STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, interviews, and record reviews the facility failed to have resident meals served within 45 minutes of the start of the posted scheduled mealtimes. This affected all 103 residents in the facility.Findings include:Signs posted throughout the facility indicated breakfast on Cedar, Elm and Spruce units started at 7:45 a.m. Breakfast on [NAME] (memory care unit) started at 8:15 a.m. Lunch on Cedar, Elm, and Spruce units started at 12:00 p.m., and lunch on [NAME] started at 12:30 p.m. Dinner on Cedar, Elm, and Spruce units started at 5:45 p.m., and dinner on [NAME] started at 6:15 p.m.During an observation at the Cedar unit on 3/9/26 at 7:45 a.m., food arrived at the kitchenette, had been placed on the steam tables and had been temperature checked. One culinary aide (CA) was in the kitchenette, and two nurse assistants (NA)s were in the dining hall. The CA and NAs were observed conversing and looking into the dining hall with residents waiting for their meals. At 8:15a.m., the CA began dishing up plates of food and the NA's began placing trays of food into meal carts. At 8:28 a.m., one aide left the dining hall with the meal cart to hallway 1. The other aide stayed in the dining hall to serve residents present. The last resident on Cedar unit did not receive their meal until 9: 03 a.m. This was 1 hour and 18 minutes after the scheduled start of mealtime.During an observation on the Cedar unit on 3/9/26 at 12:00 p.m., the food had arrived at the unit and was ready to be served. The last resident did not receive their tray until 1:02 p.m. 1 hour after the scheduled start of mealtime.On 3/10/26 at 5:32 p.m. an announcement was made that dinner service would start 30 minutes later than scheduled.During an observation on the Cedar unit of 3/10/26 that began at 5:45 p.m., residents were in the dining room along with nursing staff, waiting for food to arrive. At 6:26 p.m., food arrived and was placed in the kitchenette steam tables. Trays were set up and placed in the tray carts to go to hallway 1. At 6:39 p.m., the tray cart left for hallway one and the first resident in the dining hall received their tray. The last resident received their tray at 7:12 p.m. 1 hour and 27 minutes after the scheduled start of mealtime.During an observation on the Spruce unit on 3/10/26 that began at 5:45 p.m., (the start of dinner service). The first tray was not passed until 6:35 p.m., with the last tray passed at 7:16 p.m. 1 hour and 31 minutes after the start of mealtime.During an observation on the [NAME] unit on 3/10/26 at 5:54 p.m., food had arrived on the unit. At 6:45 p.m. nursing staff were in the dining hall with the residents, but no culinary staff had arrived. Residents had started to get restless. At 6:59 p.m., culinary staff arrived on unit, and the meal service began. At 7:25 p.m., the last resident was served. 1 hour and 10 minutes after the scheduled start of mealtime.During an interview on 3/10/26 at 6:45 p.m. registered nurse (RN)-A stated the facility had been on a streak where the dinner had been always late.During an interview on 3/11/26 at 12:52 PM CA-A stated the NA would give them the meal ticket, the CA would fill the plate and then the NA would set the tray up and deliver the meal. A lot of times there would be delays because either the food did not make it up in time, issues in the kitchen, and equipment forgotten or the CA would have to wait for nursing staff to get into the dining hall to start getting trays ready and getting them passed.During an interview on 3/12/26 at 9:35 a.m. NA-A stated several times the food would be late because staff would still be getting residents up and out of bed. When there were a lot of residents who needed assistance up it took more time.During an interview on 3/12/26 at 10:03 a.m. the culinary (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	services manager (CSM) stated both the kitchen staff and the nursing staff worked together to make sure meals were passed timely. The times posted were the times when meal service began and passing of trays to the residents should begin at that time. An allowable amount of time would be 45 minutes for all residents to be fed, but anything beyond an hour from start of service was to long for residents to wait for meals. During an interview on 3/12/26 at 10:42 am the administrator and administrator of record both stated 45 minutes to an hour is ok for all residents on a unit to be served meals. Anything beyond one hour from start of mealtimes is not acceptable.On 3/12/26 at 11:48 a.m., an announcement was again made that the lunch service on that day would start 30 minutes late.The dining hall and service line policy was requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that proper glove use and hygiene was completed during food service. This had the ability to affect all 26 residents on the [NAME] unit.Findings include: On 03/10/2026 at 6:59 p.m., cook (C)-A arrived in dining room to begin plating meals on [NAME] unit. C-A began removing plastic coverings from food in steam table. C-A then left and went to another unit and grabbed a cart with cups. She then returned near steam table and donned gloves. No observation of hand sanitization. She grabbed a plate and ladle, placed them down, then went to the fridge and grabbed another metal tray and placed in the steam table. She then grabbed a plate and began plating food from steam table. Other staff members poured drinks and began to serve plated food. With the same gloves on, C-A went to another unit touching door handles on her way and returned carrying plates covers. With same gloved hands she placed them on the counter and grabbed another plate and began plating food. During plating of food she went to fridge, opened fridge, grabbed another metal container and placed it in the steam table with the same gloved hands. She then continued to plate food touching the bread of each sandwich with the same gloved hands and placing them on plates.During interview on 03/10/2026 at 7:26 p.m., C-A stated, that is my bad. I should have taken off my gloves, went out there, sanitized my hands, and put on new gloves prior to plating food.During interview on 03/12/2026 at 10:38 a.m., the director of nursing (DON) stated that her expectation would be that the staff would have removed the gloves, completed hand hygiene, and donned new gloves prior to plating food.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident prescribed an as needed (PRN) antipsychotic (AP) medication received a face-to-face visit with the provider before re-ordering the medication and failed to have documentation to support PRN AP medication use for 1 of 5 residents (R83) reviewed for unnecessary medications.Findings include:R83's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of dysthymic disorder, anxiety, adjustment insomnia, and delusional disorder. Section N identified R83 took an AP medication.R83's care plan . Mood/behavior - observe/monitor/document behaviors/m ood and notify supervisor, SW and/or MD as needed, psych services as ordered, at risk for agitation and reassure and reapproach as needed. Risk for noncompliance.R83's electronic medical record (EMR) identified the following in 2026:1/10, an order for olanzapine (an atypical antipsychotic medication) 5 mg tablet by mouth PRN one time a day for agitation or anxiety for 14 days, discontinue on 1/23/26.1/11, a medication administration record (MAR) entry for PRN olanzapine 5 mg.1/13, a MAR entry for PRN olanzapine 5 mg.1/21, a MAR entry for PRN olanzapine 5 mg.1/23, an order for olanzapine 5 mg tablet by mouth PRN one time a day for agitation or anxiety for 14 days, discontinue on 2/26/26.1/27, a MAR entry for PRN olanzapine 5 mg.2/26, an order for olanzapine 5 mg tablet by mouth PRN one time a day, discontinue on 3/2.2/26, a MAR entry for PRN olanzapine 5 mg.3/2, an order for olanzapine 5 mg tablet by mouth PRN one time a day for agitation or anxiety, discontinue on 3/12.3/4, a MAR entry for PRN olanzapine 5 mg.Evidence of correlating behavior documentation and face-to-face provider visits weren't found in R83's EMR. During an interview on 3/12/26 at 12:11 p.m., RN-E, a nurse manager, would expect an order to be discontinued after 14 days if that is what the order was for, and stated she wasn't sure what happened. RN-E stated her expectation was for behavior charting to be done every shift and when using a PRN AP medication. During an interview on 3/12/26 at 2:59 p.m., pharmacy consultant (PC)-G would have expected the order to stop after 14 days, and for the provider to see the resident face to face if renewing an as-needed antipsychotic. A policy, Unnecessary Drugs-Psychotropic Drugs dated 2/27/23, identified residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN antipsychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication. The provider should determine and document the following:Is the antipsychotic medication still needed on a PRN basis?What is the benefit of the medication to the resident?Have the resident's expressions or indications of distress improved as a result of the PRN medication?

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to investigate an accident that resulted in injuries for 1 of 8 residents (R106) reviewed for accidents. Findings include:R106's quarterly Minimum Data Set, dated [DATE], identified R106 had diagnoses which included disease of spinal cord, dementia, diabetes mellitus, paranoid schizophrenia, insomnia, nicotine dependence, tobacco use, and repeated falls. In addition, R106's MDS identified he was moderately cognitively intact.R106's current care plan report identified he was at risk for falls. Interventions included the following:Call light positioned for easy access initiated on 4/10/25Fall Review per facility protocol initiated on 4/10/25Have commonly used articles within easy reach initiated on 4/10/25Wheelchair-anti-rollbacks initiated on 5/19/25Call don't fall sign placed initiated on 5/19/25R106's care plan report identified R106 smoked. Interventions included the following:Assess for safe smoking practice upon admission, quarterly, and as needed initiated on 4/10/25Educate/remind of the facility smoking policy as needed. Has agreed to follow the policy initiated on 4/10/25Smoking material will be stored in locked drawer in room or designated safe area for example on person or in a pocket initiated on 4/10/25The facility smoking list provided on 3/9/26, listed R106 as a current smoker.The facility's investigation of R106's fall on 1/26/26, identified the following:The date the incident occurred, the location, R106's description of the incident (he was unable to say how he fell), immediate actions taken (lifted off of the ground with an assist of two, brought inside, nasal bleeding stopped, sent to the emergency department for evaluation). The explanation was Fell off his w/c (wheelchair) outside in the smoking area. Unable to explain incident. No statements gathered, no further notes on follow-up, no root cause analysis, no changes made to R106's care plan.During an interview on 3/11/26 at 2:36 p.m., registered nurse (RN)-D stated he was unsure if a root cause analysis had been completed after R106's fall. He stated they did not complete a smoking assessment after the fall citing the resident's power of attorney no longer wanted R106 to smoke. During an interview on 3/12/26 at 11:36 p.m., the director of nursing (DON) verified that a thorough investigation of R106's fall had not been documented. The DON stated there was not any education completed for staff on falls, smoking, or smoking during inclement weather. The DON stated it was important to complete a root cause analysis to figure out why the incident occurred, and to prevent reoccurrence. The facility's root cause analysis of the incident was requested but not provided. Incident Investigation Procedure dated 2/8/24, identified, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The policy identified any corrective action would be documented and other pertinent data as necessary or required. The policy further identified, Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet the requirements for a bed hold notification, including having it in writing and including contact information for the area office of ombudsman for long term care, for 1 of 2 residents (R51) reviewed for hospitalization.Findings include:R51's annual minimum data set (MDS) dated [DATE], identified intact cognition and a diagnosis of chronic pulmonary edema.R51's electronic medical record (EMR) identified R51 was transferred to the hospital on 3/7/26 at 11:26 p.m. A progress note identified a resident transfer charting template which included the reason for the transfer and other questions where the writer could enter in the text. There was an affirmative response to the question does resident or power of attorney (POA) want a bed hold?.During an interview on 3/11/26 at 11:56 a.m., registered nurse (RN)-F stated bed holds were done on a form, and they would ask the resident if they wanted a bed hold but wasn't sure what the current process was because they were trying to get rid of paper, but he could find out.During an interview on 3/11/26 at 12:00 p.m., RN-B stated they would make note of whether the resident wanted a bed hold. RN-B thought there was a form the resident would sign and probably get uploaded to the chart. During an interview on 3/11/26 at 1:04 p.m., the director of nursing (DON) demonstrated the template used in the electronic medical record (EMR) when residents were transferred out of the facility indicating if they wanted a bed hold or not. The DON added they had just changed to this process, but they did go over bed hold information with residents on admit and annually. A policy, Bed Holds dated 9/8/24, identified the resident or responsible party must be notified concerning the bed hold policy of Hilltop Healthcare and sign the policy as evidence that they have been properly notified prior to being charged for any service. A copy of this policy will be sent with the resident when transferred to the hospital. At the time of transfer or therapeutic leave, staff will provide the current resident/responsible party with a copy of the policy. In case of emergency transfer, staff will attempt to provide the resident with a copy and will notify the responsible party of the transfer and policy within twenty-four (24) hours. Staff will follow up with a phone call to clarify any questions concerning the policy on the next working business day.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to update a resident's care plan, including the resident's inability to safely smoke after a fall from wheelchair while smoking, for 1 of 1 resident (R106) reviewed for accidents.Findings include:R106's quarterly Minimum Data Set, dated [DATE], identified R106 had diagnoses which included disease of spinal cord, dementia, diabetes mellitus, paranoid schizophrenia, insomnia, nicotine dependence, tobacco use, and repeated falls. In addition, R106's MDS identified he was moderately cognitively intact.R106's current care plan report identified he was at risk for falls. Interventions included the following:Call light positioned for easy access initiated on 4/10/25Fall Review per facility protocol initiated on 4/10/25Have commonly used articles within easy reach initiated on 4/10/25Wheelchair-anti-rollbacks initiated on 5/19/25Call don't fall sign placed initiated on 5/19/25R106's care plan report identified R106 smoked. Interventions included the following:Assess for safe smoking practice upon admission, quarterly, and as needed initiated on 4/10/25Educate/remind of the facility smoking policy as needed. Has agreed to follow the policy initiated on 4/10/25Smoking material will be stored in locked drawer in room or designated safe area for example on person or in a pocket initiated on 4/10/25The facility smoking list provided on 3/9/26, listed R106 as a current smoker.The facility's investigation of R106's fall on 1/26/26, identified the following:The date the incident occurred, the location, R106's description of the incident (he was unable), immediate actions taken (lifted off of the ground with an assist of two, brought inside, nasal bleeding stopped, sent to the emergency department for evaluation). The explanation was Fell off his w/c (wheelchair) outside in the smoking area. Unable to explain incident. No statements gathered, no further notes on follow-up, no root cause analysis, no changes made to R106's care plan.During an interview on 3/11/26 at 2:36 p.m., registered nurse (RN)-D recalled the incident when R106 fell. RN-D was unsure if R106's care plan had been updated but did state his power of attorney no longer wanted R106 to smoke, RN-D reviewed the care plan and verified it had not been updated.During an interview on 3/12/26 at 11:36 a.m., the director of nursing (DON) verified there were no updates made to the resident's care plan after the incident.Incident Investigation Procedure dated 2/8/24, identified, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The policy identified any corrective action would be documented and other pertinent data as necessary or required. The policy further identified, Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor weights to identify possible congestive heart failure (CHF) exacerbation for 1 of 1 resident (R119) reviewed for quality of care.Findings include:R119's entry Minimum Data Set (MDS) dated [DATE], identified R119's cognition had not been assessed. R119's diagnoses included acute on chronic CHF, acute resp failure with hypercapnia, diabetes mellitus type 2 (DM2), hypertension (HTN), morbid obesity, and obstructive sleep apnea (OSA).R119's 48-hour Care Plan (paper document) dated 3/6/26 indicated R119 is cognitively intact with admission diagnoses of acute diastolic heart failure and obesity.R119's care plan dated 3/12/26, instructed:Record weights a minimum of monthly or per MD/RDN.R119's provider orders dated 3/12/26 included:Daily weight one time a day related to acute diastolic (congestive) heart failure, ordered 3/9/26.Elevate legs and prevent extended periods where legs are down, every dayshift for lower extremity edema management.Bumetanide Oral Tablet 2 MG (Bumetanide) Give 1 tablet by mouth at bedtime related to acute on chronic diastolic (congestive) heart failure.Spironolactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth one time a day related to acute on chronic diastolic (congestive) heart failure.R119's treatment administration record (TAR) dated 3/12/26, instructed staff to obtain a daily weight one time a day related to CHF, with order dated 3/9/26 at 12:51 p.m.R119's Admission/readmission Tool dated 3/6/26 at 2:50 p.m., identified a most recent weight of 327.0 dated 9/23/25 while other most recent vitals were dated 3/6/26.Review of R119's weight record dated 3/12/26, identified an admission weight dated 3/6/26, a struck-out weight dated 3/10/26, and two weights on 3/11/26 (at 10:14 a.m. and 5:40 p.m.). This record was also reviewed on 3/9/26 and no weights were entered at that time.R119's nurse progress notes for 3/2026 were requested but not received.During an observation on 3/9/26 at 1:05 p.m., R119 was in their wheelchair in their room. They asked registered nurse (RN)-C to assist with elevating their legs on the bed. RN-C assisted with positioning bilateral legs on bed. R119 stated his physician wanted him to elevate his legs often to reduce swelling.During an interview on 3/11/26 at 3:39 p.m., RN-B stated staff obtain a weight on admission, residents with CHF would be weighed daily, and all residents were weighed weekly on their shower day. They stated the nurse enters the standing order when a resident with CHF is admitted . They confirmed their concern that weight gain in a CHF resident could be a sign of fluid retention, which could lead to breathing issues and the need for diuresis. RN-B stated they identified on 3/9/26 that R119 had no order for daily weights and entered the standing order. Reviewing R119's weight record, they confirmed that no admission weight was entered and R119 had a recorded weight gain of 19.1 pounds in one day (338.3 pounds on 3/10/26 to 357.4 pounds on 3/11/26). RN-B stated they were present at R119's admission, requested a mechanical lift weight, and observed it being done.During an interview on 3/12/26 at 10:11 a.m., RN-C stated vitals, including weight, would be taken immediately on admission. They stated the standing order was daily weights for three days then weekly unless there was a specific order for a resident with CHF or dietary concerns which required continuing daily weights. They confirmed they would be concerned for significant weight change in a resident with CHF. RN-C stated if there was a weight change, they would reweigh the resident and notify the physician of a significant change.During an interview on 3/12/26 at 10:15 a.m., RN-B stated they found R119's admission weight on the admission nurse's handwritten notes. RN-B stated they entered the weight historically in R119's medical record. RN-B stated the nurse that entered R119's weight on 3/10/26 thought it was entered incorrectly so RN-B struck the weight from R119's record.During an interview on 3/12/26 at 10:24 a.m., director of nursing (DON) stated vitals, including weight would be taken on resident admission, then daily weight for three days to establish a baseline, and then weekly unless the resident has CHF or malnutrition diagnoses, which may require more frequent monitoring. The DON stated if there is a weight discrepancy, the electronic medical record would flag it in red, and they expected staff to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reweigh the resident for accuracy, complete an assessment, and update the provider. The facility parameters for significant weight loss was more than 2 pounds overnight or 5 pounds in a week. With weight gain in CHF residents, the DON was concerned for fluid retention, shortness of breath, edema, and CHF exacerbation.Review of undated facility document of hand-written nurse notes indicated R119's admission weight was 352.8.The facility document Standing Orders for Skilled Nursing Facilities signed and dated 6/13/25, in admission to facility, indicated daily weights for residents with heart failure unless otherwise directed.

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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** Based on observation, interview and document review, the facility failed to ensure the care plan was followed to prevent potential aspiration for 1 of 9 residents (R99) reviewed for accidents.Findings include:R99's Medicare 5 day Minimum Data Set (MDS) dated [DATE], identified R99 had diagnoses which included enterocolitis due to clostridium difficile recurrent (a severe infection causing inflammation of the colon [large intestine]), retention of urine, pressure ulcer, dysphagia (difficulty swallowing), and long term use of opiate (a type of medication that acts on the central nervous system to reduce pain, cause sleep, or induce feeling of euphoria). R99's MDS identified she required set up for meals.R99's Order summary identified R99 has orders for a cardiac mechanical soft texture, regular/think consistency dated 3/4/26.R99's care plan dated 2/13/26, identified R99 had actual complications with deficits with activities of daily living related to current medical/physical status. Interventions included eating; set up, ensure resident is up in wheelchair for all meals, encourage to eat in the dining room, upright at 90 degrees for oral intake and for 30 minutes afterwards. R39's swallow evaluation dated 2/24/26, identified strategies recommended by speech therapy were to have the resident alternate liquids and solids, general swallow techniques/precautions and bolus size modifications and have an upright posture during meals and for greater than 30 minutes after meals. During an observation on 3/11/26 at 8:28 a.m., room trays were being passed to residents who were eating in their rooms. R99 received her breakfast in her bed.-at 8:34 a.m., R99 was seated in her bed. The bed was elevated to about 45 degrees as she was eating her breakfast.-at 8:49 a.m., R99 remained in bed. Both hands were under the covers; she was still at about 45 degrees her tray remained on the overbed table in front of her.-at 1:22 p.m., R99 was observed in bed eating lunch. Her bed was at about 45 degrees.During an interview on 3/11/26 at 1:24 p.m., registered nurse (RN)-B looked in R99's room and verified the bed was elevated at about 45 degrees. RN-B stated the bed should be at 90 degrees when R99 declined to get out of bed and come to the dining room for her meals. RN-B stated the head of the bed at 90 degrees was important to prevent choking.A policy on dysphagia was requested but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely implementation of a pharmacist recommendation and subsequent provider order to help prevent unnecessary medication use for 1 of 5 residents (R83) reviewed for unnecessary medications.Findings include:R83's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes mellitus, and hypertension.R83's provider orders dated 3/25/25, identified acidophilus (a supplement with beneficial bacterium) two times per day for prevention of urinary tract infections (UTI).A document, Physician/Provider Recommendation dated 9/12/25, identified a pharmacist recommendation to consider a trial discontinuation of acidophilus to help prevent polypharmacy, excessive pill burden, and unnecessary medication. The provider responded on 10/3/25 to discontinue lactobacillus (acidophilus) due to therapy completed.During an interview on 3/12/26 at 12:02 p.m., registered nurse (RN)-E, a nurse manager, stated the pharmacy recommendations went to the providers as soon as they got to the nurse managers. RN-E added she wasn't sure what happened with this one, her expectation would be that all orders were acted on.During an interview on 3/12/26 at 2:52 p.m., the pharmacist consultant (PC)-G stated she would expect follow up on pharmacy recommendations within 30 days. A policy regarding unnecessary medications, non-psychotropic, was not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information included the required information and was posted on the weekend. This had the potential to affect all 103 residents, families and visitors who would wish to review the information.Findings include:During an observation on 3/9/26 at 7:27 a.m., the nurse staffing was posted in the main hallway where visitors entered. The posting was dated 3/6/26, it had the name of the facility at the top of the page, the date and the day of the week, the census, the nursing hours and the hours per patient day. Below these were listed the roles starting with the certified nursing assistant listed as 25 with a total of 189.5 hours. Licensed practical nurses were listed as four with a total of 29.5 hours. Registered nurses were listed as 10 with a total of 84 hours. The posting dated 3/6/26 was for Friday in addition, the posting lacked nurse staffing separated out by shifts and did not include any information on trained medication aides.During an interview on 3/12/26, staffing coordinator (SC)-D stated the nurse staffing was supposed to be posted daily which would include weekends. SC-D also verified the posting was supposed to include the staff working by shift and not just a total of all hours worked in a 24-hour period.During an interview on 3/12/26 at 12:16 p.m., the director on nursing (DON) stated the staff posting was supposed to be posted for families and residents so they would be able to see how many staff were working on each shift.The Daily Staff Posting dated 10/17/25, identified the posting would include the following information: Content Requirement: Posting must include the number of nursing staff (RN, LPN, TMA, CAN) on duty per shift. Must list the total number and actual hours worked along with the current resident census. The title identified the posting would be posted daily.