Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b)4) 300.1210 d)3) 300.2040 b)2) 300.2040 d) 300.2040 e) 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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
S9999	Continued From page 1	S9999		

care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

2) The diet shall be served as ordered.

d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record.

e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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
S9999	Continued From page 2	S9999		

sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess nutritional needs on admission, follow recommendations for monitoring daily weights and provide nutrition supplement to a resident with high nutrition risk and weight loss. This resulted in R233 losing 7.4% (10.6 pounds) weight in 13 days. This applies to 1 of 2 residents (R233) reviewed for nutrition in the sample of 13.

The findings include:

R233's EHR (electronic health record) included that R233 was admitted on 10/13/21 with diagnoses including of moderate protein-calorie malnutrition, abnormal weight loss, diaphragmatic hernia without obstruction or gangrene, pneumothorax. R233's MDS (minimum data set) dated 10/26/21 included that R233 was cognitively intact. R233's POS (Physician Order Sheet) included diet order of Regular diet, nutritional supplement dessert lunch and dinner twice a day (Start date 10/20/21), nutritional supplement drink TID/ three times a day (Start date 10/20/21). The same POS included an order for calorie count x (times) 3 days with meals (10/21/21-10/23/21), daily weight x 1 week once a day (10/21/21-10/28/21). R233's EHR included admission weight of 143 pounds on 10/14/21.

On 10/25/21 at 12:02 PM, R233 was observed eating lunch with special utensils and was edentulous (lacking teeth). R233 received a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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
S9999	Continued From page 3	S9999		

regular consistency pork cutlet, rice pilaf (that had wild rice in it) and carrots. R233's diet card showed a nutritional supplement dessert at lunch and did not receive the same. R233 also did not receive the nutritional supplement drink with R233 meal which was on the diet order. R233 was noted to be seated leaning backward in the wheelchair that was set at 45-degree angle and the food was spilling unto R233's lap. R233 only ate a few bites and stated that R233 had difficulty chewing and pointing to the meat and remarked "This takes a lot for me and I have to work hard to eat this."

On 10/27/21 at 1:44 PM, R233 was in R233 room and was asked if he drank the nutritional supplement drink and stated "They did not give me any today at lunch. I like it and wish they gave it to me."

On 10/26/21 at around 11:01 AM, R233's daily weights were requested from the facility.

On 10/27/21 at 11:03 AM, V2 (Interim Director of Nursing) stated "We looked for the weights yesterday and couldn't find it. They didn't get it done daily." V2 was able to produce R233's weight log that listed the following weights in pounds: 143 (10/14/21), 136 (10/22/21), 135.8 (10/23/21). Facility weight was obtained for 10/27/21 and entered in the computer as 132.4 lbs. These weight changes showed that there was a significant weight loss of 7.4% since admission (10/14/21-10/27/21).

On 10/27/21 at 12:47 PM, V13 (Dietitian) stated that she comes to the facility twice monthly, and the facility also contacts her with referrals as needed. V13 stated that R233 was admitted on 10/13/21 and that she received an initial consult

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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
S9999	Continued From page 4	S9999		

for R233 on 10/19/21. V13 stated that on that same day (10/19/21) she recommended a 3-day calorie count and added nutrition supplements and requested for daily weights for one week. V13 stated that she has not received the calorie count to and weights yet. V13 stated that she expects that R233 receives nutrition supplements as recommended and ordered by Physician.

On 10/27/21 at 1:18 PM and 4:15 PM, V2 stated that she expects that the facility sends the completed calorie count back to V13 at least by 10/25/21 and that the weekly weight be done as ordered and V13 be notified of the same. V2 also stated that V13 should have been notified a lot sooner than 10/19/21 of R233's initial nutrition consult.

On 10/28/21 at 12:16 PM, V17 (Physician Assistant) stated that it would be the intend that the facility follow the dietician recommendations that were approved by the Physician. V17 added that when issues of chewing or swallowing are brought to their attention, the Physician would recommend a speech therapist consult to downgrade the diet as needed. V17 stated that R233 had multiple issues, chewing problems, and not receiving supplements could be factors that contribute to weight loss.

V13's referral progress note dated 10/19/2021 11:10 AM included the following:
"(This assessment is being completed remotely). Received communication from Admin [administration] which indicates resident is getting weak and is malnourished - and Admin is requesting for supplement for calories and protein." "Recommendations: (nutritional supplement drink) BID [two times daily], (nutritional supplement dessert) with lunch and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004451	A. BUILDING: ______ B. WING ______	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD YORKVILLE, IL 60560

(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
S9999	Continued From page 5	S9999		

dinner, daily weight x 1 week then weekly weights, calorie count x 3 days (and fax to dietitian when complete)."

Facility policy and procedure titled "Nutrition Assessment" (revised January 2012) included the following:
Policy:
All residents who experience significant weight loss shall be assessed for nutritional status and required intervention by the registered licensed dietitian. A course of action increasing calories shall be implemented unless the weight loss is deemed desirable and necessary for improvement of medical status. Residents on supplementation shall be monitored for acceptance of the supplemental calories by Dietary/Nursing. Weight shall be reported to the RDLD [Registered Dietitian Licensed Nutritionist] for review and assessment.
Procedure:
3. Dietary staff shall provide the increased calories according to the Physician order.
4. Residents shall be thoroughly assessed for progress monthly by the consultant dietitian and adjustments to care made according to progress.
5. Residents progress shall be reviewed with the Director of Nursing and Dietary Manager.

"C"