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	09/04/2025

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 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. 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 for 1 of 1 kitchen and 1 of 3 nourishment refrigerators (200/300 hall) reviewed for food services in that:The facility failed to store foods in the kitchen refrigerator and freezer that were sealed and labeled with an identifier and/or opened/expiration date for 1 of 2 refrigerator/freezers.The facility failed to store foods and drinks in a unit nourishment refrigerator that were sealed and labeled with an opened date for 1 of 2-unit refrigerators. These failures could place residents at risk for decline in nutritional health status and foodborne illness.Findings included: In an observation on 09/02/2025 at 10:50 AM, during the initial tour of the facility kitchen, revealed the following:Large walk-in fridge/freezer:1 large clear plastic zipper unsealed bag of cheese with one date, 7/25, wrote in red permanent marker. 1 large clear plastic zipper sealed bag that contained 2 smaller bags with one date of 8/5 and guacamole wrote on bag with permanent marker. In an observation on 09/03/2025 at 11:15 AM, during rounds on nourishments refrigerators, revealed the following:Small refrigerator at nurses' station for 200/300 Hall:1 opened carton of milk that expired 08/29/2025.1 plastic bottle that appeared to contain soda with no wrapper, no label, and the number 302 wrote on the lid.On a door shelf, there was a crusty brown substance as well as a brown sticky substance. 1 glass container with lid that contained leftover spaghetti with meat sauce and broccoli that was not labeled or dated.1 opened water bottle that was not labeled or dated.Inside the back panel of the fridge, there was condensation running down along with an orange rust substance from a screw. In an interview on 09/02/2025 at 11:15 AM, the DM stated foods received were dated with green marker and when they were opened, they were marked with red marker. The DM stated he does not like this method and is in the process of changing back to printing labels as this was his 3rd week working at this facility. The DM stated the bag of cheese in the refrigerator dated 7/25 should have already been discarded and that these items, once opened, were good for 7 days, with leftovers like the tub of mixed veggies on the opposite shelf were good for 2 days and were used this morning for the chicken pot pie. The DM stated his expectation was that all staff members were proactive in watching for dates and discarding anything that was out of date range. He further stated a negative outcome would be the residents becoming ill from food borne illness depending on the food product. In an interview on 09/03/2025 at 1:42 PM, [NAME] A stated it was the responsibility of all staff to check dates every shift. He further stated this was to make sure food items that have been opened more than the set number of days were discarded and not served to the residents. [NAME] A stated leftovers were only kept for 2 days and other things like the shredded cheese was kept for 7 days after opening. [NAME] A stated the red marked dates are when the item was received, and the green dates are when it was opened. [NAME] A stated the expectation was for all outdated items to be discarded, and a negative outcome could be food borne illness depending on the food in question. In an interview on 09/03/2025 at 1:55 PM, LVN B stated the night shift nurse does temperature checks on the unit fridge, all help to clean it out when needed, and housekeeping also helps making sure all dates are good. LVN B stated the expectation was no food would be left any longer than the dates on the item or thrown out by expiration. LVN B tated a (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	negative outcome could be the resident could become ill. In an interview on 09/03/2025 at 2:00 PM, RN C stated it's the nurse's responsibility to keep up with the temperature logs, make sure all items were labeled correctly with names/dates, and when expired they were to discard of them. Stated sometimes management would come around and help when the nurses are busy. Stated the expectation was to keep the refrigerators clean and temp logs up to date. He further stated a negative outcome could be a resident or staff member becoming ill should something be expired. In an interview on09/03/2025 at 2:45 PM, the DON stated her expectation was for the night shift nurses to update the temperature log and clean out any expired foods, drinks, or anything not labeled. The DON stated a negative outcome would be, if consumed, it could cause someone to become sick. She also stated to her knowledge there has been no issues with food borne illnesses. Review of the facility policy for Food Storage, dated 10/1/2018, revised 6/1/2019, revealed [in part]:Policy: To ensure that all food served by the facility is good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines.Procedures:2. Refrigeratorsd. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Review of the facility policy for Refrigerators and Freezers, not dated, revealed [in part]:Policy: This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.Policy Interpretation and Implementation:7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes.9. Supervisors will inspect refrigerators and freezers monthly for gasket conditions, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs.10. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were secured on 1 of 6 medication carts (medication cart E) and 1 of 3 medication rooms (medication room B) reviewed for pharmacy services. The facility did not ensure medication carts and medication storage rooms were secured and locked. This failure could put residents at risk for drug diversions. Findings included: During an observation on 9/3/25 at 9:10 am, medication room on hall 300 was observed to be unlocked and the door open with no nurse or staff at nurses' station for approximately 10 minutes. Upon entering unlocked medication storage room, medication was observed on counter in plain sight. Medication storage refrigerator was unlocked with medications inside. During an observation on 9/3/25 at 9:12 am, medication cart E on hall 300 was observed unlocked and unattended in the hall. The nurse was removing items from the cart and walked across the hall into room [ROOM NUMBER]. She did not lock the cart. During an interview on 9/3/25 at 9:30am, LVN D stated, she forgot to close the medication room. LVN D stated they were supposed to be closed and locked. She stated she was the only one with a key and was responsible for the medications stored in that room. LVN D stated other residents could go in and take medications that could harm them. She then stated the policy on medication carts was they were supposed to be locked. She stated she did not realize she did not shut the medication cart and lock it. Medication Cart was out of her sight and should have been locked. LVN D stated a possible negative outcome could have been unauthorized person taking medications out of cart. During an interview on 9/3/25 at 1:27 pm, DON stated her expectations for the nurses regarding safety with medication rooms and carts were that they were all always kept locked and clean when unattended. She further stated a negative outcome could have been other staff or residents taking medications that did not belong to them and possibly harm them. Record review on 9/3/25 of a facility policy undated with revised date of April 2019 titled Storage of Medications revealed [in part]: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. #8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. #9. Unlocked medication carts are not left unattended #12. Only persons authorized to prepare and administer medications have access to locked medications.