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	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Skilled Nsg & Rehab	910 West Polk Street Charleston, IL 61920

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34058 Based on observation, interview, and record review, the facility failed to maintain cleanliness of resident's mattresses. This failure affects one resident (R3) out of 24 reviewed for environmental cleanliness on the sample list of 43. Findings include: R3's Medical Diagnoses List dated 10/18/24 documents R3 experiences medical conditions including Dementia, Acquired Absence of Right Leg Above the Knee, and Acquired Absence of Left Leg Below the Knee. On 10/15/24 at 1:21 PM, there were smeared and mounded clumps of an unidentified white food substance resembling cake at the foot end of R3's mattress. The two clumps were one and one-half inches long by three-quarters of an inch wide. On 10/16/24 at 3:13 PM, the residue of the clumps of white food substance remained on the foot end of the mattress. The mounded clumps were not present, the surface residue was still on the mattress. On 10/16/24 at 3:18 PM, V10, Certified Nursing Assistant (CNA), stated, As far as I know the housekeeping only cleans the mattresses when they need to be sanitized, I don't know if they have a schedule to clean them on resident's shower days. V10 further stated, The CNAs and the nurses have access to the sanitizing bleach wipes to use, what this looks like is the crumbs were probably on the sheets so when they move the sheets it gets down to the bottom of the bed. On 10/16/24 at 3:23 PM, V11, Housekeeping Supervisor, stated, Housekeepers do clean mattresses for their deep cleaning sessions which they do one resident room daily for deep cleaning. V11 then stated, I know the CNAs brushed off the mattress yesterday because that was this resident's shower day and I was in the room cleaning the floor. The CNAs had asked me if they could swipe the crumbs on the floor so I could sweep them, but they obviously didn't wipe the mattress, just swiped the crumbs on the floor.

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to accurately encode residents' minimum data set assessments concerning dental conditions. This failure affects two residents (R16 and R41) out of three reviewed for dental conditions on the sample list of 43. Findings include: 1. On 10/15/24 at 10:51 AM, R16's upper denture was falling down to her lower lip while speaking. R16 was pushing the denture upwards with her tongue and lower lip repeatedly during a brief conversation, impairing R16's speech pattern. R16 stated, I know they have adhesive but I don't like to use it. R16's Census Detail dated 10/18/24 documents R16 was admitted to the facility 9/10/24. R16's Comprehensive Minimum Data Set (MDS) dated [DATE] Section L documents R16 has no broken or loosely fitting dentures. This same MDS section documents unable to examine. 2. On 10/16/24 at 09:57 AM, R41's upper denture was falling down to her lower lip while speaking. R41 was repeatedly pushing the upper denture back into place with her tongue and lower lip during a brief conversation. R41 stated, I don't know if they have any adhesive, I never asked but I know my dentures move around a bit. If I decide to try some adhesive it would be nice to know they have it. R41's Census Detail dated 10/18/24 documents R41 was admitted to the facility 5/6/24. R41's Comprehensive MDS dated [DATE] documents R41 has no broken or loosely fitting dentures. This same MDS documents unable to examine. On 10/17/24 at 11:26 AM, V12, Minimum Data Set Coordinator (MDSC), stated, Those MDS were completed by (V13, former MDSC), who worked like a consultant and was not here at the facility but was completing the MDS offsite, so the 'unable to examine' was because (V13) was not onsite to do an examination of the residents. The Minimum Data Set Manual dated October 2024 for Section L documents the person conducting the dental and oral assessment should use a gloved finger and a light source to examine the resident's mouth, lips, gums, palate, and cheek lining. This same manual documents for the person conducting the assessment to inspect a resident's dentures for cracks, chips, and cleanliness, and removal of the dentures is necessary for adequate assessment. This manual documents the code for 'unable to examine' is to be used for uncooperative residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan to include residents with denture problems. This failure affects two residents (R16 and R41) out of three reviewed for dental problems on the sample list of 43. Findings include: 1. On 10/15/24 at 10:51 AM, R16's upper denture was falling down to her lower lip while speaking. R16 was pushing the denture upwards with her tongue and lower lip repeatedly during a brief conversation, impairing R16's speech pattern. R16's Census Detail dated 10/18/24 documents R16 was admitted to the facility 9/10/24. R16's Comprehensive Minimum Data Set (MDS) dated [DATE] Section L documents R16 has no broken or loosely fitting dentures. R16's Care Plan dated beginning 9/11/24 does not include any focus or problem area about R16's dentures including proper fit or cleaning care. 2. On 10/16/24 at 09:57 AM, R41's upper denture was falling down to her lower lip while speaking. R41 was repeatedly pushing the upper denture back into place with her tongue and lower lip during a brief conversation. R41 stated, I don't know if they have any adhesive, I never asked but I know my dentures move around a bit. If I decide to try some adhesive it would be nice to know they have it. R41's Census Detail dated 10/18/24 documents R41 was admitted to the facility 5/6/24. R41's Comprehensive MDS dated [DATE] documents R41 has no broken or loosely fitting dentures. R41's Care Plan dated beginning 5/6/24 does not include any focus or problem area about R41's dentures including proper fit or cleaning care On 10/17/24 at 11:26 AM, V12, Minimum Data Set Coordinator (MDSC), stated, Those MDS were completed by (V13, former MDSC), who worked like a consultant and was not here at the facility but was completing the MDS offsite, so the 'unable to examine' was because (V13) was not onsite to do an examination of the residents. V12 further stated, I don't know if coding the loosely fitting dentures would trigger a CAA (Care Area Assessment) for a care plan, but I can confirm that the dental CAA is not triggered in Section V. The Minimum Data Set Manual dated October 2024 for Section L documents, For individualized care planning purposes, consideration should be taken for residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication pass, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to complete a recapitulation of stay for one (R58) resident out of one resident reviewed for discharge in a sample list of 43 residents. Findings include: R58's undated Face Sheet documents R58 admitted to facility on 8/20/24 and discharged on [DATE]. R58's Minimum Data Set (MDS) dated [DATE] documents R58 as cognitively intact. This same MDS documents R58 as requiring maximum assistance with toileting, bathing, dressing, personal hygiene and transfers. R58's Physician Order Sheet (POS) dated August 2024 documents medical diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Repeated Falls, Amnesia, Intervertebral Disc Degeneration, Benign Prostatic Hyperplasia, Obstructive Sleep Apnea, Acute Respiratory Failure with Hypoxia and Diabetes Mellitus Type II. R58's Electronic Medical Record (EMR) does not document a completed recapitulation of stay. R58's Discharge Plan and Instruction Report dated 8/30/24 documents a section titled 'Recapitulation of Stay' which was blank. On 10/17/24 at 1:35 PM V1 Administrator stated the facility is unable to provide documentation of R58's recapitulation of stay. V1 stated R58 had a brief stay in the facility for therapy. V1 Administrator stated the facility does not have a policy on completing a resident's recapitulation of stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to provide safe and adequate assistance with showers to a dependant resident. This failure affected one of one resident (R39) reviewed for Activities of Daily Living on the sample list of 43. Findings Include: R39's Medical Diagnoses List dated October 2024 documents R39 is diagnosed with Lumbar Spondylopathies, Spinal Cord Injury of Lumbar Region, Neuromuscular Dysfunction of Bladder, Depression, Left and Right foot Drop, and Neurogenic Bowel. R39's Minimum Data Set, dated dated dated [DATE] documents R39 is cognitively intact. No documentation was entered for R39's showering needs. R39's Minimum Data Set, dated dated dated [DATE] documents R39 requires partial to moderate assistance with showering and lower body dressing. R39 requires substantial or maximum assistance for putting on or taking off footwear. R39 requires supervision or touching assistance for tub or shower transfers. R39's Care Plan dated 2/29/24 documents R39 has a self-care deficit and requires one person staff assistance for bathing. R39 is also at risk for falls and needs to be observed by staff for unsteady gait and balance. The undated Shower Schedule documents R39's scheduled shower days are Mondays and Thursdays. R39's Shower Sheets from 8/12/24 through 10/17/24 document R39 did not receive eight of the twenty scheduled showers she should have received. The dates of the missing showers are 8/15/24, 8/29/24, 9/5/24, 9/9/24, 9/12/24, 9/26/24, 10/14/24, and 10/17/24. On 10/17/24 at 3:30 PM R39 stated she is supposed to get assistance with showers two times per week on Mondays and Thursdays. R39 stated most of the staff help her without any issues as she cannot reach her legs, feet, back, private areas, and occasionally needs help with washing her hair. R39 stated she is also a fall risk and does not feel safe being in the shower room, in the shower chair alone. R39 stated one particular staff member (V8 Certified Nurses Assistant CNA) does not want to provide the necessary assistance R39 requires for safe showering. V8 will either refuse to assist her with getting washed up or she will leave R39 in the shower room by herself and instruct her to pull the call cord when she is done. R39 stated this makes her feel uncomfortable and unsafe and she is not sure why V8 CNA doesn't want to help her (R39). R39 stated she will refuse showers if V8 is the one that is supposed to give it to her or sometimes V8 CNA won't even offer to give her showers. R39 stated on average she actually gets about one shower per week although she would like to receive the scheduled two showers per week at least. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/24 at 11:02 AM V2 Director of Nurses confirmed staff are never to leave residents in the shower room in the shower chair alone. V2 confirmed R39 does require some assistance from staff to shower and is a fall risk, especially on wet tile or when attempting to maneuver the shower chair. V2 confirmed residents are scheduled for two showers per week. V2 confirmed V8 CNA should be assisting R39 with showers with a kind and respectful attitude. V2 confirmed R39's medical record should document all of her scheduled showers were either given or refused. The undated Bath or Shower Procedure documents the purpose of the procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Staff is to stay with the resident throughout the bath and never leave the resident unattended in the shower. If feasible, the resident may bathe him or herself and staff will assist as needed. Staff are to assist with drying the resident and clothing the resident. Staff are to document procedure in the resident's electronic health record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to ensure resident medical equipment was properly utilized for three (R8, R18, R42) residents out of three residents reviewed for safety in a sample list of 43 residents. Findings include: 1.) R8's undated Face Sheet documents medical diagnoses as Comminuted Fibula Fracture, Morbid Obesity, Diabetes Mellitus Type II, Chronic Respiratory Failure, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominate side, Obstructive Sleep Apnea, Pulmonary Hypertension, Legal Blindness and Dependence on Supplemental Oxygen. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. R8's Hospital Discharge Record dated 10/11/24 documents R8 is to utilize 5 Liters of Oxygen per Nasal Cannula continuously. On 10/15/24 at 11:55 AM R8 was wearing her nasal cannula with her oxygen concentrator set at 5 Liters. R8's Oxygen concentrator was plugged into a pink extension cord laying on top of her bedside dresser. On 10/16/24 at 1:15 PM R8 was wearing her nasal cannula with her oxygen concentrator set at 5 Liters. R8's Oxygen concentrator was plugged into a pink extension cord laying on top of her bedside dresser. On 10/15/24 at 11:57 AM R8 stated I have to wear Oxygen all the time. I can't go without it at all. The girls (staff) will plug me in wherever. I had someone bring in my pink extension cord so that I could plug in my phone and my small refrigerator. There are not enough plug ins in this room. On 10/17/24 at 12:35 PM V14 Maintenance Director stated R8's Oxygen Concentrator should not be plugged into her extension cord. V14 Maintenance Director removed R8's Oxygen Concentrator plug from the extension cord and plugged it directly into a wall outlet. 2.) R18's undated Face Sheet documents medical diagnoses as Chronic Congestive Heart Failure, Interstitial Pulmonary Disease, Protein-Calorie Malnutrition, Lymphedema, Iron Deficiency Anemia, Peripheral Vascular Disease, Epilepsy, Edema, Borderline Intellectual Functioning, Cellulitis of Right and Left Lower Limbs, Kyphosis, Ileostomy status and Chondromalacia Patella. R18's Minimum Data Set (MDS) dated [DATE] documents R18 as cognitively intact. On 10/15/24 at 10:18 AM R18's bed was plugged into a power strip nailed to the wall next to R18's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 12:15 PM R18's bed was plugged into a power strip nailed to the wall next to R18's bed. On 10/16/24 at 12:18 PM R18 stated I don't have enough wall plug ins for everything so I have to plug things into the extension cord (pointing to the extension cord nailed to the wall). 34058 3) On 10/15/24 at 2:01 PM, R42's electric bed was plugged into an extension cord power strip, along with a personal unit refrigerator. On 10/17/24 at 12:30 PM V14 Maintenance Director stated all of the resident beds and all medical equipment should be plugged directly into the wall outlets. V14 stated There is too much electrical draw on the extension cords for the beds and medical equipment to be plugged into those. It could be a fire hazard. I do building rounds monthly and have had to move electrical cords before. I tell the staff not to do that but they (staff) do it anyway. On 10/17/24 at 2:15 PM V1 Administrator stated the facility does not have a policy that states medical equipment should not be plugged into extension cords. V1 stated the expectation for staff is to plug all resident beds and medical equipment into the wall outlet for safety.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34058 Based on interview and record review, the facility failed to obtain physician responses from pharmacist recommendations in a timely manner, and failed to develop their pharmacist policy to include timeframes for the steps in the monthly medication regimen reviews. This failure affects two residents (R16 and R44) out of five reviewed for unnecessary medications on the sample list of 43. Findings include: 1. R16's Census Detail dated 10/18/24 documents R16 was admitted to the facility 9/10/24. R16's Hospital Discharge Orders dated 9/10/24 document R16 had a physician ordered prescription for Semaglutide (Rybelsus) (Antidiabetic) 7 milligrams daily. R16's current Physician Order Sheet dated 10/17/24 documents R16's medication Rybelsus did not start until 9/24/24. R16's Consultant Pharmacist (V20) Recommendation dated 9/14/24 documents a notation R16 had a physician order for the medication Rybelsus on R16's hospital discharge record which was not present in the R16's electronic medical record. V20 documented to clarify this with the physician and update the electronic medical record for R16. This same recommendation was not signed by the primary physician until 9/23/24. On 10/17/24 at 12:00 PM, V2, Director of Nursing, stated, The admitting nurse put a checkmark beside that medication on the hospital discharge orders, she must have not known what it is because it doesn't populate in the electronic medical record. She must have put the question mark there and was going to come back to it and just forgot. In anyway, the medication got missed. V2 further stated, We do have a process that a second nurse is supposed to review the admission orders for each resident so things don't get missed. 2. R44's Consultant Pharmacist Recommendations to Nursing dated 4/10/24, V21, Consultant Pharmacist documents R44 has an order for Lorazepam PRN (as needed) without a stop date, according to regulations PRN medications can only be used for 14 days without a physician documenting a rationale for continued use. This recommendation form has checkboxes for a physician response to: 1) discontinue the medication; 2) continue use of the medication for (specify) number of days as the benefits outweigh the risks; and a space for the physician to document a rationale for continued use past the 14 days. This same form documents hospice patients are not excluded from this requirement. R44's electronic medical record contained identical Pharmacist Consultant Recommendations dated 6/12/24, and 8/12/24. None of the three recommendations had a signature, a selected option, nor rationale from a physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/24 at 10:20 AM, V2, Director of Nursing, stated , (R44) is receiving hospice services so it is just a main standard for hospice, but I don't find any response from the doctor about it. V2 then stated, Usually the way these are supposed to work is the pharmacist sends us the recommendations, then I send them to the physicians. The facility policy Consultant Pharmacist Service Provider Requirements dated 1/18/24 does not include any timeframe for the pharmacy medication regimen review process for the facility to obtain a response from the physician.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to honor one (R260) residents food preferences out of nine residents reviewed for meal service in a sample list of 43 residents. Findings include: R260's undated Face Sheet documents medical diagnoses as Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Orthostatic Hypotension, Dementia, Vitamin D Deficiency, Anemia and Chronic Kidney Disease Stage 3. This same Face Sheet documents R260 admitted to the facility on [DATE]. R260's Minimum Data Set (MDS) dated [DATE] documents R260 as moderately cognitively impaired. R260's Electronic Medical Record (EMR) does not include a food preferences interview. R260's Nutritional careplan was initiated 10/15/2024. R260's Careplan did not include a nutritional focus area, goal nor interventions prior to 10/15/24. R260's careplan intervention dated 10/8/24 documents R260 is of Hindu faith. On 10/15/24 at 12:45 PM R260 was served a Polish sausage, macaroni salad, spinach, chocolate chip cake with a glass of water and a glass of tea for the lunch meal. On 10/15/24 at 1:45 PM R260 stated no staff offered him any alternatives for lunch. On 10/16/24 at 1:02 PM R260 stated he has no medical restrictions on his diet and that he does not eat pork due to his religion. R260 stated I just don't eat it if they bring it. I don't ask for anything else. On 10/16/24 at 3:00 PM V9 Dietary Manager stated all residents should be interviewed to determine their preferences and for any foods that they might not wish to eat based on their religion. V9 stated I have only been here a couple of months and am trying to get everything in order. I had already found that there are problems with these things. There is no list of resident preferences for anyone over the last several months. I am planning on talking to all the residents that admit to the facility and also those that have been here a few months to update their diet slips. Residents should be able to be served foods that they like and they should not be served foods that go against their religion. The facility policy titled Food and Nutrition Services Dining Services dated 9/1/2021 documents the food preference interview will be entered into the medical record. The individual tray assembly ticket will identify all food items appropriate for the resident based on diet order, allergies and intolerances, and preferences.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to provide foods that were palatable and at appropriate temperatures, and failed to provide a meal for a resident for five of nine residents (R8, R20, R30, R53, R163) reviewed for dining in a sample list of 43 residents. Findings include: The facility Resident Council Minutes for the Month of July, 2024 document resident concerns of the food being served cold. The facility Resident Council Minutes for the Month of August, 2024 document resident concerns of the "food temperatures not being warm enough and food sometimes comes out burned. The facility Resident Council Minutes for the Month of September, 2024 document resident concerns that the facility needs to update diet tickets two times a year with likes and dislikes. The facility Resident Council Feedback form dated 9/20/2024 documents Department Response: Tickets will be updated with likes and dislikes twice yearly. 1.) R163's undated Face Sheet documents medical diagnoses as Heart Failure, Pulmonary Edema, End Stage Renal Disease, Chronic Respiratory Failure, Toxic Encephalopathy and Weakness. R163's Admission assessment dated [DATE] documents R163 as cognitively intact. R163's Physician Order Sheet (POS) dated October 2024 documents a physician diet order of Regular diet, Regular texture, Thin/Regular consistency with Renal precautions. R163's Care Plan goal dated 10/15/2024 documents R163 receives Hemodialysis due to end stage renal failure. On 10/15/24 at 12:55 PM the cart carrying the meal trays for 300 hall where R163 resides was delivered to 300 hall. This same cart was not plugged in and was not warm. On 10/15/24 at 1:10 PM R163 was served his lunch meal in his room. R163's lunch plate was delivered without the cover. On 10/15/24 at 1:20 PM V9 Dietary Manager obtained temperatures of R163's lunch meal items. R163's macaroni salad had a temperature of 45.2 degrees Fahrenheit (F), Spinach 105.5, pork chop with pork gravy 78.6. F. (continued on next page)

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	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Skilled Nsg & Rehab	910 West Polk Street Charleston, IL 61920

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 1:15 PM R163 stated I haven't had a warm meal yet. Every single meal is served cold. They (staff) try to warn it up but by the time my food comes back to me it's cold again. I have to order out (pointing at fast food bag on dresser). I am only here to get therapy and then can go home again. Yesterday I had (Renal) Dialysis at 11:30 AM. I was in the chair for four and a half hours and then the drive back here to the facility. I didn't get back until about 5:00 PM. They (facility) didn't give me anything to eat or send any food with me. I was completely worn out by the time I got back. Why can't they (facility) just serve the meals warm and not forget to feed people their meals? On 10/15/24 at 1:25 PM V9 stated R163 is on a renal diet. V9 stated R163's lunch meal items of spinach and pork chop with gravy were not at a safe temperature. V9 stated R163's food temperatures should have been hotter. V9 stated R163's macaroni salad temperature was too warm. V9 stated the facility does not have warmer plates or carts to serve the resident's food on. V9 stated I know this has been a problem and I have asked for more equipment to be able to serve the resident's warm meals but I only have what I have. We (facility) do the best with what we have. Unfortunately we (facility) just do not have the equipment we need. V9 Dietary Manager stated (R163) did not receive a lunch meal on 10/14/24 and should have. (R163) was served a grilled cheese sandwich when he returned but that was at the same time as supper so in reality he really did miss an entire meal. 2) R53's undated Face Sheet documents medical diagnoses as Severe Protein-Calorie Malnutrition, Nonalcoholic Steatohepatitis, Cirrhosis of Liver, Ischemic Cardiomyopathy, Myocardial Infarction and Chronic Kidney Disease. R53's Physician Order Sheet (POS) dated October 2024 documents a physician diet order of NAS (No Added Salt) diet, Regular texture, Thin/Regular consistency, Heart Healthy for 2000 milligram (mg) sodium restriction, low fat, low cholesterol diet. R53's Minimum Data Set (MDS) dated [DATE] documents R53 as cognitively intact. On 10/15/24 at 1:00 PM R53 was served a polish sausage, spinach, macaroni salad and a full piece of chocolate chip cake. R53 ate 25% of her meal. On 10/15/24 at 11:40 AM R53 stated The riblets they (facility) served for supper last night (10/14/24) were hard as a brick. I couldn't eat them. I like ribs too. I would have enjoyed even having the fake ribs. It was a real disappointment. Lots of times they (facility) run out of the main meal so they serve us whatever they have in the store room. One time, I was supposed to get the ham and potatoes and they gave me a cold bologna sandwich instead. I am supposed to watch what I eat because of my heart. I am pretty sure bologna is not heart healthy. 3.) R8's undated Face Sheet documents medical diagnoses as Comminuted Fibula Fracture, Morbid Obesity, Diabetes Mellitus Type II, Chronic Respiratory Failure, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominate side, Obstructive Sleep Apnea, Pulmonary Hypertension, Legal Blindness and Dependence on Supplemental Oxygen. R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. On 10/16/24 at 1:00 PM R8 was sitting at her dining room table. R8 had eaten less than 10% of her meal. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 1:15 PM R8 was sitting at the dining room table. R8 had eaten less than 10 % of her meal. On 10/15/24 at 1:40 PM R8 stated The food is inedible. The ribs they (facility) served last night (10/14/24) were so tough you couldn't even stab a fork in them. They were awful. Many of the meals are so over cooked you can't eat them. The food is cold and awful. On 10/16/24 at 1:18 PM R8 stated Today's lunch was polish sausage, spinach and macaroni salad. The sausage was greasy and cold, the spinach was cold and the macaroni salad didn't have any flavor. I told them (staff) about it and they brought me a pudding cup. That is not a meal. They (facility) really need to work on their food. 4.) R30's undated Face Sheet documents medical diagnoses as Nondisplaced Fracture of Right Femur, Diabetes Mellitus Type II, Morbid Obesity, Myelodysplastic Syndrome, Chronic Pulmonary Edema, Cardiomyopathy, Pulmonary Hypertension, Benign Paroxysmal Vertigo, Vitamin D Deficiency and Carpal Tunnel Syndrome. R30's Minimum Data Set (MDS) dated [DATE] documents R30 as cognitively intact. R30's Physician Order Sheet (POS) dated October 2024 documents a physician ordered diet of Consistent Carbohydrate diet, Regular texture, Thin/Regular consistency On 10/15/24 at 10:10 AM R30 stated I go to the meeting for residents and complain there too because I am sure I am not the only one who can't eat the food. But what if someone doesn't like the food and just can't speak up for themselves. I feel like I should do that. I have to order out because the food is like dog food. It is never hot. The riblets last night were horrible. I couldn't even cut through them they were so overcooked. They were harder than jerky. 35347 5. On 10/1520/24 at 2:04PM, R20 reported eating all meals in R20's room and reported the facility meals are always cold. On 10/17/2024 at 12:01PM, dietary staff were assembling resident meals in the facility kitchen on ceramic plates. The plates were stored at room temperature beside the service line and were not held inside of any warming device. On 10/17/2024 at 12:30PM, a transportation/warming cart containing resident meal trays was located in the 100 hallway. The cart was not plugged into an electrical receptacle and the interior of the cart was room temperature.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to serve a resident meals consistent with a resident's allergies for one of nine residents (R6) reviewed for meal service in a sample list of 43 residents. Findings include: R6's undated Face Sheet documents medical diagnoses as Diabetes Mellitus Type II, Morbid Obesity, Gastroesophageal Reflux Disease (GERD), Spinal Stenosis, Dizziness and Giddiness, Mild Intellectual Abilities, Fusion of Spine, Major Depressive Disorder, Borderline Personality Disorder and Post Traumatic Stress Disorder (PTSD). This same Face Sheet documents R6's allergies as Bupropion, Regadenoson, Tetracycline, Valproic Acid, Buspar, Penicillin and Onion. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. R6's Physician Order Sheet (POS) dated October 2024 documents a physician diet order for Consistent Carbohydrate (CCHO) diet, regular texture and thin/regular consistency. R6's undated diet ticket documents R6 is allergic to onions. R6's Care Plan intervention dated 9/9/2024 documents to provide R6's diet as ordered by Physician. On 10/15/24 at 12:23 PM R6 was sitting at a dining room table with lunch meal of polish sausage, macaroni salad with pieces of onion, spinach with pieces of onions and chocolate chip cake sitting on table in front of R6. R6's diet slip documents No Brussels sprouts, cabbage, chowder soup and salt. Allergies: Onion. R6 didn't eat the macaroni salad and spinach. On 10/15/24 at 12:30 PM R6 stated If I eat onions I will go to the hospital. Onions make me throw up and get very sick. On 10/16/24 at 3:10 PM V9 Dietary Manager stated R6's diet ticket documents R6 is allergic to onions and should not have been served any onions. V9 Dietary Manager stated I am glad to see that (R6) did not eat them or she could have gotten very sick. (R6) had a history of being force fed onions as a child so I think that is why it is listed as an allergy but either way she should not have been served any onions. The facility policy titled Food and Nutrition Services Dining Services dated 9/1/2021 documents the food preference interview will be entered into the medical record. The individual tray assembly ticket will identify all food items appropriate for the resident based on diet order, allergies and intolerances, and preferences.