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 06/27/2018

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 # 1814179/ IL 103733	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)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 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee

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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 ensure equipment device for toileting was in safe condition and failed to ensure a resident was supervised while toileting who is at risk for falls. These failures resulted in R1 falling from the toilet and sustaining a laceration above the left eye and a subdural hematoma.

This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 7.

The findings include:

The Physician Order Sheets dated through June 2018 shows R1 has a diagnosis including history of falls, cerebrovascular disease, hemiplegia and hemiparesis affecting left side.

The Minimum Data Set assessment dated June 19, 2018 shows R1's cognition is intact and requires two person extensive assist with transfers.

The fall risk assessment dated June 19, 2018 shows R1 is at risk for falls.

The Care Plan dated through September 2018 shows R1 is at risk for falls related to gait/balance problems, has limited physical mobility related to a stroke affecting (R1's) left side. R1's interventions include (R1) should be supervised during toileting.

The facility's Incident Report dated June 25, 2018

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shows R1 had a fall with injury. R1 is alert and oriented and was found on the bathroom floor and was bleeding. R1 was able to recall what happened and said (R1) was trying to scoot (R1's) self on the toilet chair and slid down on (R1's) left side and hit (R1's) head. R1 was sent to the local hospital and was treated for a laceration to (R1's) left eyebrow and a subdural hematoma.

On June 27, 2018 at 9:20 this surveyor was in R1's room talking with R7 (R1's roommate). R1 was not in R1's bed. At 9:22 AM, V10 (Certified Nursing Assistant-CNA) entered the room and knocked on the bathroom. R1 was in the bathroom unsupervised. R1 had a laceration with sutures above R1's left eye/brow and bruising below R1's left eye. V10 transferred R1 from the toilet to the wheelchair. R1 was not steady on R1's feet during the transfer, R1 stated, "I'm having a hard time moving my left foot." At 10:00 R1's toilet had a white plastic toilet riser placed over the toilet. The riser was unsteady and moved when gripped.

On June 27, 2018 at 9:30 AM, R1 said R1 fell a couple of days ago. R1 said a CNA (Certified Nursing Assistant) assisted R1 to the bathroom. R1 told the CNA R1 needed a toilet riser. R1 said the CNA got the toilet riser from the shower and placed it over the toilet. R1 said the CNA transferred (R1) from the wheelchair to the toilet. R1 said (R1) placed R1's hands on the toilet riser's arm rest to reposition R1's self on the toilet seat. R1 said the toilet riser was unstable and (R1) tipped over and fell on the floor. R1 said (R1) hit (R1's) head on the floor and (R1) was bleeding. R1 stated, "It scared the shit out of me." R1 said (R1) fell because the toilet riser wasn't right.

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On June 27, 2018 at 10:50 AM, V10 (CNA) said (V10) assisted R1 to the bathroom the day (R1) fell on June 24, 2018. V10 said R1 told (V10), (R1) needed to use the bathroom. V10 said (V10) was not too familiar with R1. V10 said (V10) got a plastic chair from R1's shower and placed it over the toilet. V10 said (V10) transferred R1 from (R1's) wheelchair to the toilet and left the bathroom. V10 said (V10) waited in the hallway when (V10) heard R1 yell "help me." V10 said R1 was on the floor in the bathroom and (R1) was bleeding from (R1's) face. V10 said (V10) asked R1 what happened. R1 told V10, (R1) was trying to reposition (R1's) self on the toilet and fell.

On June 27, 2018 at 10:40 AM, V8 (Licensed Practical Nurse-LPN) said (V8) was R1's nurse on June 24, 2018. V8 said V10 alerted (V8) R1 fell in the bathroom and was bleeding. V8 said R1 is alert and oriented and said (R1)was trying to move (R1's) self on the toilet.

On June 27, 2018 at 11:25 AM, V11 (Maintenance) said (V11) removed R1's toilet riser today because it slides, does not lock and does not have grippers.

On June 27, 2018 at 12:08 PM, V2 (Director of Nursing-DON) said R1 is a high risk for falls and should be supervised during toileting. V2 said if equipment is not in working order staff should report it.

The undated Policy for Accidents and Supervision states, "The resident environment remains as free of accidents and hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents."

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