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 _____	C 08/28/2018

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

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S 000	Initial Comments Complaint investigation#1815632/IL105327	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b)4) 300.1210c) 300.1210d)3)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Vi[illegible]	

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includes measurable objectives and timetables to 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.

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. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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

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S9999	Continued From page 2 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidence by: Based on observation, interview and record review the facility failed to supervise a resident who was exhibiting attempts to get out of R1's chair and was at risk for falls. This failure resulted in R1 sustaining fractures of the 1st and 2nd cervical vertebrae of the neck. The facility failed to safely turn a resident in bed to prevent resident from rolling out of bed. This applies to 2 of 3 residents (R1, R2) reviewed	S9999		

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S9999	Continued From page 3 for safety and supervision in the sample of 5. The findings include: 1. R1's Physician Order Sheet (POS) dated August 2018, shows R1 has diagnoses of right sided Hemiplegia and stroke (Cerebrovascular Accident) R1's Minimum Data Set Assessment dated August 19, 2018 shows R1 is moderately cognitively impaired. The same MDS shows R1 has limited range of motion on upper and lower extremities. R1's Fall Risk Assessment dated August 2018 shows R1 is at high risk for falls. R1's Progress Notes dated August 19, 2018 at 5:07 PM shows, "R1 on the floor from reclined wheelchair, lying on right/center forehead. R1 sent to local hospital via 911." R1's Emergency Report dated August 19, 2018 shows that R1 came from a nursing facility who fell out of R1's chair. R1 was nonverbal. R1 was sent directly for CT scan. (Computerized x-ray) of R1's head and neck. R1's CT scan results shows R1 has neck fractures of the spine, Cervical 1 and Cervical 2 (1st and 2nd cervical vertebrae of R1's neck.) R1's Neuro Surgery Note dated August 20, 2018 shows [R1 has] mildly displaced fractures of left arch of C1 and left lateral body of C2. (Neck fractures) and due to overall health condition and nature of R1's fractures, treatment will be conservative, no surgical intervention. On August 27, 2018 at 2:00 PM, R1 was at a local	S9999		

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hospital, lying quietly in bed. R1 would open R1's eyes but R1 was nonverbal. R1 had cervical collar on R1's neck.

On August 27, 2018 at 7:10 AM, V3 (family member) said that V3 was at the facility on August 19, 2018. R1 was in R1's room sitting in R1's reclined wheelchair. R1 kept on moving in R1's chair. R1 would repeatedly attempt to lean forward or swing R1's good leg (left leg) to try to get out from R1's reclined wheelchair. V3 said there were no staff that would come and check on R1. V3 said V3 left R1 at around 3:45 PM and was worried that R1 will fall out of R1's wheelchair. V3 stated, "That is exactly what happened, I received a phone call from the facility, I was informed that [R1] threw herself on the floor. I don't believe that, how can R1 threw R1's self, R1 was paralyzed. [R1] leaned forward and fell.out of R1's wheelchair." V3 said V3 was informed that R1 sustained 2 fractures in R1's neck. V3 said V3 was told by hospital staff that R1 was not a good candidate to undergo surgery.

On August 27, 2018 at 10:11 AM, V4 (R1's friend) said V4 went to visit R1 on August 19, 2018 the day R1 fell. V4 said R1 was repeatedly attempting to lean forward. V4 said R1 also smelled like R1 had a bowel movement. V4 said V4 went and told the nurse that R1 was leaning forward, R1 seems uncomfortable and R1 might need to be changed. V4 said no staff went to check on R1. V4 said R1 continued to lean and pull R1's self up from the chair. V4 said V4 would remind R1 to sit back in R1's chair. V4 stated "at around 4:30 PM, I went to the nurse again and told her that I am leaving now, R1 was by R1's self in R1's room and that R1 might fall as R1 was leaning forward and kept moving in R1's chair. I learned later that night from R1's son that

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R1 fell and was sent to the hospital."

On August 27, 2018 at 12:35 PM, V5 (Registered Nurse-RN) said V5 was the nurse working the day R1 fell. (August 19, 2018). V5 (RN) said R1's friend (V4) came to the nurses station and informed V5 that R1 was leaning forward and that R1 might fall from R1's chair. V5 said V4 also told V5 that R1 might need to be changed. V5 said V5 knew R1 was gotten up at around 3:00 PM and that R1 was dry. V5 said V18 (R1's Certified Nursing Assistant- CNA) was on break and the other CNA's were busy with other residents. V5 said when V4 informed V5 that V4 was leaving and that R1 was leaning forward V5 said V5 went to check on R1. R1 was leaning forward so she repositioned R1 and reclined R1's chair so R1 would not fall. V5 said V5 also turned R1's chair so R1 can watch the TV. V5 said V5 left R1's room and went to check the other residents. V5 said later that afternoon, while V5 was passing the evening medication, a family member of another resident informed V5 that R1 fell out of R1's chair. V5 said V5 immediately went to R1. R1 was on the floor, on the side of R1's chair. V5 said R1 was sent to the hospital via 911. V5 said V5 tried to monitor R1 at the same time V5 was passing V5's medication but V5 was also busy with other residents at that time. V5 said R1's CNA was assigned to both the 300 and 500 wing.

On August 28, 2018 at 12:45 PM, V18 (CNA) said V18 was assigned to R1 on August 19, 2018 the day R1 fell. R1 was sliding down from R1's chair, V18 said R1 seems uncomfortable in R1's chair. V18 said V18 didn't know why. V18 said V18 then went to take care of the other residents assigned to V18 in 300 wing then went on break. V18 said V18 was informed that R1 fell and was

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S9999	Continued From page 6 sent to the hospital. On August 28, 2018 at 11:41 AM, V2 (Director Of Nursing) said R1 had been attempting to get out of bed or R1's wheelchair since day 1. R1 should have been placed in a highly populated area where R1 was visible. R1 should have been closely supervised. R1's care plan dated August 2018 shows R1 is at risk for falls related to CVA and right sided hemiplegia with interventions that include: prompt response to all requests for assistance. On August 28, 2018 at 12:06 PM, V9 (Orthopedic Doctor) said neck fractures (C1 and C2) are very dangerous and can be fatal. 2. R2's POS dated August 2018 shows R2 has diagnoses of Alzheimer's Dementia, and open reduction and internal fixation of R2's right hip. R2's MDS dated August 28, 2018 shows R2 needs extensive assist of 2 staff for bed mobility. R2's medical record also shows R2 was just readmitted to the facility on August 21, 2018 after undergoing a right hip surgery. R2's Progress Notes dated August 22, 2018 at 3:30 AM shows "writer called to the room, [R2] was on the floor between the wall and the bed. CNA was in the middle of changing R2. CNA turned around to get to the other side of the bed and R1 rolled out bed. R2 stated R2 fell off the bed and landed on R2's right side." (Surgical site.) On August 27, 2018 at 9:30 AM, R2 was in the dining room eating her breakfast. R2 said R2 fell	S9999		

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from R2's bed and had surgery but cannot remember when.

On August 28, 2018 at 12:02 PM, V14 (CNA) said that on August 22, 2018 at around 3:00 AM, V14 went to change R2 who was wet. V14 said V14 pulled R2's bed away from the wall to get to the other side of the bed to change R2. V14 said V14 turned R2 facing the wall and told R2 not to move. V14 said R2 rolled out of bed between the wall and the bed. V14 said V14 thought V14 could change R2 by V14's self.

On August 28, 2018 at 9:12 AM, V13 said that on August 22, 2018 at 3:00 AM, V13 was informed by V14 that R2 fell between the bed and the wall. V13 said V14 was turning R2 by V14's self. V13 said V13 told V14 that R2 is a two person assist for bed mobility.

R2's Physical Therapy Assessment dated August 22, 2018 shows R2 need maximum assist of 2 staff when rolling R2 side to side when R2 was in bed.

An undated facility policy entitled Accident and supervision shows the resident environment remains free of accident hazards as possible and each resident receives adequate supervision to prevent accidents.

(B)