STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145862	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Skilled Nsg & Rehab	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide timely antibiotic treatment and provide perineal care after toileting for one resident (R3) out three residents reviewed for infection control in a sample list of four residents. Findings include:R3's Minimum Data Set (MDS) dated [DATE] documents R3 is cognitively impaired and requires maximum assistance with toileting.R3's Nurse Progress Note dated 3/18/2026 at 6:06 PM documents R3 will return to the facility with a diagnosis of urinary tract infection (UTI) and will be on an antibiotic.R3's Nurse Progress Note dated 3/18/2026 at 6:55 PM documents R3 returned from the hospital with UTI and orders for Cephalexin (antibiotic) 500 milligrams (mg), one capsule every eight hours for ten days. R3's Hospital discharge instructions dated 3/18/2026 documents a physician order for Cephalexin 500 mg oral capsule, give by mouth every 8 hours.R3's Medication Administration Record (MAR) for March 2026 documents Cephalexin was initiated on 3/24/2026 at 9:00 AM.R3's urine culture and sensitivity (C&S) dated 3/20/2026 is documented as complete at 8:40 AM.On 4/8/2026 at 1:20 PM, V11 and V12 (Certified Nurses Assistants) assisted R3 to the toilet. After R3 finished using the toilet V11 and V12 did not cleanse R3's front perineal area.On 4/7/2026 at 11:00 AM, V4 Assistant Director Nursing (ADON)/ Infection Preventionist (IP) stated the facility has a backup medication dispenser for newly ordered medications. V4 stated the facility has an after hours and emergency pharmacy if medication needed is not available in the backup dispenser. V4 stated the expectation is for staff to provide immediate antibiotic treatment for infections. V4 stated R3's antibiotic was held until the urine culture and sensitivity (C&S) was resulted. V4 stated the facility is not able to receive laboratory results on the weekends. V4 stated facility staff called the hospital on 3/18/26 and left a message asking for R3's C&S results. V4 stated they have difficulty reaching the hospital medical records for laboratory results. V4 stated they called the hospital on 3/18/2026 and left a message asking for the C&S results. V4 stated that they were unaware the results were completed. On 4/7/2026 at 12:50 PM, V10 (Release of Information Representative at the hospital) responded on the first attempt to call the medical records department. V10 stated that when a facility calls for laboratory results they are sent immediately via facsimile. V10 stated the turn around time for laboratory results is immediate and they are processed within the day of request.

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