

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255260</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                          |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/29/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HILLTOP MANOR HEALTH AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>101 KIRKLAND STREET</b><br><b>UNION, MS 39365</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                                                     | INITIAL COMMENTS<br><br>Initial Comments<br><br>CI MS #25816; CI MS #25819; CI MS #26045;<br>and CI MS #26053<br><br>On October 28, 2024 the State Agency conducted<br>four (4) onsite complaint investigations: CI MS<br>#25816 and CI MS #25819 that both alleged that<br>the facility had neglected to properly care for a<br>Resident and that the facility had refused to allow<br>a Resident to speak to family via telephone; and<br>CI MS #26045 and CI MS #26053 that alleged<br>that a Resident had lost 10% of his body weight in<br>two (2) weeks as a result of the facility's neglect.<br>The SA determined that the facility was in<br>compliance with the Standards for participation in<br>Medicare and Medicaid and no deficiencies were<br>cited. The facility was licensed for 60 beds and<br>the census was 57 on 10/28/24. |                                                                            |  | F 000                                                                                         |                                                                                                                          |                                                                    |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/06/2024

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.