STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146130	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Retirement Village	1740 North Circuit Drive Round Lake Beach, IL 60073

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview, and record review the facility failed to ensure a resident was provided care and services who required a rheumatology consult. This applies to 1 of 24 (R22) residents reviewed for quality of care in the sample of 24. The findings include: R22's face sheet shows she is a [AGE] year old female with diagnoses including age related osteoporosis, arthropathic psoriasis, dysphagia, heart disease, atrial fibrillation, and protein calorie malnutrition. On 9/23/24 at 10:07 AM, R22 was lying in bed, her arms were thin and bony. She complained of pain to her back, toes, shoulders form her psoriatic arthritis. She said she used to take a medication for her arthritis that helped. She had an appointment scheduled to see the Rhemotologist months ago and it was canceled. She said she would still like to see the Rhemotologist, but does not know what is going on with her appointment. On 9/24/24 at 1:39 PM, V2 (DON) said R22 is alert and oriented, she has terrible arthritis. She had an appointment scheduled on July 24, 2024 and they called the day before and canceled because they did not take her insurance. She sets up the appointments for residents and confirmed she did not schedule another appointment for R22. She needs it, she is definitely uncomfortable. R22's Nurse Practitioner Note dated 7/10/24 documents (R22) is requesting for Rheumatologist .she reports chronic arthritic pain to multiple sites including shoulders, back, hips, knees and toes. R22's Nurses note dated 7/12/24 documents appointment scheduled with Rheumatologist for July 24, 2024.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 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, 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 35178 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 [DATE]. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R23's Fall Risk assessment dated [DATE] shows, High Risk for Falls. The facility's undated Mechanical Lift policy shows, two staff members must be present when using any mechanical lift. One staff member directs mechanical lift towards the receiving surface while the other staff member gently guides resident. 47552 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. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47552 Based on observation, interview, and record review the facility failed to ensure a blender pitcher used to puree lunch was sanitized before use. This applies to 4 of 4 residents (R22, R26, R34, R72) reviewed for pureed diets in the sample of 24. The findings include: On 9/23/24 at 9:35 AM, V23 (Dietary Aide) filled all three compartments of the three-compartment sink. On 9/23/24 at 9:39 AM, V22 (Cook) was beginning to puree the pureed couscous for lunch. At 9:52 AM, V22 finished the pureed couscous and brought the blender pitcher and blender lid to the three-compartment sink to be washed. At 9:53 AM, V22 proceeded to run the blender pitcher and blender lid through the three-compartment sink. At 9:55 AM, the blender pitcher and blender lid were removed from the third sink and allowed to air dry. On 9/23/24 at 9:57 AM, V22 grabbed the blender pitcher from the drying area to begin pureeing the mixed vegetables. V22 grabbed a new, clean pitcher lid from a nearby rack before starting the puree mixed vegetables. On 9/23/24 at 10:11 AM, V23 (Dietary Director) used a test strip to check the concentration of the third sink for the three-compartment sink. V23 said the test strip didn't register there was any sanitizer solution in the sink and that the sink did not appear to have any sanitizer in it. V23 proceeded to empty the sink and re-filled the sink with a pre-diluted sanitizer and water mixture. When finished filling the sink, V23 re-tested the concentration and the test strip read at 400 parts per million, within the manufacturer's range for effective sanitizing. Facility provided list of residents on a puree diet show R22, R26, R34, and R72 receive pureed diets. Facility Manual Sanitizing in the Three-Compartment Sink policy dated 2017 states, . After washing and rinsing the utensils and equipment are sanitized in the third sink by immersion in either: . Chemical sanitizing solution used according to manufacturer's instructions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35119 Based on observation, interview, and record review the facility failed to ensure enhanced barrier precautions (EBP) were in place for 6 of 6 residents (R98, R41, R111, R114, R93, R117) reviewed for infection control in the sample of 24. The findings include: 1. On 09/23/24 at 09:55 AM, during initial tour, R98 was in bed sleeping, with a urinary collection bag hanging from the bed frame. There was no enhanced barrier precaution sign on his door. V25 Licensed Practical Nurse said R41 and R98 have urinary catheters and R114 has a urostomy. 2. On 9/23/24 at 10:09 AM, R111 said he had wounds on his toes that the nurse was putting a bandage on. R41's, R111's, and R114's rooms did not have EBP signs on their doors. On 09/25/24 at 09:33 AM, V4 Infection Control Nurse said she thought EBP was still voluntary. V4 said she will get that going and has a lot of reading to do regarding EBP. V4 said the facility did not yet have a policy on EBP. The facility's provided list of wounds, catheters, urostomy, ileostomy, and feeding tubes shows R41 and R98 have urinary catheters, R114 has a urostomy, and R111 has arterial wounds. 47552 3. R93's Care Plan created on 3/7/24, shows R93 has an indwelling catheter. On 9/24/24 at 9:16 AM, R93 was sitting in a wheelchair in her room. R93 was wearing shorts that rested just above her knee and her catheter bag was visible, sticking out from underneath the bottom of her shorts. The door to R93's room did not have any signage denoting R93 was on enhanced barrier precautions and there was not a personal protective equipment (PPE) station located outside of R93's room. 4. R117's Care Plan created on 6/4/24, shows R117 receives nutrition through a percutaneous endoscopic gastrostomy (PEG) tube. On 9/24/24 at 10:19 AM, R117 was lying in bed in her room. The door to R117's room did not have any signage denoting R117 was on enhanced barrier precautions and there was not a PPE station located outside of R117's room.