STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004428	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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S 000	Initial Comments Complaint Investigation 2347072/IL163620	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3240 c) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) These requirements are not met as evidenced by: Based on interview, observation, and record review, the facility failed to maintain a resident's dignity and failed to thoroughly investigate an allegation of abuse in 1 of 4 residents (R2) reviewed for resident rights in the sample of 4. This failure resulted in R2 having a negative impact on her self-esteem and self-worth. Findings include: R2's Face Sheet, Undated, documents R2 has a diagnosis of Unspecified Depressive Episodes, Osteoarthritis, Abnormalities of Gait and Mobility, Type 2 DM and Muscle Weakness R2's Minimum Data Set (MDS), dated 6/18/23, documents R2 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of a 13, has depression, and requires assistance with ADLs (Activities of Daily Living). R2's Care Plan, dated 5/4/21, documents R2 has depression and has an ADL self-care performance deficit. On 8/29/23 at 7:40 AM, R2 was observed in her room. R2's hair appeared dry, was cut short about 1 inch in length, and was a dark brown/black color. R2 stated she had bought some hair dye a while back, but didn't use it	S9999		

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S9999	Continued From page 2 because her hair was too long, and she wanted it cut before she applied the hair dye. R2 stated she (R2) cut her hair and a nurse, (unsure of name, later identified as V5, Agency Licensed Practical Nurse/LPN) didn't like it and "was going to fix it" and put dye on her hair. R2 stated this nurse put the dye on her hair and left it on for 2 hours; she (R2) had to get into the shower to rinse it out. R2 stated the dye was only supposed to be left on for 20 minutes. R2 stated, "It is a terrible thing, my hair looks terrible. I was just going to do it myself, leave it on for 20 minutes and then rinse it out. They thought they could do it better. I don't know why they did it that way. It was horrible. I don't like it. I had cut my hair myself, but then that girl, a Certified Nurses Assistant (CNA), (unsure of name, later identified as V6, Agency CNA), thought she could do better, so she kept cutting and clipping my hair, there was a bunch of my hair all over the floor and all over me. It was one of the worst things I've ever had to do. I had to get into the shower, it took so long my legs were hurting and they never did get all the dye out. Then she used a hair thing that burnt my neck. I kept telling her my legs hurt, but she didn't listen. It happened about a week ago during the afternoon/evening time. It feels terrible. I don't feel right. I feel like a man. I feel bad, alone, and I don't like it. It ruined my hair and I don't feel like a woman." On 8/30/23 at 11:10AM, R2 stated she feels that it was abuse and purposeful when the nurse (V5) left the hair dye on her for 2 hours and when the CNA (V6) cut her hair and when she (R2) was telling the CNA that her legs were hurting, the CNA was arguing with her. R2 stated the CNA kept cutting her hair and ignored her telling her that her legs were hurting.	S9999		

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S9999	Continued From page 3 On 8/29/23 at 7:35 AM, V1, Administrator, stated R2 was trying to cut and dye her own hair, and an agency nurse (V5) helped her. V1 stated V6, Agency CNA, has caused problems in the facility, and she has canceled all of V6's upcoming shifts with her agency. On 8/29/23 at 8:05 AM, V4, CNA, stated she was here for part of what had occurred with R2. V4 stated R2 wanted to cut and dye her own hair, there was an agency nurse, unsure of name, that put hair dye all over R2's hair and someone had cut it. V4 stated she is not sure what happened after that as her shift ended and she left the facility. V4 stated when R2 cut her hair it looked "cute", and when she (V4) came in the next day, you could tell it had been cut after R2 had cut it. V4 stated R2 was upset about it. On 8/29/23 at 8:15 AM, V6, Agency CNA, stated on 8/26/23, she was working the 6 AM - 6 PM shift and there was an agency nurse, unknown name (later identified as V5), that was working 2 PM-6 PM that cut R2's hair and put hair dye in it. V6 stated R2 had chemical burns to her ears, head/scalp and chin. V6 stated the dye burned R2's hair and there was hair dye everywhere. V6 stated she took R2 into the shower and had to shampoo R2's hair 4 times to get the dye out. V6 stated she was asked by V1, Administrator, to provide a statement, which she did, but hasn't been allowed to come back to the facility. V6 stated V1 canceled all of her future shifts and she is unable to sign up for more. On 8/30/23 at 8:50 AM, V3, Assistant Director of Nurses (DON), stated she was informed by V12, Licensed Practical Nurse/LPN, that R2 applied hair dye on her own hair, the nurse tried to help her and wash it out. V3 stated it had been on her	S9999		

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S9999	Continued From page 4 hair a long time, she was told an hour, and then someone else said 2 hours. V3 stated she has not talked to R2 about the incident. On 8/29/23 at 9:30 AM, V5, Agency Nurse, stated she was working on the 200 hall on 8/26/23. V5 stated there were 2 extra nurses working that day, and the Wound Nurse, unsure of name or if she was agency or facility staff, dyed R2's hair and that is all she knows about it. V5 denies cutting or dying R2's hair. On 8/30/23 at 10:55 AM V12, LPN, stated she was at the facility when the incident with R2 occurred. V12 stated a staff member, unsure of name, came off of the 300 hall where R2 resides and told her (V12) that she was leaving, her shift had ended, and R2 had hair dye in her hair that needed rinsed out. V6, Agency CNA, stated to her (V12) that she would give R2 a shower to wash the hair dye out. V12 stated she reported it to R2's nurse and she doesn't know of anything that happened after that. On 8/30/23 at 2:00 PM, V1, Administrator, stated she talked to R2 on 8/28/23, and R2 told her that she was cutting her own hair and was going to put hair dye on it; they (V5, Agency LPN and V6, Agency CNA) told her they would assist her because R2 was going to do it and wanted it done. V1 stated R2 told her R2 couldn't tell who it was or what they looked like, that put the hair dye in her hair. V1 stated R2 told her it was the blonde aide (V6) that cut her hair because she was already cutting it and they were trying to help her. V1 stated she asked R2 if she needed help and R2 told her "she was trying to get it off of her shoulders, so yes." V1 stated R2 told her she felt her hair was too short, but didn't say it made her feel bad. V1 stated R2 did not tell her it was	S9999		

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S9999	Continued From page 5	S9999		

abuse, if R2 would've used that word she would have reported it. V1 stated she told R2 that V6 would no longer be in the building. V1 stated she (V1), put her (V6) on the do not return list with the facility she had CNAs and nurses calling and telling her V6 was being rude to the residents.

On 9/1/23 at 10:45 AM, V14, LPN, stated on 8/26/23, she was working on the 400 hall and overheard in report, not sure who the staff member was, asking who dyed R2's hair. V14 stated V6, Agency CNA, stated an agency nurse was dying R2's hair. V14 stated V6 told her (V14) she had given R2 a shower, and had to cut her hair to fix what "they" had messed up. V14 stated she told V6 to lay R2 down because R2 doesn't like being up for very long because it causes her pain in her legs. V14 stated about 15 minutes later, she went and looked at R2's hair and did not see any redness or anything that resembled chemical burns. V14 stated R2's hair was dyed and cut short. V14 stated R2 told her she hurt a lot and she didn't like her hair.

The Facility Investigation, dated 8/26/23, documents the following: "(V6, Agency CNA), called and stated a nurse had colored (R2's) hair and left it on for too long, and she felt she (R2) had burns from it. Spoke to (V12, LPN), regarding hair dye incident. She stated an agency nurse found (R2) in her room cutting her own hair and trying to dye it. Nurse tried to help with incident. Black hair dye was left on for about an hour, which was within limits. Hair dye was scrubbed off. Spoke to (V14, LPN), regarding concerns with (V6, Agency CNA), and (V6) working out of her scope. She (V14) stated she and (V19, LPN) went down to talk to (R2) about her hair, and (R2) stated (V6) was very rude to her and talked down to her. 8/27/23 - CNA (V6) placed on do not

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S9999	Continued From page 6 return list from facility due to multiple concerns including the way she talked to resident. Called agency supervisor and reported incident." The facility Initial Report to the Illinois Department of Public Health (IDPH), dated 8/30/23, documents an alleged abuse involving R2. Incident summary: On 8/30/23, Administrator and Social Services followed up with R2 on an incident that occurred on 8/26/23. R2 stated today that she felt she was treated poorly by on 8/26/23 by an agency aide (V6) who cut her hair after it had been colored by someone else. R2 stated she did tell agency aide not to cut her hair while in the shower room, but she (V6) did it anyway. Due to the concerns voiced today, a full investigation was started and report to follow. On 9/1/23 at 9:35 AM, V2, Director of Nurses (DON), stated she would expect the residents to be treated with dignity and respect. The Resident Rights policy, dated 2018, documents employees shall treat all residents with kindness, respect, and dignity. The Abuse, Prevention and Prohibition policy, dated 10/2022, documents the following: "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Two management level staff will conduct interviews with witnesses or other staff, residents,	S9999		

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S9999	Continued From page 7 or visitors who could have knowledge of the allegation. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on." (B)	S9999		