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
	IL6004477	A. BUILDING: ______ B. WING ______	11/01/2023

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 Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 observation, interview and record review the facility failed to provide adequate supervision to prevent a resident from leaving the building resulting in a fall outside on the sidewalk (R52) and failed to remove a mechanical lift sling from underneath a resident to prevent sliding in the wheelchair (R18) for two of eight residents (R52, R18) reviewed for accidents in the sample list of 34. This failure resulted in R52 exiting the building unaccompanied and falling resulting in abrasions to R52's face, hand and knee and a bruise to R52's face.

Findings include:

The facility's Accidents and Incidents policy with a revised date of 9/7/23 documents, "Purpose: To provide staff with guidelines for investigating, reporting, and recording Accidents and incidents. Policy: All accidents/incidents involving a resident

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S9999	Continued From page 2 shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions." 1.) R52's Order Summary Report dated 10/31/23 documents diagnoses including Orthostatic Hypotension, Personal History of Transient Ischemic Attack, Other Specified Disorders of the Brain, Vascular Dementia, Adjustment Disorder With Depressed Mood, Suicidal Ideations, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Auditory Hallucinations, Other Seizures, Mild Cognitive Impairment of Uncertain or Unknown Etiology and Repeated Falls. This Order Summary documents an order for an electronic alert device placement every shift for monitoring and an order to check the function of the device every shift with an order date of 10/10/23. R52's Nurse's Note dated 9/5/23 at 9:27 AM documents R52 was exit seeking and electronic alert device was placed to R52's left leg. This note documents R52 stated R52 wanted to walk outside. R52's Nurse's Note dated 9/6/23 at 8:43 AM documents R52 removed the electronic alert device at breakfast and Social Services was made aware. R52's Nurse's Note dated 10/10/23 at 9:47 AM documents that staff noticed R52's electronic alert device sitting on the bedside stand. This note documents R52 stated R52 bit it off of R52's wrist. This note then documents the Social Services Director was able to talk R52 into putting the electronic alert device back on R52's wrist.	S9999		

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R52's Nurse's Note dated 10/26/23 at 2:00 PM documents the nurse was alerted by staff that R52 was outside on the ground by the smoking area. R52 was non-compliant with fall alarm and electronic alert device and was walking without assistance resulting in a fall. Assessment showed abrasion to the right knee, a bruise to the left middle back, a skin tear to the right great toe and right hand, and bruising and an abrasion to the left temple and cheek.

R52's Minimum Data Set (MDS) dated 9/11/23 documents R52 is moderately cognitively impaired and requires assistance of one staff member for ambulation. This MDS documents that R52's balance is not steady when walking, that R52 can only be steady with staff assist.

R52's Care Plan dated 9/5/23 documents R52 has a potential risk of elopement, cognitive deficit, exit seeking behavior (with purpose to leave), history of elopement, history of wandering, repetitive pacing (ambulatory), walks or wheels about aimlessly w/o (without) purpose. This Care Plan has interventions dated 9/5/23 to place an electronic sensor device to alert staff of exit attempt (or if unavailable place on 1:1 observation), check placement device, check battery function and evaluate effectiveness. Monitor whereabouts regularly, recognize any unsafe conditions or escalating patterns and respond to any alarm activation promptly.

On 10/30/23 at 9:55 AM, R52 was in R52's bed sleeping. R52 had a bruise on R52's left eye. There was a mat on the floor and a pressure alarm on the bed.
On 10/30/23 at 3:01 PM, R52 was in R52's wheelchair outside smoking. There was a staff member outside with R52. On 10/31/23 at 12:35

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PM, R52 was in R52's bathroom with the door open. R52's wheelchair was sitting outside of the bathroom door and the pressure alarm was sitting in the wheelchair not sounding. V6 Certified Nursing Assistant was notified and immediately went to assist R52. V6 stated that R52 turns off the pressure alarm so they do not know when R52 gets up.

R52's Fall report dated 10/26/23 documents the nurse was notified of R52 being found on the ground face first. Nurse assessed R52 and addressed skin impairments and applied first aid. Nurse located electronic alert device and placed it to R52's right ankle and all staff were notified to check the placement of the electronic alert device.

On 10/31/23 at 3:05 PM, V26 Certified Nursing Assistant stated that when R52 fell on 10/26/23 V26 was the only CNA working on R52's hall and V26 did not see R52 leave. V26 stated that R52 removed the electronic alert device and left it in R52's room and rolled the wheelchair to the front door, stood up and pushed the button to turn off the door alarm and walked out the door. V26 stated that R52 walked around the building to the smoking area and R52's shoe slipped off when R52 got to the grass area and R52 fell face first into the concrete. V26 stated that another resident's family was outside with that resident and found R52. V26 stated no one in the facility knew that R52 had gotten outside alone. V26 stated that if that family hadn't found R52 who knows how long R52 would have laid out there.

On 11/1/23 at 2:52 PM, V2 Director of Nursing stated regarding R52's fall on 10/26/23 that V2 can't speak to the fact of whether R52 had the electronic alert device on or not as V2 was not in

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the building at the time of the fall. V2 confirmed that R52 exited out the front door and got out without anyone knowing R52 left the building. V2 confirmed R52 should not have been outside by R52's self. V2 confirmed that R52 has removed the electronic alert device multiple times and they replace it when they find it.

On 11/1/23 at 2:58 PM, V1 Administrator confirmed that another resident's family found R52 outside after R52 had gotten out of the building and fell. V1 confirmed that R52's current black eye is from the fall on 10/26/23 and V1 confirmed that R52 was not supposed to be outside alone.

On 11/1/23 at 3:04 PM, R52 stated on 10/26/23 when R52 fell, R52 went out the front door of the facility and walked through the parking lot to the smoking area and when R52 got to the grass area R52's shoe got caught on the grass and R52 tripped and fell and hit R52's face on the concrete sidewalk.

2.) R18's care plan with a revision date of 10/30/23 documents R18 is at risk for falls and injuries related to impaired balance and mobility. This care plan includes an intervention for a mechanical lift.

On 10/30/23 from 12:12 PM to 12:29 PM, R18 was sitting in the dining room. R18 complained multiple times that he was sliding down in the wheelchair. R18 was noted to be sitting on a pressure relief cushion. A mechanical lift sling was positioned under R18's buttocks and on top of the pressure relief cushion. The sling was noted to be bunched in places. V6 Certified Nurse's Assistant assisted R18 with re-positioning in the wheelchair.

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S9999	Continued From page 6 On 11/01/23 at 2:51 PM, V6 stated she helped R18 with repositioning in the dining room on 10/30/23. V6 stated the mechanical lift sling lying on top of the pressure relief cushion did cause sliding of the sling. The facility's mechanical lift policy with a revision date of 1/23/23 documents instructions to remove the mechanical lift sling from underneath the resident after transferring the resident. On 11/1/23 at 11:40 AM, V19 Director of Operations stated she thinks the mechanical lift sling is supposed to be removed after transfer for the prevention of pressure. When asked if it was also to prevent residents from slipping out of the wheelchair, V19 stated yes. At 11:50 AM, V19 stated she called the person who made the policy and they have now amended the policy a few minutes ago to state that they only remove the sling when transferring to bed. V19 verified that the amended policy was not changed until it was questioned and that it used to say to remove the sling after transfers. (B)	S9999		