STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004477	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP SKILLED NSG & REHAB	910 WEST POLK STREET CHARLESTON, IL 61920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2166525/IL137895	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)6) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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: 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. These requirements were not met as evidenced by: Based on record review and interview the facility failed to monitor a resident who knowingly slid down in bed resulting in a fall with major injury for one (R45) resident in a sample list of 65 residents. This failure resulted in R45 sustaining a fracture of the right femur. Findings include: R45's undated Face Sheet documents R45 admitted to facility on 8/5/21 with diagnoses including Acute and Subacute Infective Endocarditis, Recent History of Urinary Tract Infection, Right Upper Arm Muscle Contracture, Stage 4 Pressure Ulcer Left Buttock, Sacral Pressure Ulcer, Paraplegia, Legal Blindness, and Acute and Chronic Respiratory Failure. R45's Minimum Data Set (MDS) dated 8/12/21 documented a Brief Interview for Mental Status score of 7 out of 15 total possible points indicating moderate cognitive impairment. This same MDS documented R45 as requiring	S9999		

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S9999	Continued From page 2 extensive assistance of two staff for bed mobility and transfers. R45's Care Plan intervention dated 8/21/21 documents for staff to use two staff for bed mobility. R45's Physician Order Sheet (POS) dated September 1-30, 2021 documents a Physician order for a low air loss mattress for wound management ordered 8/20/21. R45's Nurse Progress Notes documented on 9/6/21 at: 6:00 AM V18 (Licensed Practical Nurse/LPN) documented "At 0600 CNA was doing walking rounds and observed res. on floor beside low bed." 9:30 AM V19 (LPN) documented "Night nurse (V18) spoke with resident's daughter (V24), she (V18) stated she (V24) would like her mother (R45) sent in to be looked at to rule out any issues with her (R45) considering she (R45) is saying she (R45) is in pain. Mobile X-ray has been notified and will be out today. Resident (R45) has been in her (R45) room this morning screaming out 'help me, help.' When staff arrived in her (R45) room she (R45) stated she (R45) wanted a drink of water and her (R45) leg was broken. (V19) Told resident (R45) that there was a call out for portable X-ray. Resident's (R45) legs were assessed for injury; no obvious issues and resident (R45) had full range of motion (ROM). Resident (R45) was asked to use call light to notify staff of issues, not to holler out causing alarm when it is not an emergency." 9:06 PM V19 (LPN) documented "Mobile X-ray	S9999		

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S9999	Continued From page 3	S9999		

came around 6-630 pm performed X-ray. Received call from radiologist stating that resident (R45) has a fracture to the right distal femur. Family notified, Physician (V25) called for further orders. Physician (V25) wanted patient (R45) sent out (to emergency room). Resident (R45) sent to hospital to evaluate and treat."

R45's Post Fall Report dated 9/6/21 at 6:57 AM documents "resident description: When resident (R45) was asked what happened resident (R45) stated 'I don't know. I was sliding.'"

R45's Computerized Tomography (CT) report dated 9/6/21 documents "findings: there is a commuted impacted fracture of the distal femoral metadiaphysis with lateral angulation and displacement of the main distal fracture fragment. The fracture extends to the anterior superior knee joint space. There is a joint effusion. impression: distal femur fracture."

On 9/10/21 at 11:05 AM V2 (Director of Nurses/DON) stated "She (R45) was constantly sliding down in the bed due to she (R45) was on an air mattress." V2 stated staff were continually repositioning her (R45) back to center of bed. V2 stated "It was our (facility) oversight for not monitoring her (R45) more closely and not adding this safety need to her (R45) care plan."

On 9/10/21 at 11:30 AM V25 (Physician stated) V25 was not notified of (R45's) fall until after portable X-Ray results were reported to V25. V25 stated "There was a new nurse at facility that day and I told her (V19) that the Physician always has to be made aware of any fall." V25 stated "I (V25) would have sent this patient (R45) out to the emergency room. She (R45) is paraplegic and blind and complaining of pain after a fall. Mobile

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S9999	Continued From page 4 X-Rays are not always accurate. She (R45) should have been sent to the emergency room for evaluation and X-Rays. I (R45) was never notified that the family wanted her (R45) sent into the emergency room. I would rather have her gone to the emergency room rather than obtain a portable X-Ray. The facility should have called me, but they (facility) did not. The facility should have been monitoring her (R45) more closely in order to prevent such a fall with such a major injury. This fall and surgery could have been prevented." On 9/10/21 at 12:00 PM V18 (LPN) stated (V18) was on duty the early morning of 9/6/21. V18 stated "Staff had checked on her (R45) several times during the night due to she (R45) kept sliding down in bed because of the air mattress. She (R45) would wiggle enough to get to a more dangerous position and staff would reposition her (R45)." On 9/10/21 at 2:00 PM V1 (Administrator) stated R45 was known to put both feet over side of bed. V1 stated "We (facility) should have managed that better. We (facility) should have care planned for this. Maybe if everyone (staff) would have known to monitor her (R45) more closely, this might not have happened. She (R45) fell and broke her (R45) femur. That's our (facility) fault." (A)	S9999		