroleptic Medication Treatment). The rule requires consent in writing by the resident or by a person authorized by law to consent on behalf of the resident. Verbal consent does not meet the rule requirements. NF staff cannot sign on behalf of the resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to be free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms 1 of 6 residents (Resident #3) whose records were reviewed for chemical restraints. Resident #3 was administered Quetiapine (Seroquel), an antipsychotic, without a diagnosis for justification of use. The facility's failure could affect residents by placing them at risk for adverse reactions and negative side effects from the administration of medication that was not indicated for use to treat medical conditions and symptoms. The findings included:Record review of Resident #3's electronic face sheet dated 3/11/2026 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease (progressive mental deterioration that can occur in middle age or old age due to degeneration of the brain), Vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), stroke (a medical emergency occurring when blood flow to the brain is blocked or a vessel bursts causing rapid brain cell death). Review of Resident #3's Physician Order Report dated 11/01/25 to 11/30/2025 Revealed orders for Quetiapine tablet 50 mg 1 tablet to be administered daily at bedtime for vascular dementia with agitation. Record review of Resident #3's physician order dated 11/23/2025 revealed orders for: Quetiapine tablet 50 mg 2 tablets to be administered at bedtime for vascular dementia with agitation. Record review of Resident #3's MAR dated November 2025 revealed Resident #3 received Quetiapine (Seroquel) 50 mg 1 tablet at bedtime starting the night of 11/10/2025 - 11/22/2025, and two 50 mg tablets at bedtime starting 11/23/25 - 11/26/25. Record review www.drugs.co website on 3/17/2026, revealed Quetiapine (Seroquel) was an antipsychotic typically used in the treatment of schizophrenia (a chronic severe mental disorder) and bipolar disorder (a chronic disorder characterized by severe mood swings). Its stated common side effects include sedation, fatigue, weight gain, Constipation, and dry mouth. Other side effects include low blood pressure with standing, seizures, high blood sugar, tardive dyskinesia (a neurologic disorder that causes involuntary, uncontrollable, and repetitive movements which typically appears with the long term use of antipsychotics), and neuroleptic malignant syndrome u(a rare and life-threatening reaction to the use of almost any kind of antipsychotic) in older people with dementia, its use may increase the risk of death.During an interview with Interim DON on 03/17/26 at 1:00 p.m. she stated Vascular Dementia with agitation was not an appropriate diagnosis for Quetiapine. She stated the medication could cause over sedation in the elderly. During an interview with the CCN on 03/17/2026 at 1:30 p.m., she agreed Vascular Dementia with Agitation is not a proper diagnosis for the use of the antipsychotic medication Quetiapine. She stated a negative outcome to the residents could be oversedation. She stated that the Hospice nurse had obtained the order for the Quetiapine. Record review of the facility's policy for Antipsychotic Medication Use, dated as revised March 2025, revealed the following [in part]:Policy: Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician, nurse practitioner, and other staff will gather and document information to clarify the resident's behavior, mood function, medical condition, specific symptoms, and risk to the resident and others. Anti-psychotic medications should generally be used only for the following conditions diagnosis: schizophrenia, schizoaffective disorder, delusional disorder, mood disorders, psychosis, and in the absence of dementia. Antipsychotic medications will be prescribed at the lowest possible dose for the shortest period of time, and are subject to the gradual dose reduction and re -review.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident within 48 hours of the resident's admission for 1 of 6 residents (Resident #3) whose records were reviewed. The facility failed to ensure Resident #3 had a Baseline Care Plan developed and implemented within 48 hours following admission to the facility. This failure could place the residents at risk of not receiving care and services required to meet their individual needs from the date and time they were admitted to the facility. The findings includedRecord review of Resident #3's face sheet, not dated revealed a [AGE] year-old female admitted on [DATE] with diagnoses to include: Alzheimer's disease (progressive mental deterioration that can occur in middle age or old age due to degeneration of the brain), Vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging brain tissue), acute cystitis (inflammation of the bladder) stroke (a medical emergency occurring when blood flow to the brain is blocked or a vessel bursts causing rapid brain cell death).Record review of Resident #3's admission MDS assessment dated [DATE] revealed the following: Resident #3 had a BIMS score of 02 which indicated the resident had severe cognitive impairment, Resident #3 had delusions (misconceptions or beliefs that are firmly held, contrary to reality), and physical behavioral symptoms directed toward others . Resident #3 used a walker and required touch assistance and supervision to ambulate. She required partial to moderate assistance with transfers. Resident #3 was also incontinent of bowel and bladder. Resident #3 received a scheduled pain medication .Review of Resident #3's clinical record revealed a baseline care plan had not been completed within 48 hours following the resident's initial admission to the facility on [DATE]. During an Interview with the CCN on 03/16/26 at 3:00 PM, she stated the form titled Baseline care plan in the Resident's EMR was not completed. She stated that the prior DON was responsible for delegating the task, but she was unsure who was assigned to complete it for Resident #3 She stated the failure could put residents at risk for not getting needed care. During an Interview with the MDS Nurse A on 03/16/26 at 3:30 PM, she stated the form titled Baseline Care Plan in the Resident's EMR had been deleted and was not completed. She stated her name was on the deleted form , but she was not sure who deleted it or why it was not completed. She stated the failure could have put residents at risk for not getting needed care. Review of the facility's policy and procedure titled Care Plans- Baseline dated - November 14, 2023, revealed the following [in part]: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. Policy Interpretation and Implementation1) To assure that the residents immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission.2) The interdisciplinary team will review the health care practitioner's orders and implement a baseline care plan to meet the residents immediate care needs including but not limited to:a. Initial goals based on admission orders.b. Physician orders.c. Dietary orders.d. Therapy services.e. Social services.3) The baseline care plan will be used until the staff can conduct comprehensive assessments and develop an interdisciplinary person-centered care plan.4) The resident and the representative will be provided with a copy of the baseline care plan that includes but is not limited to:a. The initial goals of the resident.b. The summary of the resident's medication and dietary instructions.c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility and,d. Any updated information based on the details of the comprehensive care plan, as necessary.