

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 02/11/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 observation, interview and record review the facility failed to ensure the safety of four (R1, R2, R4, R5) residents through the use of extension cords for medical devices out of four residents reviewed for physical environment in a sample list of five residents. Findings include:1.R1's Electronic Medical Record (EMR) documents medical diagnoses as Obstructive Sleep Apnea, Chronic Respiratory Failure, Heart Failure and Atrial Fibrillation.R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact.On 2/6/26 at 3:33 PM, R1's Nebulizer machine, Oxygen concentrator and BI-PAP machine were all plugged into an outlet strip extension cord which was plugged into the wall outlet. R1 stated she only has one outlet, so her bed and the extension cord is plugged into her outlet. 2.R2's Electronic Medical Record (EMR) documents medical diagnoses as Asthma, Morbid Obesity, Atrial Fibrillation, Pericardial Effusion, Obstructive Sleep Apnea, Heart Failure, Cardiomyopathy, Chronic Respiratory Failure and Hypoxia.R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact.On 2/6/26 at 3:15 PM, R2's pacemaker monitor, and Nebulizer machine were plugged into an outlet strip extension cord that was attached to the wall beside her window. R2 pointed to her extension cord and stated, 'that looks like a fire hazard to me, but what do I know'. 3.R4's Electronic Medical Record (EMR) documents medical diagnoses as Chronic Respiratory Failure, Obstructive Sleep Apnea, Tachycardia and Chronic Obstructive Pulmonary Disease (COPD)R4's Minimum Data Set (MDS) dated [DATE] documents R4 as cognitively intact. On 2/10/26 at 3:15 PM, R4's BI-PAP and Nebulizer machine was plugged into an outlet strip extension cord which was plugged into the wall outlet. R4's Oxygen concentrator was plugged into a separate outlet strip extension cord behind her recliner chair. 4.R5's Electronic Medical Record (EMR) documents medical diagnoses as Obstructive Sleep Apnea, Chronic Obstructive Pulmonary Disease (COPD), Malignant Neoplasm of Bronchus and Lung, Pulmonary Fibrosis, Emphysema and Chronic Pulmonary Edema.R5's Minimum Data Set (MDS) dated [DATE] documents R5 is cognitively intact. On 2/10/26 at 10:00 AM, R5's Oxygen concentrator was plugged into an outlet strip extension cord. R5 stated she sometimes puts her Nasal Cannula on or takes it off 'but I never mess with the plug ins'. On 2/10/26 at 2:45 PM, V5 Maintenance Director stated the room outlets are going to be changed to hospital grade circuit breaker types over a period of time. V5 stated once the outlets are changed out residents will have more outlets to plug medical devices into. V5 stated there is really no other way around this situation other than to change out all of the electrical outlets across the facility. V5 stated plugging in multiple medical devices that require more of an electrical draw into an outlet strip that is plugged into the wall outlet could be a fire hazard. On 2/10/26 at 3:00 PM, V1 Administrator stated the facility is in the process of changing all the electrical outlets as a concern arises. V1 Administrator stated there are multiple residents who have multiple medical devices that are plugged into an extension cord due to that is the only option. V1 Administrator stated the facility does not have a policy for the use of medical devices plugged into an extension</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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cord.

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide palatable foods for residents. This failure has the potential to affect all 64 residents residing in the facility. Findings include: The facility daily midnight census dated 2/6/26 documents 64 residents reside in the facility. The facility Food Committee Meeting Minutes dated 12/8/25 documents the broccoli soup tasted scorched and was not mixed well and the tomato soup was watered down. The facility Food Committee Meeting Minutes dated 1/23/26 documents residents are not happy with evening meals and the night meal is not good. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. On 2/6/26 at 12:25 PM, R1 stated the food looked good and tasted good. R1 stated It's a welcome surprise because the food is usually awful. R1 stated the food is served cold and inedible. R1 stated there are times you cannot decipher what the food is. On 2/6/26 at 12:35 PM, V9 Manager in Training served a test tray of food. V9 obtained the temperatures of the sample portion of chicken which was 163 degrees, macaroni and cheese was 180 degrees and mixed vegetables ranged from 110-125 degrees. V9 used her bare hands to push the mixed vegetables together in order to increase their temperature. V9 stated the vegetables were not at the right temperature and felt 'cold'. On 2/6/26 at 3:10 PM R2 stated the food is 'atrocious'. R2 stated the french fries are soggy, and the food is burned with black crust all over it. R2 stated the chicken is dry and leathery, the bread is left out, so it gets dry, the pasta is either mushy or crunchy and the meals are cold. R2 stated the meals are not appealing. R2 stated the facility does have an alternative menu but the foods are still burned or mushy. R2 stated she has asked for chocolate milk and was told chocolate milk is a 'luxury' and the facility can't be expected to fill such an 'extravagant and expensive' request. On 2/10/26 at 8:50 AM, R3 stated the facility has had a 'major' problem with the kitchen not serving hot, appetizing, and tasty meals. R3 stated the foods served have been cold, not appealing to look at, and not cooked properly. R3 stated Here let me show you pictures. R3 showed pictures of what she called garlic toast where one side was white bread, and the other side was entirely dark black with a thick swipe of yellow paste (butter) all over it. R3 stated she asked about this and was told that there were two pieces of sliced bread that the dietary staff put into the same toaster slot, so one side was burned and one side was white. R3 showed another picture of a ground ball of red unidentified food. This unidentified food had the shape of a kitchen serving scoop. R3 stated this was lasagna. There were no signs of cheese, noodles, meat, spice, etcetera. R3 stated once she cut into the red ball, there was one piece of a lasagna noodle. R3 stated two days ago (2/8/26) the facility served what was supposed to be chicken pot pie, but it did not have any crust. R3 showed a picture of the chicken pot pie which showed mixed vegetables in gravy in a flat layer on a plate with no bread/crust included. On 2/6/26 at 10:30 AM, V8 Certified Dietary Manager (CDM) stated she has been onsite since Wednesday 2/4/26. V8 stated prior to her being onsite a dietary district manager CDM (V7) was onsite to assist with the kitchen concerns. V8 CDM stated the facility kitchen has had a multitude of problems with staffing turnover and multiple resident complaints of food that is overcooked, not appealing to look at and/or cold.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review the facility failed to prevent cross contamination during meal services. This failure has the potential to affect all 64 residents residing in the facility. Findings include: The facility daily midnight census dated 2/6/26 documents 64 residents reside in the facility. The facility meal menu dated 2/6/26 documents the lunch meal will consist of fried chicken, mashed potatoes with gravy, creamed corn, drink and banana pudding. On 2/6/26 at 11:58 AM, V9 Manager in Training stated the fried chicken was not at a high enough internal temperature to serve. V9 was assisting in preparing other foods to be served. V9 then walked over to the service line, wiped her bare hands on her pants and picked up a thermometer by the shaft with her palm and fingers making full contact. V9 used this contaminated thermometer to test six pieces of chicken in a full pan of fried chicken. V9 then stated none of the chicken pieces tested were at the appropriate temperature so she used potholders that were laying on the contaminated counter to place that pan of chicken back in the oven. V9 then using the same potholders removed a second pan of chicken out of the oven. V9 again picked up the thermometer with her palm and fingers. V9 used the same contaminated thermometer to test the temperature of eight pieces of chicken from the second pan. V9 repeated this process with the first and second pans two more times until the internal temperature was safe to serve to the residents. On 2/10/26 at 9:00 AM, V8 Certified Dietary Manager (CDM) stated V9 should have washed her hands and wiped off the thermometer prior to obtaining the temperature of the chicken. V8 stated there is a lot of education to be done and V8 will continue to educate staff.</p>		