

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365994	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER Hillsboro Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 175 Chillicothe Avenue Hillsboro, OH 45133	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and record reviews, the facility failed to ensure food was stored, prepared and served in a safe and sanitary manner to prevent foodborne illness. This affected all 76 residents who received foods from the kitchen. The facility total census was 76. Findings include: Observations during the kitchen tour on 05/26/26 at 8:17 A.M., revealed there were two ceiling vents directly above the food preparation areas and stove which had a visible buildup of gray colored debris. There were three stacks of unopened boxes of food stored directly on the floor of the freezer. There was an open thickener container with no open date. There was no thermometer inside the milk cooler. Review of the dishwasher temperature and sanitation log on 05/26/26 at 8:30 A.M. for May 2026 with Dietary Manager #500 (DM), revealed no record of the sanitation testing results for the dishwasher. DM #500 stated the facility changed from a high temperature style dishwasher, which did not require sanitization testing, to a low dishwasher style, which required sanitation testing, sometime in May 2026. DM #500 verified the dishwasher logs from 05/01/26 through 05/27/26, had no recordings of the dishwasher sanitation testing completed. DM #500 verified the low temperature dishwasher sanitation must be monitored and recorded during the dishwasher cycles after each meal to ensure the proper level of sanitation is reached by the dishwasher. Observation of the 400-unit resident refrigerator on 05/28/26 at 9:00 A.M. with Licensed Practical Nurse (LPN) #408, revealed a sign on the outside of the refrigerator stating all items must have a date, name of resident and name of item. There were three containers of food identified as staff foods in the refrigerator. There were six open-food items, identified as residents' foods, with no open dates. During an interview on 05/28/26 at 9:00 A.M., LPN #408 verified the resident refrigerator should be for the storage of resident food items only and the open foods should have an open date. Observation on 05/28/26 at 9:15 A.M. with the Director of Nursing, (DON) revealed the resident designated refrigerator on the 200-unit had an area of approximately four inches by two inches area on the bottom shelf of dried red debris. The freezer had approximately one inch built up of ice around top and sides of freezer. Interview at the same time, the DON verified that the bottom shelf needed to be cleaned and the freezer needed to be defrosted. The DON stated the night shift aides are to maintain the cleanliness of the resident refrigerators. Review of facility policy titled, Sanitation, dated 2008, revealed the low temperature dishwasher must have a final rinse of 50 parts per million, (PP) for at least 10m seconds. Review of facility policy titled, Food Storage , dated 2008, revealed the foods shall be received and stored in a manner that complies with safe food handling. Review of facility policy titled, Safety of Foods Brought by Visitors, dated 2008, revealed staff will ensure food is in a labeled container with resident's name and discarded three days from date received.		

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, staff interviews and record reviews, the facility failed to provide and serve foods as planned by the Registered Dietitian (RD). This affected four Residents (#1, #2, #57, and #4) of the four residents reviewed. The facility total census was 76. 1) Record review of Resident #1 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #1 included diabetes, chronic obstructive pulmonary disease, morbid obesity, and respiratory failure. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed Resident #1 had intact cognition and required set up assistance for meal and unable to ambulate. Review of the physician order for Resident #1 dated 03/31/26, revealed the resident was ordered a consistent carbohydrate large portion diet. Review of Resident #1's breakfast ticket on 05/27/26 at 8:06 A.M., revealed the resident was to receive a consistent carbohydrate regular portion diet. Observation on 05/27/26 at 8:10 A.M. with Dietary Manger (DM) #500 revealed Resident #1 received two servings of egg and two servings of biscuit with sausage gravy and two servings of egg. Observation on 05/28/26 at 8:00 A.M. with DM #500 revealed Resident #1 received no syrup or butter with his meal of waffles. During an interview on 05/27/26 at 8:15 A.M., DM #500 verified Resident #1 should not have received two servings of biscuit with sausage gravy and two servings of egg on consistent carbohydrate regular or on a large portion diet. DM #500 verified there was no specified definition of the measurement of description of what a large portion consisted of on the meal spreadsheet or in a policy. DM #500 stated the cook was to follow the food portions listed on the residents' meal ticket and the therapeutic diet meal spreadsheet. During an interview on 05/28/26 at 8:05 A.M., DM #500 verified Resident #1 received no syrup or butter with his meal of waffles and should have received diet syrup and butter with his meal of waffles, as listed on his meal ticket and the therapeutic diet meal spreadsheet. 2) Record review of Resident #2 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #2 included chronic obstructive pulmonary disease (COPD), anxiety disorder, kidney failure, cerebral vascular accident, heart failure, and diabetes. Review of the physician order for Resident #2 dated 04/13/26, revealed the resident was ordered to receive a consistent carbohydrate large portion diet. Review of the MDS comprehensive assessment dated [DATE], revealed Resident #2 had intact cognition and required assistance with Activities of Daily Living (ADL). Review of Resident #2's breakfast meal ticket dated 05/02/26 at 8:08 A.M., revealed the resident was to receive one biscuit with sausage gravy and one egg. Observation on 05/27/26 at 8:05 A.M. with DM #500, revealed Resident #2 received two servings of egg and two servings of biscuit with sausage gravy and two servings of egg. The resident received regular syrup with his meal of waffles as listed on his meal ticket and the therapeutic diet meal spreadsheet. During an interview on 05/27/26 at 8:15 A.M., DM #500 verified Resident #2 should not have received two servings of biscuit with sausage gravy and two servings of egg on consistent carbohydrate regular or on a large portion diet. DM #500 verified there was no specified definition of the measurement of description of what a large portion consisted of on the meal spreadsheet or in a policy. The cook was to follow the food portions listed on the residents' meal ticket and the therapeutic diet meal spreadsheet. Observation on 05/28/26 at 8:05 A.M. with DM #500, revealed Resident #2 received regular syrup with his meal of waffles. Interview at the same time, DM #500 Verified Resident #2 received regular syrup with his meal of waffles and should have received diet syrup on with his meal of waffles, as listed on his meal ticket and the therapeutic diet meal spreadsheet 3) Record review of (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #57 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #57 included dementia, chronic obstructive pulmonary disease, hypertensive heart disease, diabetes, and chronic kidney disease. Review of the physician order for Resident #57 dated 05/09/23, revealed the resident was ordered to receive a no added salt diet and house supplement three times a day .Review of the MDS comprehensive assessment dated [DATE], revealed Resident #57 had severely impaired cognition and required assistance with Activities of Daily Living, (ADL) skills. Review of the Resident #57's meal ticket on 05/27/26 at 8:35 A.M., revealed the resident was to receive a 2-gram sodium no added salt diet. The breakfast meal ticket indicated the resident was to receive a low sodium fried egg sandwich. Review of the recipe for low sodium fried egg sandwich on 05/27/27 following reviewing the meal ticket, the sandwich was to consist of one large fried pasteurized egg between two slices of white toasted bread. Observation on 05/27/26 at 8:35 A.M. with DM #500, revealed Resident #57 received a sliced biscuit with scrambled eggs in between the slices of biscuit. During an interview on 05/27/26 at 9:35 A.M., DM #500 and [NAME] #501 verified Resident #57 received a sliced biscuit with scrambled eggs in between the slices of biscuit and should have received a fried egg sandwich . The sandwich should have consisted of one large fried pasteurized egg between two slices of white toasted bread. [NAME] #501 revealed there were no pasteurized eggs available, and she was unaware of the Resident #57 diet required a fried egg sandwich. 4) Review of Resident #4 medical record revealed an admission date of 11/12/24 with diagnoses including dementia, diabetes mellitus type two, unspecified psychosis, osteoporosis, hypertension and hypothyroidism.Review of the physician order for Resident #4 dated 09/25/25, revealed the resident was ordered to receive a no added salt and consistent controlled carbohydrate diet.Review of the Quarterly MDS dated [DATE] revealed Resident #4 had cognitive impairments and is dependent on staff for set-up/clean up assistance with eating, oral hygiene, and upper and lower body dressing including footwear. She requires partial to moderate assistance with showering and bathing. Review of Resident #4's meal ticket on 05/27/26 at 7:35 A.M., revealed the resident was to receive a 2-gram sodium no added salt diet. The breakfast meal ticket revealed the resident was to receive a low sodium fried egg sandwich.Observation on 05/27/26 at 7:35 A.M. revealed Resident #4 received a biscuit and gravy. There was no substitute or preference written the tray ticket for biscuit and gravy. During an interview on 05/27/26 at 7:35 A.M., [NAME] #501 verified Resident #4's meal ticket stated a fried egg sandwich was to be served as listed on the meal ticker for the 2-gram sodium diet and on the diet meal spreadsheet. [NAME] #501 verified the resident received biscuit and gravy and there was no documentation the resident had requested biscuits and gravy instead of the fried egg sandwich. During an interview on 05/27/26 at 1:12 P.M. the RD, #900 revealed the 2-gram sodium diet is the same as the no added salt diet on the therapeutic diet meal spreadsheet. RD #900 verified the foods served should be the foods listed on the meal ticket and as listed on the therapeutic diet spreadsheet. RD #900 did not have a definition of the large portion. Review of facility policy titled, Therapeutic Diets , dated 2008, revealed the food service manager will use a tray identification system to ensure that each resident receives his or her diet as ordered. Residents will not receive extra portions that are not part of the diet. There was no definition of large portion measurement 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, staff interview, and record review the facility failed to ensure infection control standards were implemented. This affected four residents (Resident #80, Resident #13, Resident #62, and Resident #51) out of five residents reviewed for infection control. The facility census was 76. Findings Include: 1) Record review for Resident #80 revealed this resident was admitted to the facility on [DATE]. Diagnoses included acute posthemorrhagic anemia, dementia, and cerebrovascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 had severe cognitive impairment evidenced by a Brief Interview for Mental Status (BIMS) score of 01. This resident was assessed to require to be dependent on staff for all activities of daily living (ADL). Record review for Resident #13 revealed this resident was admitted to the facility on [DATE]. Diagnoses included acute parkinsonism, depression, and dementia. Review of the MDS assessment dated [DATE], revealed Resident #13 had severe cognitive impairment. The resident was dependent on staff for all ADL. Record review for Resident #62 revealed this resident was admitted to the facility on [DATE]. Diagnoses included acute chronic kidney disease, stage 2, chronic kidney disease, and major depressive disorder. Review of the MDS assessment dated [DATE], revealed Resident #62 had severe cognitive impairment evidenced by a BIMS score of 03. This resident was assessed to require maximal assistance for ADL. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE]. Diagnoses included acute muscle weakness, dysphagia oropharyngeal phase, and displaced intertrochanteric fracture of left femur. Review of the MDS assessment dated [DATE], revealed Resident #51 had intact cognition evidenced by a BIMS score of 15. This resident was dependent for all ADL. Resident is always incontinent of bladder and bowel. Observation of the medication administration on 05/27/26 at 7:50 A.M. to 8:30 A.M. revealed Registered Nurse (RN) #402 administered medications to Resident #80, Resident #13, and Resident #62 without any hand hygiene. RN #402 was observed to go help another staff member and then prepared and administered Resident #80's medications without using hand hygiene. RN #402 was observed using their bare hands to place Resident #62's medication in their medication cup. During an interview on 05/27/26 at 8:35 A.M., RN #402 confirmed there was no hand hygiene used between administering medications to Resident #80, Resident #13, and Resident #62. RN #402 verified using bare hands to place Resident #62's medication in their medication cup. 2.) Observation of incontinence care on 05/28/26 at 11:48 P.M. completed by Certified Nursing Assistant (CNA) #210 and Nurse Supervisor (NS) #410 revealed CNA #210 did not change gloves after incontinence care and used the same gloves to apply a clean brief to Resident #51. CNA #210 did not change gloves from the beginning to the end of care. During an interview on 5/28/26 at 12:15 P.M., NS #410 confirmed CNA #210 did not change gloves from the beginning to the end of care. Review of the facility policy, Administering Medications dated on December 2009 revealed staff shall follow infection control procedures when administering medications. Review of the facility policy, Perineal Care dated on December 2011 revealed staff must discard gloves, use hand hygiene, and apply clean gloves prior to putting a clean brief on a resident.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of facility documentation, the facility failed to maintain comfortable water temperatures. This affected one (#10) out of the five residents reviewed for environment but had the potential to affect all 22 residents on the 100-hallway. The facility census was 76. Findings include: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses include type II diabetes mellitus, generalized muscle weakness, adjustment disorder with anxiety, and essential hypertension. Review of Minimum Data Set (MDS) dated [DATE], revealed Resident #10 was cognitively intact. During an interview on 05/26/26 at 10:17 A.M., Resident #10 stated she has not had hot water in her bathroom since February. Resident #10 stated she receives a tub of warm water in the morning and evening to wash with but would like to be able to use the hot water in her bathroom. During an interview with Resident #10, the hot water was turned on and left running for five minutes and did not get warm. During an interview on 05/26/2026 at 2:20 P.M., Maintenance Director #308 confirmed that the residents of the 100-hallway have not had hot water in their rooms since March 2026. Maintenance Director #308 stated two hot water heaters on 100-hallway were replaced in March but did not fix the problem. Maintenance Director #308 stated after the water heaters were replaced, they discovered a water line was busted which needed to be fixed in order for the hot water to be functional on the 100-hallway. Maintenance Director #308 stated he had submitted the bid for the repair to corporate office on/around April 2026, but it has not yet been approved. Observation of the water temperatures for the 100-hallway on 05/26/26 at 3:40 P.M. and taken by Maintenance Director #308, revealed that seven of the nine bathrooms on the 100 hallways had hot water temperatures in the 63 - 67 degree Fahrenheit range.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review the facility failed to ensure medications were labeled properly. This affected two residents (Resident #39 and Resident #4) out of five residents reviewed. The facility also failed to ensure immunizations were stored properly. This had the potential to affect all residents. The facility census is 76. Findings include: Record review for Resident #39 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: type 2 diabetes, hypothyroidism, and unspecified fracture of the lower right leg. Review of the physician order for Resident 39 dated 05/04/26, revealed the resident was ordered to receive Fiasp (ultra-fast acting insulin aspart) FlexTouch subcutaneous solution pen-injector and Trulicity (diabetes) subcutaneous injection. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #39 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. This resident was assessed to require to be dependent on staff for all activities of daily living (ADL). Record review for Resident #4 revealed the resident was admitted to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus with hyperglycemia, gastro-esophageal reflux disease without esophagitis, and hypertension. Review of the physician order for Resident #4's dated 10/01/25, revealed the resident was ordered to receive Lantus (long-acting insulin injection) Solostar subcutaneous solution pen-injector. Review of the MDS assessment for Resident #4 dated 04/08/26 revealed the resident had moderate cognition evidenced by a BIMS score of 8. This resident was assessed to require moderate assistance for activities of daily living (ADLs). Observation of the 400-hall medication room on 05/26/26 at 4:06 P.M. with the Director of Nursing (DON), revealed there was one vial of tuberculin in the medication refrigerator with an open date for 02/11/26. Interview with the DON at the same time verified the findings. Observation of the 100-hall medication cart on 05/26/26 at 4:32 P.M. with the DON revealed one Fiasp FlexTouch solution pen-injector and one Trulicity solution auto injector for Resident #39. Both were open with no open date and no expiration date. The DON verified the findings at the time of the observation. Observation of the 200-hall medication cart on 05/26/26 at 4:34 P.M. with the DON, revealed one Lantus Solostar solution pen-injector for Resident #4. The Lantus pen was opened with no open date or expiration date. The DON verified the findings at the time of the observation. Review of the facility policy titled, Administering Medications revealed when opening a multi-dose container, the date shall be recorded on the container.		