STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675988	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Hilltop Park Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 970 Hilltop Dr Weatherford, TX 76086	

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on observation, interview and record review, the facility failed to coordinate the assessment for one of four residents (Resident #74) with the pre-admission screening and resident review (PASRR) program, of resident assessments reviewed for PASRR evaluations. The facility did not identify Resident #74 as having a mental illness with a with diagnoses of Paranoid schizophrenia, bipolar disorder and dementia that would require a PASRR 1012 form or a new PL1 form to initiate a PASSR evaluation by the local intellectual and developmental disability authorities. This failure could affect residents with mental illness who may not be evaluated for PASRR services and place them at risk of not receiving services needed for care and treatment. The findings included: Review of Resident #74s Face Sheet and Orders dated 08/21/2024 reflected she a was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #74's diagnoses included: dementia with behavioral disturbance (impaired though processes that affect the ability to function independently) onset date 07/03/2023, mood disturbance (altered mood) onset date 11/30/2023, paranoid schizophrenia (a mental disorder that causes suspicion, fear and distrust of others accompanied by a belief in things that are not real) onset date 07/03/2023, and bipolar disorder (an alteration in mood that is characterized by extreme and inappropriate highs and lows) onset date 07/03/2023. Review of Resident #74's active Physician Orders dated 08/21/2024, reflected an order for Lamictal (a mood stabilizer) 50 mg by mouth at bedtime for a diagnosis of bipolar disorder, and Seroquel 25 mg at bedtime (an antipsychotic medication) for paranoid schizophrenia. Review of Resident 74's Quarterly Minimum Data Set (MDS dated [DATE], reflected Resident #74 could usually understand others and was usually understood by others; had a moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 6 severe cognitive impairment. No mood or behavior concerns were documented. Review of Resident #74's Care Plan dated revised 07/11/2024 reflected the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675988	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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F 0644

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Focus: The resident uses psychotropic medications - Seroquel for diagnosis of Paranoid Schizophrenia

Goal: The resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date.

Review of Resident #74's PASRR Level One Screening Form dated 07/03/2023 completed by the transferring facility reflected Resident #74 had no diagnosis of mental illness, intellectual disability, or developmental disability.

Review of Resident #74's PL 1 form dated 7/3/24 which was viewed in Resident 74's electronic records and the long-term care portal. These records reflected there was not a 1012 form or a new PL1 completed.

An interview on 08/21/2024 at 6:10 PM with MDS Coordinator #1 who stated that the resident #74 should have a yes for mental illness documented on his PL1 form in section C. She stated she had forty years' experience as an MDS Coordinator but had just been at this facility for about three months. She stated she and MDS Coordinator #2 were both hired at the same time. She stated she asked MDS Nurse Coordinator #2 to complete a Form 1012 or a new PL1 for Resident #74 but did not check to ensure to that it was done correctly. Stated she had been given the responsibility of monitoring the forms for accuracy. She stated she had been in the process of doing an audit to check diagnoses on all residents.

In an interview on 08/21/24 at 6:16 PM, MDS Coordinator #2 stated she completed a 1012 form and had the physician sign it, but she did not check to see that a New PL1 should have been completed instead.

In an interview on 8/21/24 at 2:30 PM the Regional Clinical Reimbursement Specialist stated she reviewed Simple LTC, diagnosis and dates of onset and PL1 dated 7/3/23. She said Section C on the PL1 was not coded correctly for Mental Illness and stated the Schizophrenia diagnosis dated 7/3/23 and Bipolar diagnosis dated 07/03/23 would make Resident #74 positive for Mental Illness. She also stated the administrator, or the DON should monitor to see that diagnosis are monitored for changes that would affect PASRR eligibility. She stated the failure occurred because of the prior MDS Nurses failing to monitor diagnosis routinely.

Review of the facilities policy and procedures titled: Preadmission screening for MI dated 04/26//2016 reflected the following in part:

The intent of the management group is to meet and abide by all state and federal regulations that pertain to resident preadmission and screening resident review rules (PASRR).

The intent of the guideline is to identify residents with Mental Illness Intellectual Disability or Developmental Disability. And to ensure they are properly placed, whether in the community or in a Nursing facility and to ensure they receive the services they require for their MI or ID/DD

(continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social worker or designee will input the PL1 into the long-term care portal. If the PE is positive the social worker or designee will notify the LIDDA or LMHA within two calendar days to schedule the IDT and initiate the PE process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 20 residents (Residents #26 and #61) reviewed for comprehensive care plans. 1. Resident #26 had orders for the antipsychotic medication Seroquel and the mood stabilizing medication Nuedexta. The medications were not included in the resident's comprehensive care plan. 2. Resident #61 received an order dated 6/11/24 to be admitted to hospice care services with a diagnosis of Alzheimer's disease. A significant change MDS assessment dated [DATE] was completed due to the resident being admitted to hospice care services. The resident's comprehensive care plan did not address the hospice care services. These failures placed the residents at risk for not receiving necessary care and services to meet their individual needs and to promote a feeling of wellbeing during daily life within their living environment. The findings included: 1. Review of Resident #26's Admission Record, dated 8/21/2024, reflected an [AGE] year-old male initially admitted to the facility on [DATE]. The resident's diagnoses included: unspecified dementia; anxiety disorder; major depressive disorder, recurrent; bipolar disorder (a mental health condition that causes extreme mood swings); psychotic disorder with delusions; pseudobulbar affect (nervous system disorder that causes inappropriate involuntary laughing and crying); insomnia; post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event with symptoms including flashbacks, nightmares, or severe anxiety); and delusional disorder. Review of Resident #26's active medication orders reflected the following: - Nuedexta Oral Capsule 20-10 mg - give 1 capsule by mouth two times a day related to pseudobulbar affect, with an order date of 7/10/24. - Seroquel Tablet - give 200 mg by mouth in the morning for psychotic disorder with delusions, with an order date of 8/15/24. - Seroquel Tablet - give 200 mg by mouth at bedtime for psychotic disorder with delusions, with an order date of 8/15/24. Review of Resident #26's Quarterly MDS Assessment, dated 8/07/24, reflected the resident had received antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's comprehensive care plan, dated 6/18/24, reflected it addressed the use of psychotropic medication, with the approach to administer psychotropic medications as ordered by the physician. The care plan did not specify the antipsychotic medication of Seroquel or the indication for use. The comprehensive care plan did not address mood state, mental health services, and the administration of Nuedexta for mood stabilization. In an interview on 8/22/24 at 4:07 PM, the ADON for the secure unit stated Resident #26 had received psychiatric/mental health services since he was admitted to the facility during 2014. She stated the resident had a lot of anger when he first came and was doing much better now. The ADON stated he had been seen by the psychiatrist and the nurse practitioner. She stated Resident #26 had received counseling services, and now was mostly seen for evaluation of medication and medication management by the psychiatric practitioner. During an interview and record review on 8/22/24 at 5:33 PM, MDS Coordinator #1 reviewed Resident 26's care plan dated 6/18/24 and stated usually she would be a lot more specific and would include the category of antipsychotic medication and the indication for use. She stated the resident's care plan was done by a traveling nurse for the company and was completed before she started employment in the facility on 5/20/24. 2. Review of Resident #61's Admission Record, dated 8/21/2024, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: Alzheimer's disease; anxiety; depressive disorder; insomnia; and pain. Review of Resident #61's active physician orders reflected an order dated 6/11/24 to admit to hospice with the diagnosis of Alzheimer's disease. Review of Resident #61's Significant Change of Condition MDS Assessment, dated 6/23/24, reflected the resident received hospice care. Review of Resident #61's comprehensive care plan, dated 7/19/24, reflected it addressed his terminal condition related to Alzheimer's disease. The care plan did not address the resident's admission to hospice care services. In an interview and record review on 8/22/24 at 12:48 PM, the ADON stated if a resident was receiving hospice care services it should be included in the care plan. She reviewed Resident #61's care plan and stated she did not see a care plan for Hospice services. The ADON stated the Hospice nurse's attendance during the care plan conference would be documented in the progress notes. The ADON reviewed Resident #26's progress notes and stated she did not find documented evidence of the care plan conference in the progress notes. Review of the facility's policy and procedure for Care Plans, Comprehensive Person-Centered, dated as revised December 2016, reflected the following [in part]: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 3. The IDT includes: f. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 8. The comprehensive person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42852 Based on observation, interview, and record review, the facility failed to obtain informed consents for bed rails, prior to installation, for 1 (Resident (R#49) of 8 residents reviewed for bed rails, in that: The facility did not have consent or orders for the use of bed rails for Resident #49. This failure could put residents at risk for injuries or entrapment. The findings included: Record review of R#49's Admission Record, dated 8/20/2024, revealed R#49 was a [AGE] year-old female who was admitted to the facility on [DATE]. R#49's diagnoses included Acute Respiratory Failure, Lack of Coordination, Muscle wasting, Muscle Weakness, Unspecified Dementia, and History of falling. Review of the Physician's Orders for R#49 dated 08/20/2024 reflected there was no orders for the use of bed rails. Record review of R#49's electronic health record from 02/14/2024 through 08/20/2024 reflected no informed consent for the use of bed rails. Record review of R#49's care plan last revised 08/19/2024 revealed: no record regarding use of bed rails. Record review of Incident and Accident Tracking logs for 06/01/2024 through 08/20/2024 revealed Resident #49 has falls dated: 7/2/2024, 7/10/2024, 7/11/2024 and 7/23/2024. In an observation on 08/20/2024 at 08:15 AM revealed R#49's bed rails up on both sides of the bed. Resident was in dining hall. In an observation on 8/22/2024 at 09:30 AM Resident #49 was in room, up in recliner and side rails were up on head of bed. Resident was not interviewable. In an interview on 08/22/2024 at 8:55 AM ADON said Resident #49 had poor safety awareness. In an interview on 08/22/2024 at 11:22 AM with DON, said Resident # 49 had no side rail assessment found. DON said her expectations were that an assessment for side rails would be done and they should be done quarterly for each resident. DON said the negative outcome could be entrapment for a resident. In a record review of Facility Policy for Proper Use of Side Rails dated 1/16/2024 reflected: (Level II) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under: Purpose in part: the safe use of rails. Under General Guidelines reflected in part: 3. Upon admission, readmission, with quarterly or significant change therapy/designee will complete the Side Rail Utilization Assessment, or equivalent form to determine the resident's symptoms, risk of entrapment and rationales for using side rails prior to implementation. When used for mobility or transfer, the assessment will include a review of the resident's: A. Bed Mobility C. Risk of entrapment from the use of side rails 4. Consent for use of side rail will be obtained from Resident or legal representative, after presenting potential benefits and risks using the Informed Consent for use of bed rails. 10. The resident will be checked at least every shift for safety and proper functioning of the side rail use.

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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 - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 27938 Based on observation, interview, and record review, the facility failed to post the actual hours worked by the licensed and unlicensed nursing (RN, LVN and CNA) staff directly responsible for resident care per shift daily. The daily nursing staffing information was posted on 08/20/2024 and 08/22/2024 but did not include the total numbers of actual hours worked for RNs, LVNs, and CNAs. The facility's failure could affect the residents and/or visitors to the facility who may desire to know how many nursing staff were present and on duty and the actual time worked per each shift daily. The findings included: In an observation on 08/20/2024 at 9:45 a.m. revealed the facility's daily nursing posting failed to indicate the actual hours worked for each direct care staffing type. In an observation on 08/22/2024 at 10:00 a.m. revealed the facility's daily nursing posting failed to indicate the actual hours worked for each direct care staffing type. In an interview on 08/22/2024 at 3:00 pm the DON who stated she was not aware that the actual hours worked by licensed and unlicensed staff had to be posted until today when it was brought to her attention. She further stated the staffing was done daily by her ADON. In an interview on 08/22/2024 at 3:30 pm the ADON who stated she was responsible for the staffing and daily staffing posting and has never put the actual hours worked by licensed and unlicensed on the posting. In an interview on 08/22/2024 at 4:10 PM, the Administrator who stated his expectation was to follow policy and that the policy was not followed due to the total numbers of actual hours worked for RN's, LVN's and CNA's, and the census at beginning of each shift were not on the posting. He further stated that they would modify the form to include the requirement. Record review of the facility's policy Posting Direct Care Daily Staffing Numbers, dated 2001, reviewed July 2016 reflected the following [in part]: I. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, a d LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	2. Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living (ADLs), performing gastrointestinal feeds, giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition form for each shift. The information recorded on the form shall include: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. f Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted 50133

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 14408 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen and 1 of 2 resident nourishment rooms, in that: 1. Knife blades and serving utensils were stored on a rack and suspended in the air with their sanitized food surfaces exposed to contaminants in the air. 2. Appliances and equipment were soiled with grease and food. 3. A cardboard case with diced potatoes was stored on the floor in the walk-in freezer. 4. The ice scoop was placed on top of the ice inside the ice machine. 5. The dishwasher recorded the water temperature and sanitizer level for the low temperature dish machine on the daily dish machine log prior to running the dish machine for two meals on 8/20/24. 6. The refrigerator-freezer in the secured unit resident nourishment room was observed on 8/20/24. The refrigerator did not have an interior thermometer and resident food was not dated. The freezer compartment door gasket was loose. These failures placed the residents at risk for foodborne illness and a decline in health status. The findings included: Observations on 8/20/24 at 7:04 AM during the initial tour of the facility kitchen revealed the following: - Knives with their blades on a magnetic strip and serving utensils (whisk, spoons, scoops, tongs) were hanging from a metal frame above the food preparation counter in the middle of the room. The sanitized food surface of the utensils were exposed to potential contaminants in the air from the ceiling air duct vent near the frame. - A Cambro warmer cart was plugged into an electrical outlet and used to keep food warm. The top exterior surface was greasy and sticky to touch. - A manual can opener was mounted to the end of a stainless steel counter. The food contact surface was soiled with a dried red colored substance. - The deep fryer unit contained dark colored cooking oil; the fryer baskets were in holders and had fried food and breading crumbs stuck to them; fried food crumbs were on interior surface of the deep fryer unit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The walk-in freezer unit had a cardboard box containing diced potatoes stored directly on the floor of the walk-in freezer; a large plastic resealable bag containing what appeared to be boneless/skinless chicken breasts was not labeled/dated. - The ice scoop was inside the ice machine and was laying on top of the ice. A holder for the ice scoop was on a counter to the side of the ice machine. During an interview and record review on 8/20/24 at 7:42 AM, Dishwasher A stated the dish machine was a low temperature machine with sanitizer. He stated the water temperature and sanitizer were checked every meal 3 times daily. He stated he would check the water temperature and sanitizer level before starting to wash dishes after breakfast that morning. Dishwasher A stated the water temperature and sanitizer were documented on a daily dish machine log. A dish machine log was not observed in the dish machine room. Dishwasher A stated it was kept in a notebook binder in a cabinet in the kitchen. Dishwasher A walked to a cabinet, located outside the Dietary Manager's office, and he opened the doors and pulled out a red notebook binder used for the dish machine log. The form was dated August 2024 and documented the dish machine water temperature and chlorine sanitizer daily. The water temperature was documented at 120 degrees F and the chlorine sanitizer was documented at 100 ppm for 8/20/24 at 8:00 AM and 8/20/24 at 12:00 PM. Dishwasher A stated he had not yet run the dish machine and had not checked the water temperature and chlorine sanitizer today, but he would after breakfast and after lunch. He stated he wrote down the water temperature and sanitizer ppm in advance because he would get busy later and might forget to write down the temperatures and sanitizer levels. Observation on 8/20/24 at 4:57 PM revealed the Memory Care Nourishment Room had a residential style refrigerator/freezer unit. The gasket around the top freezer compartment door was loose and hanging down. There were small icicles hanging down from the top interior surface of the freezer. The lower refrigerator compartment did not have a thermometer dial and a thermometer was not located inside the refrigerator. The refrigerator compartment contained undated food containers with residents' names. During an observation and interview on 8/20/24 at 5:05 PM, LVN B entered the Memory Care Nourishment Room. She opened the top freezer compartment and saw the loose gasket. The LVN stated she would write a note in the Maintenance book regarding the freezer gasket being loose. She looked for a thermometer inside the refrigerator and did not find one. She opened the top freezer compartment and stated there were two thermometers in the freezer and one needed to be in the refrigerator. She removed one thermometer from the freezer compartment and placed it inside the refrigerator. The LVN stated there needed to be a cleaning schedule for the refrigerator. She proceeded to remove and throw away a few food items. In an interview on 8/21/24 at 4:40 PM, the Dietary Manager stated she had a family situation the prior day (8/20/24) and was not able to be at work. The findings from the initial tour of the kitchen on 8/20/24 were discussed with the Dietary Manager. She stated she would need to do inservice training with the dietary staff. She stated she would provide policies and procedures for kitchen sanitation and the low temperature dish machine operation. She stated the nourishment room refrigerator was the responsibility of the housekeeping department. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 8/22/24 at 9:56 AM, the Registered Dietician Consultant stated inservice training would be done with the dishwashers regarding temperatures. She stated the utensils were being removed from the halo utensil rack above the island shelf unit and going into bins. The Registered Dietician Consultant stated she had been at the facility the night before the survey (8/19/24) and everything was just fine in the kitchen. In an interview on 8/22/24 at 10:46 AM, the Registered Dietician Consultant provided copies of the policy and procedure for kitchen sanitation and cleaning. She stated the nursing department was responsible for the nourishment room and they may have a policy and procedure for refrigerators and resident food storage. In an interview on 8/22/24 at 11:19 AM, the ADON for the secure unit stated she would look for a policy and procedure for maintaining temperatures in the refrigerator in the nourishment room. She stated the nursing staff monitored the thermometer. The ADON stated she had the gasket on the freezer compartment door repaired in the secured unit. Review of the facility's policy and procedure for Foods Brought by Family/Visitors, dated as revised July 2017, reflected [in part]: Policy Statement Food brought to the facility by visitors and family is permitted . Policy Interpretation and Implementation . 4. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods must be stored in containers with lids in a refrigerator. Containers will be labeled with the use by date (usually 3 days after the food was prepared or purchased). Review of the facility's policy and procedure for Refrigerators and Freezers, dated as revised December 2014, reflected [in part]: Policy Statement This facility will ensure safe refrigeration and freezer maintenance, temperatures, and sanitation, and will observe food expiration dates. Policy Interpretation and Implementation 1. Acceptable temperature ranges are 35 degrees F to 40 degrees F for refrigerators and less than 0 (zero) degrees for freezers 7. All food shall be appropriately dated Use by dates will be completed with expiration dates on all prepared food in refrigerators . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675988	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Supervisors will inspect refrigerators and freezer monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled and followed . The Food and Drug Administration Food Code 2022 specified [in part]: Chapter 3 Food 3-202.15 Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. Chapter 4 Equipment, Utensils, and Linens 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #18) of 8 residents reviewed for infection control, in that: On 08/20/2024 at 07:36 AM the facility failed to ensure nurse put on proper personal protective equipment for resident on isolation precautions including gown, gloves, and mask while providing care to resident. Facility also failed to ensure that staff used proper hand hygiene. This failure could affect residents and place them at risk for cross contamination and infections. The findings included: Record review of Resident #18's Face Sheet dated, 08/20/2024, indicated a [AGE] year-old female admitted to the facility initially on 06/06/2024. Her diagnoses included: Enterocolitis due to clostridium difficile (stomach cramping and diarrhea due to a germ), Parkinson's Disease (nervous system disease), dehydration (not enough water and fluids in body). Record review of Resident #18's active physician orders dated included an order dated 8/11/2024 at 1:48 PM which stated: Isolation precautions for 3 months (84 days) for Sepsis, C-Diff (clostridium difficile). Record review of Resident #18's comprehensive person-centered care plan reflected a initiated date of 06/06/2024 reflected Focus: Resident #18 is on isolation - strict single room strict contact isolation related to C. Diff (clostridium difficile). Goal: Will remain in isolation until no longer contagious to others. Interventions: provide proper protective equipment. During an observation on 08/20/2024 at 07:36 AM of Resident #18's room who had Isolation Precautions sign noted on door and donning station outside room. Station to remove personal protective equipment noted inside room. LVN C was in Resident # 18 room giving medications. LVN C does not have on PPE on. LVN C exited room, walked to gel hand sanitizing station. In an interview with LVN C on 8/20/2024 at 7:39 AM regarding isolation precaution posting, LVN C stated she (Resident #18) was on isolation precautions for C-Diff (clostridium difficile), she takes vancomycin and I forgot to put on my gown and stuff. When asked about hand hygiene regarding C-Diff (clostridium difficile), LVN C then stated that she would go back into room after talking and wash her hands soap and water. LVN C further stated that you must wash your hands with soap and water because hand gel was not effective on C-Diff (clostridium difficile). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/20/2024 at 11:38 AM with ADON, who stated regarding residents with diagnosis of C-Diff (clostridium difficile) with C-Diff (clostridium difficile) you have to use soap and water for hand hygiene, you can't use alcohol gel. The proper PPE was gown and gloves, you can wear goggles if you want. It's contact isolation. It is effective every time you go in the room. ADON further stated when not following proper contact precautions infection transmitted to myself or throughout the building. In an interview on 8/20/2024 at 12:05 PM regarding expectation for infection control and residents with C-Diff (clostridium difficile), DON stated Residents would be on Isolation precautions, I think they should use all of those precautions which include, a gown, gloves and mask. DON further stated they need to use soap and water for hand hygiene. DON stated that an adverse outcome of not following proper infection control it could contaminate others. In an interview on 08/22/24 at 11:54 AM with Director of Operations regarding expectation of infection control specifically regarding isolation precautions and C-Diff (clostridium difficile). Director of Operations stated my expectation is to wear proper PPE and follow policy. When asked by regarding expectation of hand hygiene regarding resident with C-diff (clostridium difficile), Director of Operations stated to follow proper hand washing techniques. Director of Operations further stated, I can't really speculate on that. Regarding possible negative outcome for not following proper policy and procedure regarding infection control technique. Record review of the facility policy and procedure for Implementation of Standard of Transmission-Based Precautions reflected the following [in-part]: 2. Contact Precautions: are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment. Record review of the facility policy Infection Prevent and Control Program revealed the following [in-part]: Policy Statement: 2. The elements of the infection prevention and control program consist of coordination/oversight .outbreak management, prevention of infection. 6. Outbreak Management: (3) preventing spread to other residents; 7. Prevention of Infection: (6) implementing appropriate isolation precautions when necessary; and (7) following established general disease-specific guidelines such as those of the Centers for Disease Control (CDC) Review of website https://www.cdc.gov/c-diff/hcp/clinical-guidance on 3/8/24, reflected the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Isolate and initiate contact precautions for suspected or confirmed Clostridioides (formerly known as Clostridium) difficile infection (CDI).