STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395241	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare and Rehabilitation Center	700 S. Cayuga Avenue Altoona, PA 16602

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 - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on review of facility policies, as well as staff and resident interviews and observations, it was determined that the facility failed to have sufficient dietary staff to perform essential kitchen duties to ensure that meals were served at regularly scheduled times on the nursing unit, and to ensure food was served at palatable temperatures and appropriate consistencies. Findings include: The facility's policy for meal distribution, dated June 26, 2025, reported that meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Review of the facility's tray delivery logs revealed that lunch meals to be delivered to the B wing at 11:55 a.m., C wing at 12:10 p.m., main dining room at 12:20 p.m., D wing at 12:30 p.m., and A wing at 12:40 p.m. Dinner meals were to be delivered to the main dining room at 5:30 p.m., B wing at 5:40 p.m., C wing at 5:50 p.m., D wing at 6:00 p.m., and A wing at 6:10 p.m. On March 18, 2026, the lunch meal for B wing was to be delivered at 11:55 a.m. The lunch trays did not arrive until 12:45 p.m., the dining cart was 50 minutes late. On March 18, 2026, the lunch meal for C wing was to be delivered at 12:10 p.m. The lunch trays did not arrive until 1:18 p.m., the dining cart was 68 minutes late. On March 18, 2026, the lunch meal for the main dining was to be delivered at 12:20 p.m. At 12:08 p.m. there were eight residents in the dining room. A few of them were waiting for lunch, and the others were playing a dice game. The lunch trays did not arrive until 1:20 p.m., the dining room tray cart was one hour late. Interview with the Activity Aide 1 on March 18, 2026, at 1:10 p.m. indicated this was par for the course and meals are routinely late by at least 10-20 minutes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated March 7, 2026, revealed that the resident was cognitively intact, was understood, could understand, and was independent with eating. Observations of Resident 9 on March 18, 2026, at 1:16 p.m. the resident said to everyone in the dining room, This is ridiculous it has almost been an hour. I am hungry. Resident 9 appeared to be upset and slapped the table with her hand. Observation on March 18, 2026, revealed that the lunch meal was to be delivered on D wing at 12:30 p.m. The lunch trays were not delivered to D wing until 2:02 p.m. which was an hour and thirty-two minutes late. Interview with Nurse Aide 2 on March 18, 2026, at 12:47 p.m. indicated that she was informed by the dietary staff that it would be a while until the lunch trays were delivered. She indicated that this has been an ongoing problem due to new dietary management and staff. She indicated that breakfast was to be served at 8:00 a.m. and did not arrive on the unit 9:15 a.m. this morning. Observation on March 18, 2026, revealed that the lunch meal was to be delivered on A wing at 12:40 p.m. The lunch trays were not delivered to A wing until 2:22 p.m. which was an hour and forty-two minutes late. On March 18, 2026, the dinner meal for the main dining was to be delivered at 5:30 p.m. At 5:44 p.m. there were seven residents in the dining room. A few of them were waiting for dinner, and the others were playing a card game. The dinner trays did not arrive until 6:04 p.m. which was 34 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to B wing at 5:40 p.m. The dinner trays were not delivered to B wing until 6:22 p.m., which was 44 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to C wing at 5:50 p.m. The dinner trays were not delivered to C wing until 6:40 p.m., which (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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(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 - Few	was 50 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to D wing at 6:00 p.m. The dinner trays were not delivered to D wing until 6:55 p.m. which was 55 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to A wing at 6:10 p.m. The dinner trays were not delivered to A wing until 7:17 p.m. which was an hour and seven minutes late. An admission MDS assessment for Resident 12, dated February 4, 2026, revealed that the resident was cognitively intact, was understood, could understand, and required set up only for eating. Observations of Resident 12 on March 18, 2026, at 7:34 p.m. sitting up at the side of her bed eating her dinner tray. She said that the dinner trays were late, but there was a Sunday evening recently where dinner trays did not arrive until 8:45 p.m. Interview with the Nursing Home Administrator on March 18, 2026, at 3:30 p.m. confirmed that the lunch meals were served late and not at the scheduled mealtimes for all the residents in the A wing, B wing, C Wing, D Wing and the main dining room. Interview with the Nursing Home Administrator on March 18, 2026, at 8:10 p.m. confirmed that the dinner meals were served late and not at the scheduled mealtimes for all the residents in the A wing, B wing, C Wing, D Wing and the main dining room. The facility's policy regarding food preparation, dated June 26, 2025, stated all foods are prepared in accordance with the Food and Drug Administration Food Code. All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) for hot holding and less than 41 degrees F for cold food holding. The facility's policy regarding food quality and palatability, dated June 26, 2025, stated food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. The Dining Services Director and [NAME] are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction. A test tray for the lunch meal on the D nursing unit on March 18, 2026, revealed that the cart left the kitchen at 2:01 p.m., arrived on the nursing unit at 2:02 p.m., and the last resident was served at 2:15 p.m. The test tray was tasted at 2:17 p.m. The chicken breast with gravy was 118 degrees F, the broccoli was 116 degrees F, the mashed potatoes with gravy were 125 degrees F, and the milk was 45 degrees F. The chicken breast and broccoli were lukewarm to taste and not palatable at those temperatures. Interview with the Dining and Nutrition Director on March 18, 2026, at 2:25 p.m., confirmed that the food should have been served at a higher temperature. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated December 12, 2025, revealed that the resident was cognitively intact, was understood, could understand, and was independent with eating. Observations of Resident 8 on March 18, 2026, at 6:04 p.m. in the main dining room revealed that she received a serving chocolate ice cream. At 6:15 p.m. Resident 8 started to eat her ice cream, but it was completely melted and a liquid consistency. She said she did not want it since it was not ice cream anymore, and pushed it away from her. Observations on March 18, 2026, at 6:22 p.m. of B wing cart revealed the single-serving chocolate ice cream containers on the dinner trays to be very soft, so soft that the lids popped off and liquid ice cream leaked out. Interview with Nurse Aide 3 at 6:27 p.m. confirmed that the single-serving chocolate ice creams on the B wing dinner trays were melted. The Nursing Home Administer brought out a tray for another resident in the dining room at 6:18 p.m. She agreed that the ice cream was not frozen or firm, and should be. The Nursing Home Administer returned to the kitchen. There was no other frozen ice cream available, and she offered the resident a sorbet or ice cream from her office. Observations on March 18, 2026, at 9:15 a.m., revealed that the Nursing Home Administrator was working in the kitchen as a dishwasher. Interview with the Dietary Director on March 18, 2026, at 10:49 a.m. confirmed that three dietary staff members called off for that day. 28 Pa. Code 201.14 (a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(6) Management. 28 Pa. Code 211.6(f) Dietary Services.

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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. Based on facility policies and observations, as well as staff and resident interviews, it was determined that the facility failed to ensure that dietary staff served the appropriate planned portion sizes. Findings include: The facility's policy regarding food quality and palatability, dated June 26, 2025, revealed that menu items are prepared according to the menu, production guidelines, and standardized recipes. The posted lunch menu outside of the main dining room for February 18, 2026, indicated that residents had a choice of ham or chicken. Review of the facility's dietary guide sheet for the lunch menu on March 18, 2026, revealed that the portion of honey glazed ham was to be 3-ounces. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated March 7, 2026, revealed that the resident was cognitively intact, was understood, could understand, and was independent with eating. Observations of Resident 9 on March 18, 2026, at 1:16 p.m. in the main dining room revealed that she had one half slice of ham (semicircle). The ham was thinly sliced and she complained that the ham portion was small and cold. An admission MDS assessment for Resident 4, dated February 4, 2026, revealed that the resident was cognitively intact, was understood, could understand, and required set up for eating. Observations of Resident 4 on March 18, 2026, at 1:48 p.m. in the main dining room revealed that she had one half slice of ham (semicircle). The edges were curled up and sliced thinly, similar to a slice of lunch meat. Interview with Resident 4 at the time of the observation, revealed that she felt that it was very thin and tasted like leather. She took one bite of the ham and said she did not want any more. Observations of the lunch meal tray line on March 18, 2026, at 2:08 p.m., revealed staff serving only one small thin crescent shaped slice of ham to each resident. The surveyor requested the Regional Dining and Nutrition Director to weigh the portion of ham, and the food scale revealed that the ham weighed only one ounce. At that time the Dietary Director obtained the large ham roll from the cooler and proceeded to slice more ham and was noted to weigh each slice to ensure a three-ounce slice per resident. Interview with Regional Dining and Nutrition Director on March 18, 2026, at 2:08 p.m. confirmed that the ham slice should have weighed more than one ounce, that it should have weighed 3 ounces per the recipe. Interview with the Regional Dining and Nutrition Director on March 18, 2026, at 3.52 p.m. revealed that the prep cook had prepared breakfast size portions of the ham slice and not the entree size and also confirmed that most residents did not receive a three ounce serving of ham. 28 Pa. Code 211.6(a) Dietary Services.

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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. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures and consistencies.Findings include: The facility's policy regarding food preparation, dated June 26, 2025, stated all foods are prepared in accordance with the Food and Drug Administration Food Code. All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) for hot holding and less than 41 degrees F for cold food holding. The facility's policy regarding food quality and palatability, dated June 26, 2025, stated food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. The Dining Services Director and [NAME] are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction. A test tray for the lunch meal on the D nursing unit on March 18, 2026, revealed that the cart left the kitchen at 2:01 p.m., arrived on the nursing unit at 2:02 p.m., and the last resident was served at 2:15 p.m. The test tray was tasted at 2:17 p.m. and the chicken breast with gravy was 118 degrees F, the broccoli was 116 degrees F, the mashed potatoes with gravy were 125 degrees F, and the milk was 45 degrees F. The chicken breast and broccoli were lukewarm to taste and not palatable at those temperatures. Interview with the Dining and Nutrition Director on March 18, 2026, at 2:25 p.m., confirmed that the food should have been served at a higher temperature. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated December 12, 2025, revealed that the resident was cognitively intact, was understood, could understand, and was independent with eating. Observations of Resident 8 on March 18, 2026, at 6:04 p.m. in the main dining room revealed that she received a serving of chocolate ice cream. At 6:15 p.m. Resident 8 started to eat her ice cream, but it completely melted and was liquid consistency. She said she did not want it since it was not ice cream anymore and pushed it away from her. Observations on March 18, 2026, at 6:22 p.m. of B wing cart revealed the single-serving chocolate ice cream containers on the dinner trays to be very soft, so soft that the lid popped off and liquid ice cream leaked out. Interview with Nurse Aide 3 at 6:27 p.m. confirmed that the single-serving chocolate ice creams on the B wing dinner trays were melted. The Nursing Home Administer brought out a tray for another resident in the dining room at 6:18 p.m. She agreed that the ice cream was not frozen or firm and should be. The Nursing Home Administer returned to the kitchen. There was no other ice cream available, and she offered the resident a sorbet or ice cream from her office. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary Services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on a review of the facility's meal schedule, and resident and staff interview, it was determined that the facility failed to ensure that meals were served at regularly scheduled times on the nursing unit. Findings include: The facility's policy for meal distribution, dated June 26, 2025, reported that meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Review of the facility's tray delivery logs revealed that lunch meals to be delivered to the B wing at 11:55 a.m., C wing at 12:10 p.m., main dining room at 12:20 p.m., D wing at 12:30 p.m., and A wing at 12:40 p.m. Dinner meals were to be delivered to the main dining room at 5:30 p.m., B wing at 5:40 p.m., C wing at 5:50 p.m., D wing at 6:00 p.m., and A wing at 6:10 p.m. On March 18, 2026, the lunch meal for B wing was to be delivered at 11:55 a.m. The lunch trays did not arrive until 12:45 p.m., the dining cart was 50 minutes late. On March 18, 2026, the lunch meal for C wing was to be delivered at 12:10 p.m. The lunch trays did not arrive until 1:18 p.m., the dining cart was 68 minutes late. On March 18, 2026, the lunch meal for the main dining was to be delivered at 12:20 p.m. At 12:08 p.m. there were eight residents in the dining room. A few of them were waiting for lunch, and the others were playing a dice game. The lunch trays did not arrive until 1:20 p.m., the dining room tray cart was one hour late. Interview with the Activity Aide 1 on March 18, 2026, at 1:10 p.m. indicated this was par for the course and meals are routinely late by at least 10-20 minutes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated March 7, 2026, revealed that the resident was cognitively intact, understood, could understand, and was independent with eating. Observations of Resident 9 on March 18, 2026, at 1:16 p.m. the resident said to everyone in the dining room, This is ridiculous it has almost been an hour. I am hungry. Resident 9 appeared to be upset and slapped the table with her hand. Observation on March 18, 2026, revealed that the lunch meal was to be delivered on D wing at 12:30 p.m. The lunch trays were not delivered to D wing until 2:02 p.m. which was an hour and thirty-two minutes late. Interview with Nurse Aide 2 on March 18, 2026, at 12:47 p.m. indicated that she was informed by the dietary staff that it would be a while until the lunch trays were delivered. She indicated that this has been an ongoing problem due to new dietary management and staff. She indicated that breakfast was to be served at 8:00 a.m. and did not arrive on the unit 9:15 a.m. this morning. She indicated that the supper meal was to be served at 6:00 p.m. and last evening, the trays did not arrive on the unit until around 6:40 p.m. Observation on March 18, 2026, revealed that the lunch meal was to be delivered on A wing at 12:40 p.m. The lunch trays were not delivered to A wing until 2:22 p.m., which was an hour and forty-two minutes late. On March 18, 2026, the dinner meal for the main dining was to be delivered at 5:30 p.m. At 5:44 p.m. there were seven residents in the dining room. A few of them were waiting for dinner, and the others were playing a card game. The dinner trays did not arrive until 6:04 p.m., which was 34 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to B wing at 5:40 p.m. The dinner trays were not delivered to B wing until 6:22 p.m., which was 44 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to C wing at 5:50 p.m. The dinner trays were not delivered to C wing until 6:40 p.m., which was 50 minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to D wing at 6:00 p.m. The dinner trays were not delivered to D wing until 6:55 p.m. which was fifty-five minutes late. Observation on March 18, 2026, revealed that the dinner meal was to be delivered to A wing at 6:10 p.m. The dinner trays were not delivered to A wing until 7:17 p.m. which was an hour and seven minutes late. An admission MDS assessment for Resident 12, dated February 4, 2026, revealed that the resident was cognitively intact, understood, could understand, and required set up only for eating. Observations of Resident 12 on March 18, 2026, at 7:34 p.m. sitting at the side (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of her bed eating her dinner tray. She said that the dinner trays were late, but there was a Sunday evening recently where dinner trays did not arrive until 8:45 p.m. Interview with the Nursing Home Administrator on March 18, 2026, at 3:30 p.m. confirmed that the lunch meals were served late and not at the scheduled mealtimes for all the residents in the A wing, B wing, C Wing, D Wing and the main dining room. Interview with the Nursing Home Administrator on March 18, 2026, at 8:10 p.m. confirmed that the dinner meals were served late and not at the scheduled mealtimes for all the residents in the A wing, B wing, C Wing, D Wing and the main dining room. 28 Pa. Code 201.14 (a) Responsibility of Licensee.