

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/01/2020
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NAME OF PROVIDER OR SUPPLIER HILLTOP SKILLED NSG & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 910 WEST POLK STREET CHARLESTON, IL 61920
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S 000	Initial Comments Complaint Investigation 2067538/IL127077	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X8) DATE
10/14/20

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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to investigate the root cause and implement behavioral interventions to prevent recurrent injurious behaviors for two of three residents (R1, R3) reviewed for accidents on the sample list of 13. This failure resulted in R3 having multiple hip dislocations requiring emergency room visits to place hip back into correct position.</p> <p>Findings include:</p> <p>The facility's Accident and Incident policy dated 9/15/19 documents under 4. Investigate and Follow/up Action that, "The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties."</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1. R3's admission notes dated 8/21/20 document R3 was admitted to the facility on 8/21/20 at 4:03 PM. This note documents R3 had a hip replacement on 8/2/20 after having a fall prior to admission into the facility. This note documents R3 will have an abduction brace to the right hip.</p> <p>R3's care plan dated 8/26/20 documents R3 has a diagnosis of cognitive function/Dementia.</p> <p>R3's nursing notes dated 8/27/20 at 3:43 PM documents R3's brace was on the floor. This note documents R3 will be sent back to the hospital for hip.</p> <p>R3's nursing notes dated 8/28/20 at 12:47 AM documents at 4:00 PM on 8/27/20, R3 kept taking brace off and throwing it on the floor which caused hip to "pop" out again. R3 sent to emergency room to have hip put back in socket.</p> <p>R3's nursing notes dated 8/29/20 at 6:53 PM documents R3 removed brace three times since 3:00 PM.</p> <p>R3's nursing notes dated 9/4/20 at 2:17 PM documents R3 had a surgical revision to the hip on 9/1/20 and that R3 is to wear hip brace at all time.</p> <p>R3's nursing notes dated 9/11/20 at 1:15 PM, document noted internal rotation of right hip. This note states staff reports that R3 has been pulling on the straps to both the brace and the pillow. This note documents R3 has had a history of non-adherence to R3's orthopedic hip precautions including tampering with R3's orthopedic devices (abduction brace).</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R3's nursing note dated 9/11/20 at 1:21 PM, documents R3 was sent to the emergency room.</p> <p>R3's nursing note dated 9/11/20 at 8:45 PM documents R3 returned from the emergency room and that R3's hip was dislocated and put back into place.</p> <p>R3's nursing note dated 9/12/20 at 3:17 PM documents R3 removed brace and abductor and right leg is rotated inward. R3 sent to the emergency room for evaluation.</p> <p>R3's nursing note dated 9/13/20 at 1:05 AM documents no abductor sent back from the emergency room with R3 due to abductor brace broken.</p> <p>R3's nursing note dated 9/13/20 at 9:47 AM, documents R3's right hip has a bulge and right knee is facing inward and that a stat (immediate) X-ray was ordered.</p> <p>R3's nursing note dated 9/13/20 at 11:09 PM documents R3 returned from emergency room with an abduction pillow and that hip was put back in place in the emergency room.</p> <p>R3's nursing note dated 9/16/20 at 2:14 PM documents R3 was sent to the emergency room due to hip dislocation.</p> <p>R3's nursing note dated 9/27/20 at 10:36 AM, documents R3 was sent to the emergency room for a dislocated hip.</p> <p>On 10/01/20 at 10:13 AM, V2 (Director of Nursing) stated R3 fought the brace since the day R3 got to the facility. R3 was constantly noncompliant due to cognitive status. R3 was</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>constantly removing the brace and abductor pillow. V2 stated all emergency room visits were due to R3 removing brace or messing with the brace and causing displacement of the right hip. V2 stated the facility would basically redirect R3 from removing brace. V2 stated there are not interventions in place for R3's behaviors of removing brace in R3's plan of care.</p> <p>2. R1's wound assessment dated 9/12/20 documents two skin tears to the upper arm and bruising around elbow.</p> <p>R1's injury of unknown source form dated 9/13/20 documents: "resident locomotes in w/c (wheelchair without) regard to surroundings." This form documents that protective skin sleeves will be implemented to prevent further injury.</p> <p>R1's care plan documents a focus dated 1/02/20 that R1 roams hallways with no regard to surroundings. All interventions on this care plan are dated 1/2/20 which include reminders to open eyes, redirect, and remind R1 where R1 is going. R1's care plan dated 1/02/20 does not document protective skin sleeves as an intervention.</p> <p>On 9/30/20 at 10:09 AM, V24 (Licensed Practical Nurse/LPN) stated on 9/12/20 at 8:51 PM that, "(R1) had a skin tears to the right and left upper forearms near the elbows. I don't know how (R1) got them but (R1) is prone to skin tears. We (the facility) already had protective skin sleeves implemented but (R1) doesn't leave them on well. (R1) was not wearing long sleeves or (skin protective sleeves) when I assessed (R1). The skin tears did look new. I cannot remember who was working that night and told me about (R1's) skin tears, but we found the skin tears when they put (R1) to bed. I did not investigate the root</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>cause or put in an immediate intervention into place. No one has called me to interview me about how (R1) obtained the skin tears. (R1) is a wanderer and will propel self in wheelchair with head down and will run into things and get skin tears."</p> <p>(B)</p>	S9999		