| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004410 | A. BUILDING: _____ B. WING _____ | 07/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLCREST RETIREMENT VILLAGE | 1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073 |

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| S 000 | Initial Comments<br><br>The Annual Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>STATEMENT OF LICENSURE VIOLATIONS:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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 care needs of the resident.<br><br>Section 300.1210 General Requirements for | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>Nursing and Personal Care<br>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:<br>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.<br><br>These regulations were not met as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to safely transfer a resident to bed who has a history of falls. This failure resulted in R98 being left unattended at the foot of the bed losing his balance, falling backwards, hitting his head, and sustaining a open laceration requiring nine staples. The facility failed to supervise a resident during a transfer and use a gait belt. This applies to 2 of 22 residents (R98, R3) reviewed for safety in the sample of 22.<br><br>The findings include:<br><br>1. R98's Physician Order Sheets dated through July 2022 shows he is a 93 year old male admitted on 6/13/22 with diagnoses including vertigo, abnormalities of gait/mobility, muscle weakness, history of falls and laceration of the scalp.<br><br>R98's Fall Risk Assessment dated 6/13/22 shows he is a HIGH risk for falls.<br><br>R98's Minimum Data Set assessment dated 6/20/22 shows he is cognitively intact, requires | S9999 | | |

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| S9999 | Continued From page 2<br>extensive two person assist with transfers, bed mobility toileting, and requires extensive assist with walking.<br><br>On 7/11/22 at 10:27 AM, R98 was sitting in his wheelchair. Purple bruises were observed to both hands and R98 had a laceration to the back of his head. R98 said he had a fall in his room.<br><br>On 7/13/22 at 9:41 AM, V4 (CNA) said on 6/16/22 she toileted R98 and was assisted him back to bed. V4 said she left R98 unattended at the foot of the bed and she went to the head of the bed telling R98 to come closer to her, but R98 is very hard of hearing and he could not hear me. V4 said R98 took one step and he fell backwards hitting his head on the metal door hinge. V4 said she was too far away to grab R98 and she was not holding on to his gait belt. V4 states, "it was horrible."<br><br>On 7/11/22 at 12:21 PM, V3 (RN) said R98 was admitted to the facility last month with a history of falls from home and very hard of hearing. V3 said she was R98's nurse when he fell on 6/16/22. V3 said V4 (CNA) assisted R98 after toileting and she left him unattended and he lost his balance and fell hitting his head on the wall. V3 said R98 was bleeding from his head, he sent out to the local hospital and required staples to his head. V3 said R98 had a previous fall the same day and V4 should have held onto his gait belt and not left him unattended.<br><br>On 7/12/22 at 12:48 PM, V5 (CNA) said R98 is a two person assist and he is not steady when walking.<br><br>The nurse's note dated 6/16/22 documents (R98) was in the room with V4 (CNA) assisting him after | S9999 | | |

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| S9999 | Continued From page 3<br>using the bathroom. R98 was walking towards his bed, but lost his balance and fell backwards and hitting his head and acquiring a laceration. R98 was sent out to the local hospital....R98 returned to the facility with nine staples to his head.<br><br>The facility's Accident and Supervision Policy reviewed 6/2021 states, " The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazards and risks 2. Evaluating... 3. Implementing interventions... 4. Monitoring for effectiveness and modifying interventions when necessary..."<br><br>2.) R3's face sheet shows she has diagnoses including: unspecified dementia with behavioral disturbances, schizoaffective disorder and a history of falling.<br><br>R3's 6/27/2022 facility assessment shows she has an unsteady gait and requires extensive 2 person staff assistance with transfers and toileting.<br>R3's active care plan shows she has a self-care deficit and requires extensive assistance for all transfers.<br>R3's 6/27/2022 fall risk assessment shows she is at high risk for falls.<br><br>On 7/11/2022 at 1:11 PM, V8 (CNA) entered R3's room to assist her to use the toilet. R3 had been incontinent of stool that had leaked out of her pants and onto the floor in her room. R3 was sitting in her wheelchair and V8 pushed R3 into the bathroom. V8 did not apply a gait belt on R3 and R3 began to stand up from her wheelchair. V8 left R3 in the bathroom and went to clean | S9999 | | |

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| S9999 | Continued From page 4<br><br>stool off the floor in the room. V8 then said she was going to get housekeeping to assist with the stool on the floor and left R3 alone in the bathroom. When V8 returned R3 was standing up between her wheelchair and the toilet. V8 assisted R3 to pull down her pants and sit on the toilet. At 1:19 PM, R3 was finished using the toilet. Without applying a gait belt V8 told R3 to push up using the arms of her wheelchair to stand up. V8 pulled up R3's pants and helped her turn and sit in the wheelchair.<br><br>On 7/12/2022 at 12:28 PM, V6 (Licensed Practical Nurse/LPN) said gait belts should be used for all residents during transfers and a resident should never be left alone standing up in the bathroom for safety reasons.<br><br>On 7/12/2022 at 12:30 PM, V7 (CNA) said gait belts are always supposed to be used during transfers and residents should not be left alone in the bathroom for safety reasons.<br><br>The facility's Safe Resident Handling/Transfers policy dated 2021 states, "It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employee safe in accordance with the current standards and guidelines ..." "5. Handling aids may include gait belts, transfer boards and other devices." "13. Staff members are expected to maintain compliance with safe/handling transfer practices ..."<br><br>(B) | S9999 | | |