

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Hilltop Skilled Nsg & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 West Polk Street Charleston, IL 61920	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on interview and record review the facility failed to protect the right of a resident to be free from misappropriation of their medication. This failure had the potential to affect one of three residents (R2) reviewed for misappropriation on the sample list of five. This past noncompliance occurred from 4/16/25 through 4/24/25.</p> <p>Findings Include:</p> <p>The facility's Abuse Policy dated 9/15/23 documents the facility affirms the right of residents to be free from misappropriation of property. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent.</p> <p>The facility's Controlled Substances policy dated 5/11/20 documents, controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Upon receipt, the nurse receiving the medication and the individual delivering the medication verify the name, dose, and quantity of each controlled substance being delivered.</p> <p>The Full QA Report dated 4/16/25 documents at approximately 3:05 PM the facility received an allegation of misappropriation of controlled medications. V5 Licensed Practical Nurse (LPN) reported the pharmacy denied R2's refill of Tramadol stating it was too early because 120 tablets were just delivered on 3/25/25. Upon investigation, it was noted that 60 tabs of Tramadol were unaccounted for. The medications and corresponding count sheets were missing.</p> <p>R2's Medical Diagnoses list dated May 2025 documents R2 is diagnosed with Depression, Anxiety, Osteomyelitis, and History of Breast Cancer.</p> <p>R2's Physician Order Sheet dated May 2025 documents an order for Tramadol 50 milligrams, one tablet by mouth four times per day.</p> <p>R2's Medication Administration Record dated March through May 2025 documents all doses of Tramadol were given per physician order.</p> <p>R2's Pharmacy Delivery Record dated 3/25/25 documents on 3/25/25 the pharmacy delivered 120 tablets of Tramadol 50 milligrams to the facility for R2.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Tramadol Narcotic Count Sheets were reviewed from February 2025 through current. There were no Tramadol narcotic count sheets for 3/20/25 through 3/31/25. Two count sheets, each for 30 tablets of Tramadol were missing.</p> <p>On 5/20/25 at 1:49 PM V8 Licensed Practical Nurse LPN stated she was the receiving nurse from the pharmacy for R2's Tramadol on 3/25/25. V8 stated she is not sure how many tablets were in the bag because at that time she never actually verified the number of controlled substances being delivered. She just signed the receiving paperwork and delivered the medications to the appropriate hall nurse.</p> <p>On 5/20/25 at 11:30 AM V2 Director of Nurses verified on 4/16/25 V5 LPN reported to him that there seemed to be some Tramadol missing from R2's medications. V2 DON confirmed on 3/25/25 the pharmacy delivered 120 tablets of Tramadol 50 milligrams for R2. V2 confirmed the receiving nurse that day was V8 LPN who did not verify the number of Tramadol tablets she was receiving from the pharmacy. V2 confirmed he is not sure what happened to the 60 tablets of Tramadol and there are also two missing count sheets for R2's Tramadol. V2 stated he is not sure if someone took them. V2 stated it is hard to prove because the reconciliation process was not done correctly when the medications were received.</p> <p>Prior to the survey date of 5/16/25, the facility had taken the following actions to correct the noncompliance:</p> <ol style="list-style-type: none"> 1. In-services were completed to educate the nursing staff about the new process for receiving medications from the pharmacy and regarding the controlled medication policy. 2. The controlled medication policy was reviewed and updated. 3. Residents were identified who could be affected by the failure and resident medication count sheets and medication administration records were reviewed. 4. Audits were completed to ensure the staff were following the new process for receiving medications from the pharmacy and to ensure staff were following the controlled medication policy and procedures. 5. Audit results were discussed at the facility's Quality Assurance Program Improvement meetings. 		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to properly implement fall interventions for one of three (R1) residents reviewed for falls on the sample list of four. This failure resulted in R1 falling and sustaining a left femoral neck fracture. This past noncompliance occurred from 5/1/25 through 5/9/25.</p> <p>Findings Include:</p> <p>The Full QA Report dated 5/1/25 documents R1 had a witnessed fall on 5/1/25 at 12:05 AM. R1 attempted to stand up from her wheelchair and fell to the ground. R1's chair alarm did not sound. R1 displays poor dynamic sitting/standing balance as well as impulsiveness related to her advanced Dementia diagnosis. V4 Certified Nurses Assistant (CNA) was walking by the hallway and observed R1 attempt to stand then lose her balance and fall to the ground. V4 notified the nurse on duty (V3 Registered Nurse RN).</p> <p>R1's emergency room documentation dated 5/6/25 documents R1 had a fall on 5/1/25 onto her left hip. R1 complained of pain and an X-ray was completed on 5/2/25. The x-ray showed possible deformity to the left hip and a recommendation for further testing was indicated. On 5/6/25 R1 was sent to the emergency room to get a computed tomography (CT) scan completed of her left hip.</p> <p>R1's Radiology Report dated 5/6/25 documents R1 sustained a mildly impacted non-displaced left femoral neck fracture status post fall and suspicious findings on x-ray imaging.</p> <p>R1's Medical Diagnoses list dated May 2025 documents R1 is diagnosed with Vascular Dementia, Cognitive Communication Deficit, Impulse Disorder, Insomnia, Personal History of a Traumatic Brain Injury.</p> <p>R1's Minimum Data Set, dated [DATE] documents R1 is severely cognitively impaired, requires substantial assistance from staff to safely transfer from a seated position, and requires the use of a manual wheelchair for mobility.</p> <p>R1's Fall Risk assessment dated [DATE] documents R1 is at high risk for falls due to her disorientation, 1-2 falls in the past three months, chair bound and requiring assistance with elimination and takes medications that put her at risk.</p> <p>R1's Care Plan dated 3/18/25 documents R1 is at high risk for falls related to impaired safety awareness, poor memory, inability to retain information, attempts to self-transfer, and inability to retain safety reminders from staff. R1 has multiple fall interventions in place which include low bed with fall mats, a scoop mattress, anti-rollbacks on her wheelchair, and a pull tab alarm when in her wheelchair. R1's Care Plan documents R1 has a pull tab alarm on her wheelchair, in place for safety related to falls and a lack of safety awareness. R1's alarm is to be maintained and functioning when it is in place on her wheelchair. Staff are to check placement and functioning of R1's alarm every shift and as needed. R1 also has no safety awareness related to a cognitive deficit. Staff are to monitor R1's whereabouts regularly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/20/25 at 2:43 PM V3 Registered Nurse stated she was the nurse on duty when R1 fell on 5/1/25. V3 confirmed she was alerted of R1's fall by V4 CNA and observed R1 on the floor. V3 stated R1's tab alarm was still attached to her shirt and to the magnetic tab and was not sounding. V3 stated she pulled the alarm off the magnet, and the alarm sounded. V3 confirmed the alarm string must have been too long.</p> <p>On 5/20/25 at 11:30 AM V2 Director of Nurses confirmed R1 fell to the floor on 5/1/25 when she attempted to stand unassisted from her wheelchair. V2 confirmed the fall was witnessed by V4 CNA. V2 confirmed even though R1's pull-tab alarm was on and functioning, it did not sound as R1 stood up from her chair. V2 stated staff should have made sure the string on the pull-tab alarm was at the proper length and it was not attached to baggy clothing which could cause it to not work properly or pull from the magnet when R1 was beginning to lean forward to stand. V2 confirmed R1 sustained a left femoral neck fracture from the fall on 5/1/25.</p> <p>Prior to the survey date of 5/16/25, the facility had taken the following actions to correct the noncompliance:</p> <ol style="list-style-type: none"> 1. In-services were completed to educate the nursing and CNA staff about the importance of properly implementing all fall interventions and regarding the accidents policy. 2. The accidents/fall policy was reviewed and updated. 3. Residents were identified who could be affected by the failure and resident care plans and fall interventions were reviewed. 4. Audits were completed to ensure the staff were following the fall policy and implementing fall interventions. 5. Audit results were discussed at the facility's Quality Assurance Program Improvement meetings. 		