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	IL6004410	A. BUILDING: _____ B. WING _____	09/25/2024

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HILLCREST RETIREMENT VILLAGE	1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999		

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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:

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Based on observation, interview, and record review the facility failed to supervise a resident with a history of falls, failed to ensure a safe transfer was performed, and failed to review/revise fall interventions post fall for 3 of 24 residents (R114, R23, R93) reviewed for safety in the sample of 24.

This failure resulting in R114 sustaining a right hip fracture and R23 sustaining a head wound.

The findings include:

1. On 09/23/24 at 10:54 AM, R114 was sitting in his wheelchair, in the activity room by nurses station. R114 was unable to answer any questions.

The facility's Reporting to IDPH worksheet dated 6/25/24 shows "fall with injury-R114 was sent to hospital for evaluation and treatment of bruising to right groin. Notified that R114 had a femur fracture and would be admitted for treatment."

On 09/25/24 at 10:02 AM, V1 Administrator said V17 CNA came and told V2 Director of Nursing that something was wrong with R114, he was not walking right. V1 said upon assessment, R114 had some discoloration in his right groin area. V1 said they spoke with the doctor and got an order for an x-ray. V2 said the x-ray company wasn't coming soon enough, so they sent R114 to the hospital. V2 said she interviewed staff and R114 had no out of the normal behavior, no documented incident, no falls and no signs of pain, but something happened to his hip.

R114's Progress Note dated 6/24/24 at 10:25 PM, shows "writer called and followed up with hospital,

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per Emergency Room Nurse, R114 is being admitted due to closed fracture of right hip."

R114's hospital x-ray report dated 6/24/24 shows "comminuted intertrochanteric right hip fracture (bone broken in at least two places, caused by severe trauma- fall, car accident)."

On 09/25/24 at 11:07 AM, V17 Certified Nursing Assistant (CNA) said she got R114 up in the morning (6/24/24) and took him to breakfast. V17 said R114 sat up fine and had no complaints of pain. V17 said later when she was putting him back to bed (after therapy), R114 had a hard time standing up, and appeared to be in pain so she told the nurse.

On 09/25/24 at 10:17 AM, V18 Physical Therapist said she got R114 from the dining room that morning and took him to therapy. V18 said R114 was hardly able to stand up, which was not his norm so she brought him back to his room. V18 said she thought maybe R114 was just tired. V18 said R114 normally wants to stand up and has to be close to the nurses station for supervision.

On 09/25/24 at 11:12 AM, V16 Licensed Practical Nurse said she was the evening nurse from 6:00 PM to 6:00 AM over the weekend (6/21/24-6/23/24) and she had no issues with R114. V16 said R114 has behaviors of trying to get up out of the chair, and can be antsy. V16 said she would keep him in eyesight for supervision due to history of trying to get up.

On 09/25/24 at 11:39 AM, V14 CNA said she worked the evening shift (6/23/24) and she didn't see R114 out of bed after she put him to bed, but R114 can swing his legs over and try to get up.

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On 09/25/24 at 12:01 PM, V15 Registered Nurse said she worked with R114 all weekend (during the day) and nothing out of the ordinary occurred. V15 said R114 was antsy and was up and down all weekend and not sleeping.

On 09/25/24 at 12:20 PM, V13 (R114's Power of Attorney) said he got a call from the facility that R114 had a fall in evening trying to get up. V13 said they sent R114 to hospital. V13 said he was upset that this happened, R114 needed hip surgery and needed screws. V13 said R114 had a fall before this with bruising to his face. V13 said since R114 had a stroke, he has trouble with balance and walking. V13 said R114 needs to be monitored more.

On 09/25/24 at 11:34 AM, V20 Orthopedic Doctor (performed hip surgery at hospital for R114) was phoned and a message was left with the nurse for the doctor to call back. V20 did not return this surveyor's call.

R114's Morse Fall Scale dated 6/2/24 shows R114 is at moderate risk for falling due to medical diagnoses, impaired gait, and overestimates or forgets his limits.

R114's Care Plan shows R114 has diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, aphasia, history of transient ischemic attack, dementia and restlessness and agitation. The same Care Plan shows "R114 has moderately impaired cognitive function requiring cues and supervision in daily decision making. R114 will attempt to get up on own and has been observed crawling on bedroom floor. Resident is not verbal for the most part and has difficulty communicating. Resident is at risk for falling."

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The intervention for risk for falling of "mattress to be placed on floor next to bed at all times. Resident crawls from bed at times," was added on 9/25/24. This same Care Plan does not include interventions of close supervision.

2. On 09/24/24 at 11:38AM, R23 was sitting in the dining room. R23 with a 3.5-centimeter by 1.5-centimeter irregular shaped scabbed wound on the center of the forehead.

On 09/25/2024 at 9:30AM, V1 Administrator said, V11 CNA-Certified Nursing Assistant was with R23 when she fell on 09/15/2024. R23's fall on 09/13/2024 caused the wound to R23's forehead.

On 09/25/2024 at 9:56AM, V11 CNA said, I was with R23 when she fell. I transferred her, as I was situating her in the chair, it was like she threw herself forward. I transferred R23 with a full body mechanical sling lift; I transferred her by myself. Normally a mechanical sling lift is supposed to be performed by two staff members.

On 09/25/2024 at 11:29AM, V2 DON-Director of Nursing said, there should be two staff members present when transferring a resident with a mechanical sling lift.

R23's Progress Notes dated 9/15/2024 at 5:53PM, shows, Incident Note, Note Text: Notified by CNA that upon transferring resident out of bed onto wheelchair, resident leaned forward and fell to the ground onto her side.

R23's Fall Risk Assessment dated 09/08/2024 shows, High Risk for Falls.

The facility's undated Mechanical Lift policy shows, two staff members must be present when

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using any mechanical lift. One staff member directs mechanical lift towards the receiving surface while the other staff member gently guides resident.

3. R93's Face sheet dated 9/24/24, shows R93 has diagnoses including (but not limited to) Parkinson's disease, dementia, and epilepsy.

R93's Morse Fall Scale dated 3/7/24 shows R93 has a score of 55 which denotes R93 is at high risk of falling. This document also shows R93 has a history of falling, has an impaired gait, and overestimates or forgets her own limits.

R93's un-witnessed fall report dated 3/7/24 shows R93 had an unwitnessed fall in the dining room with no injuries.

R93's un-witnessed fall report dated 6/6/24 shows R93 had an unwitnessed fall in her room with no injuries.

R93's Care Plan dated 9/24/24 shows R93 has a care plan focus created on 1/22/2023 that states, "The resident is a risk for falls r/t (related to) Parkinson's Disease, confusion, psychotropic medication use, vision." This care plan and all interventions were last revised on 1/8/2024. No revisions were made after the un-witnessed fall on 3/7/24 or 6/6/24.

Facility Accidents and Supervision policy reviewed on 6/2024 states, "... 4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a.

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S9999	Continued From page 7 Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions. c. Modifying or replacing interventions as needed. d. Evaluating the effectiveness of new interventions." (A)	S9999		