Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6004428 **B. WING** 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Annual Licensure Survey Complaint Investigations: 2244442/IL147718 2244299/IL147539 2244448/IL147726 S9999 **Final Observations** S9999 Statement of Licensure Violations: 1 of 4 300.610 a) 300.1210 b) 300.1210 d)4)A) 300.1210 d)4)B) 300.1210 d)4)C) Section 300.610 Resident Care Policies 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 Attachment A Statement of Licensure Violations care and services to attain or maintain the highest

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/11/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: **B. WING** IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET** HILLSBORO REHAB & HCC HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 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. 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: Personal care shall be provided on a 4) 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. Each resident shall have clean. suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes. These requirements were not met as evidenced

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by:

Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity, had needs met timely, and provide privacy for 4 of 18 (R44, R46, R53, R175) residents reviewed for resident rights in the sample of 51. These failures resulted in R46 having feelings of embarrassment and she doesn't matter, R175 having feelings of embarrassment and crying when talking about

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 her experience of being exposed and with not receiving timely care, and R53 being upset and feeling dirty. Findings include: 1. On 6/22/2022 at 3:00 PM, R46 was sitting in main lobby with abdomen exposed. R46's shirt was above her abdomen beneath her breast. Staff were observed walking past R46, and no attempts were made to pull clothing down or change clothing. On 7/5/2022 at 8:30 AM, R46 was sitting in her wheelchair in the main lobby, with large stomach and abdominal dressing exposed and uncovered. Staff were observed walking past R46, and no attempts were made to assist with adjusting clothing. On 7/5/2022 at 11:05 AM, R46 stated she gets embarrassed when people look at her stomach. R46 stated no one helps her pull her shirt down. or cover her large stomach. R46 stated once her clothes are on, they are on. R46 stated when she notices someone looking at her uncovered stomach, she goes to her room and stays in there so no one can see her. R46 stated. "I don't matter." When talking about this, R46 dropped her head, and looked down and away. On 7/5/2022 at 12:20 PM, V21, Licensed Practical Nurse (LPN), stated she has worked with R46. V21 stated she has had conversations with R46. V21 stated sometimes R46 doesn't respond to her, but sometimes she does, V21 stated, "it's a 50/50." V21 stated when R46 does respond, she responds appropriately. V21 stated she is aware of R46 clothing revealing her

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abdomen, and would expect the staff to change

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Interventions: requires one staff participation with

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resident care, I will close the window blinds, pull the curtain around the bed and shut the door to

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: **B. WING** IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) S9999 Continued From page 5 S9999 maintain their privacy." On 6/30/22 at 11:05 AM, V23, CNA, stated, "For resident privacy, I make sure the door is closed, the curtain is pulled, the blinds are shut and the bathroom door is closed." On 6/28/22 at 11:15 AM, V6, Corporate Nurse, stated, "We don't have a specific policy for incontinent care. We have a check list that every employee does to get checked off for that procedure." 4. R44's Care Plan, with revision date of 6/8/22. documented R44 is dependent on two nursing staff for assistance with her care needs. R44's Minimum Data Set (MDS), dated 5/5/22. documented R44 has a mild cognitive impairment, and is not stable with her upper and lower body extremities, which requires two staff for assistance. On 6/7/22 at 10:50 AM, R44 activated her call light, and at 11:07AM, a staff member walked by R44's activated light without answering. At 11:25AM, the call light was de-activated by V5. Certified Nurse Assistant, (CNA). On 6/7/22 at 11:28 AM, when asked which resident activated their call light, V5 stated, "The resident in the first bed stated she did not need anything." When questioned if she asked (R44) in the second bed, V5 stated, "No." On 6/7/22 at 11:30 AM, R44 stated she activated her call light to have her incontinent briefs

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changed. V5 and another nursing assitant in training then assisted R44 with her care.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE

(X3) DATE SURVEY COMPLETED

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B. WING

07/07/2022

NAME OF PROVIDER OR SUPPLIER

HILLSBORO REHAB & HCC

STREET ADDRESS, CITY, STATE, ZIP CODE

1300 EAST TREMONT STREET

HILLSBORO, IL 62049

(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
S9999	Continued From page 6	S9999	**	
22 (F ₁₀)	The facility's Grievance Log, dated 6/1/22, documents, "Call lights are not answered timely. And residents can tell that staff are working short." The Grievance Log, dated 5/4/22, documented, "Call lights not answered in a timely manner, turning off lights and not coming back."			79
	The Grievance Log, dated 4/6/22, documents "In the evenings it takes a little longer for call lights to be answered." The Grievance Log, dated 3/8/22, documented, "Call lights are not answered in a timely manner."	10		**
	On 6/9/22 at 9:00AM, V1, Administrator, stated the facility does not have a policy or procedure for answering of call lights to address residents care needs.	x -		
8	The Residents' Rights for People in Long-term Care Facilities, dated 5/18, documents "You have the right to privacy."		# # # # # # # # # # # # # # # # # # #	U U
etter 30	The Facility's "Skills Checklist", undated, documents "Identify Patient, Wash Hands, and Ensure Privacy."			
1 m	(C) 2 of 4	e.		g 8
	300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3)			
	300.1210 d)5) 300.1220 b)2) 300.3240 a) Section 300.610 Resident Care Policies			se 8 — — — — — — — — — — — — — — — — — —

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3.9	•		9			
		shall have written policies and ing all services provided by the]
		policies and procedures shall				(9)
		Resident Care Policy		·		15
	Committee consisti		lk.			42
		dvisory physician or the		8		
11		ommittee, and representatives	1			
		er services in the facility. The " ly with the Act and this Part.	8			331
		s shall be followed in operating		33		-54
		be reviewed at least annually	1/4			
		documented by written, signed				V6 1.3
	and dated minutes	of the meeting.	N N			1/8
				11 ₈		N
		Medical Care Policies	5.50	- E		
		shall notify the resident's cident, injury, or significant	rane.	****		
		nt's condition that threatens the		1693	*	
		elfare of a resident, including,	177	¹²⁰	3.	=
		ne presence of incipient or				e = .
		ulcers or a weight loss or gain	_		8	V = 10
		ore within a period of 30 days.				
		tain and record the physician's care or treatment of such				2511.49
		change in condition at the time	1	#		
	of notification.	mango m condition at the time		: V		
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		General Requirements for		5		
	Nursing and Person					
99		shall provide the necessary			20	
		o attain or maintain the highest I, mental, and psychological	123	982 - 10		4
		sident, in accordance with		0.5		
		nprehensive resident care		22		
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65		care shall be provided to each	7.5	190		WH SE D
		e total nursing and personal				.0 4
101	care needs of the re			~		
		subsection (a), general nclude, at a minimum, the		*		
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FÖRM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 8 S9999 following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the nursing services of the facility, including: Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements. psychosocial status, discharge potential, dental condition, activities potential, rehabilitation

neglect a resident.

potential, cognitive status, and drug therapy.

An owner, licensee, administrator, employee or agent of a facility shall not abuse or

Section 300.3240 Abuse and Neglect

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"You can reach your doctor at one of the follow

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two blankets."

Tylenol prn as ordered and resident spit

medication out and threw it on the floor. Resident complaining that she is cold. Writer took resident to room and put on sweater, sat in recliner with

R40's Health Status Note, dated 6/25/22 at 4:45

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bandage. nois Department of Public Health

Nurse Assistant (CNA), V37, CNA, and V38, Activity Director, were in the dining room passing out breakfast trays. No one acknowledged R40, or tried to redirect her from picking at her

PRINTED: 09/11/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ **B. WING** IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 12 On 6/27/22 at 8:18 AM, V20, Licensed Practical Nurse (LPN), stopped her medication pass to redress R40's hand. R40 stated, "My hand hurts. Don't touch my hand. My hand hurts." On 6/27/22 at 8:55 AM, R40 was walking in hallway stating that her hand hurts. On 6/27/22 at 10:28 AM, V20 stated, "(R40) had like a horn growing out of the top of her hand. It is a large incision and has sutures." At this time, R40 came walking down the hall with the left hand gauze pulled up and the top of her hand bleeding, R40 stated, "My hand hurts." On 6/27/22 at 10:30 AM, V20 stated, "The night shift nurse faxed the surgeon to let him know and we are waiting to hear back from him." V20 told R40 she will get her some Tylenol to help. V20 took R40 to her room to cleanse and redress R40's left hand. R40 continued to say her hand hurt. V20 cut the remaining bandage off with scissors. R40's hand and fingers were very swollen. The top of her hand had an incision approximately 2 inches long, starting at the top of the hand, going past the knuckle to her inner finger. V20 cleansed the wound with normal saline, applied a gauze pad and wrapped the hand in gauze. R40's Health Status Note, dated 6/27/22 at 3:39 PM, documents, "Sutures intact to left hand,

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hand/fingers remain edematous and red, will not leave protective drsg on. Call out to (V50. Surgeon) regarding suture removal and the edema/redness of hand, awaiting return call."

R40's Health Status Note, dated 6/28/22 at 4:13 AM, documents, "L hand remains edematous and Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ____ B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET** HILLSBORO REHAB & HCC HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 13 S9999 reddened. Sutures appear removed at this time. Resident will not allow dressing to cover incisional wound. Area cleansed. Scant amount of sanguineous drainage noted." On 6/28/22 at 8:45 AM, R40 was walking in the dining room. R40's left hand had no bandage on it. R40's top of her hand had a small amount of drainage coming form the wound. The incision was scabbed over. R40's hand and fingers were more swollen than on 6/27/22. R40's hand remains red. R40 was telling V16, CNA, not to bump her hand and that her hand hurts. R40's Health Status Note, dated 6/28/22 at 9:53 AM, documents, "Resident continues to pick top of left hand at surgical site, area red, and edematous. Writer wrapped left hand with dressing and cling, resident said get that off, then removed dressing and began picking left hand again. (V40, Doctor) notified and awaiting response from MD." R40's Health Status Note, dated 6/28/22 at 10:26 AM, documents, "New order received from (V40. MD) to cover top of left hand with gauze, then cover with Geri sleeve or glove." R40's Health Status Note, dated 6/28/22 at 10:48 AM, documents, "(V40) MD updated on resident's surgical site to top of left hand, red, edematous, with serosanguineous drainage noted. Resident's temp 98.7 at this time. Awaiting on MD response." On 6/28/22 at 10:49 AM, V39, Registered Nurse (RN), stated, "(R40) is a picker, she won't leave anything on her hand which isn't surprising

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because it is swollen. I spoke with the doctor and he said to wrap it and to cover the dressing with a | Ilinois Department of Public Health | STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | COMPLETED | (X4) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | COMPLETED | (X4) PROVIDER/SUPPLIER/CLIA | (X5) MULTIPLE CONSTRUCTION | (X6) DATE SURVEY | COMPLETED | (X6) DATE SURVEY | (X6) DATE SURVEY | (X6) DATE SURVEY | (X6) DATE SURVEY | (X7) DATE SURVEY

IAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ILLSBORO REHAB & HCC

1300 EAST TREMONT STREET

(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
S9999	Continued From page 14	S9999		· ·
	brace or 'arm sleeve' to keep her from picking at it. I just dressed the wound." V39 stated, "The wound has some drainage on it so I am going to reach out to the doctor to see if I can get an order for a culture because I think it may be infected." V39 stated that she was notifying (V40, Medical Director).	<u>u</u> :		
	R40's Health Status Note, dated 6/28/22 at 2:19 PM, documents, "Left hand remains red and edematous, continues to pick at surgical site, removes protective drsg once on."			
# 1	R40's Health Status Note, dated 6/29/22 at 3:41 AM, documents, "Resident's L hand remains edematous and reddened. Scant amount of drainage noted. Resident has not c/o pain or discomfort thus far this shift. Continue to monitor for worsening of condition."	g 3		
₩0	R40's health status note, dated 6/29/22 at 8:30 AM, documents, "Resident is out in the dining room at this time. Resident has picked off current bandage on left hand. Hand evaled (evaluated) at this time. Residents hand is red and swollen 3 plus pitting. Resident states that it hurts when touched. Residents hand cleaned and new	p ⁷⁸		
. 48	dressing applied per MD order. Resident does have limited range of motion in her left hand related to swelling. Residents hand is not hot to touch. Will address with MD (V40) per fax to see if we can get a culture and a different dressing because resident picks this one off. Resident is unable to remember to leave dressing alone related to disease process."	W	Si e e e e e e e e e e e e e e e e e e e	5 u
	On 6/29/22 at 8:50 AM, R40 had removed the dressing from her left hand. R40's left hand and fingers were very swollen. The top of the hand was red. The redness from the hand was	=		

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 15 S9999 migrating down the fingers. The bottom of the incision that did run down the inner 4th finger has now pulled up to the knuckle and has opened up with drainage noted. The incision on the top of the hand has the the sutures intact and they were scabbed over. R40 was asked to move her fingers, R40 could not move the 4th finger and could only move the other 4 fingers slightly due to edema and pain. On 6/29/22 at 8:50 AM, V4, RN, stated, "We have gotten a culture of her hand and are waiting on results. I have given her Tylenol. The bottom of the incision has opened up, there is a little drainage, the other sutures are scabbed over. Her hand and fingers are swollen." R40's Health Status Note, dated 6/29/22 at 9:05 AM, documents, "Note faxed to MD (V40) office regarding hand dressing and culture needed. Awaiting fax back." R40's Health Status Note, dated 6/29/22 at 9:05 AM, documents, "Called MD (V40) office at this time, at 0937, asked to speak with a nurse reguarding hand and vaginal bleeding, 0938-(V71, V40's office staff), on the phone. Writer explained situation regarding residents hand and vaginal bleeding. (V71) states that (V72, Nurse Practitioner) will be in today to eval (evaluate) resident. Writer asked what time (V72) will be here because I feel like it is very important with residents hand and bleeding. (V71) states she will be in this afternoon. Writer asked if we could go ahead and get an order for a culture so that can be completed. (V71) states (V72) wants to see it before anything else is done."

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On 6/29/22 at 9:30 AM, V4, stated, "I told you wrong. The culture request was made but not

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6004428 B. WING 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 16 S9999 gotten and the doctor faxed back orders that the Nurse Practitioner will see this week. I have faxed over a request for steri-strips and a better dressing and a culture." On 6/29/22 at 9:35 AM, V4 was questioned why a phone call has not been made to the doctor instead of faxing, V4 stated, "The office will just tell us that we need to fax and wait for a response." On 6/29/22 at 10:30 AM, V4 stated she had called the doctor's office, and they said the Nurse Practitioner will come and see her today, V4 stated she asked if she could get a culture, and the office said no, the Nurse Practitioner wants to evaluate it first. On 6/29/22 at 10:41 AM, V49 (V50's Medical Assistant) stated, "We have not been made aware of any issues (R40) has been having with her incision. (V50) is in surgery until 1:30 PM, I will have him call you when he gets out." R40's Health Status Note, dated 6/29/22 at 12:37 PM, documents, "Residents hand has some purple discoloration noted to the left-hand top side, middle of the hand. (if you would look between the 2nd and 3rd finger and go up about 3cm (centimeters) and towards the ring finger, this is where the discoloration is noted). Residents radial pulse is still present. Resident continues to have 3 plus pitting edema in it and has limited range of motion. Area is red and appears shinny (sp) and taught."

can move them."

On 6/29/22 at 12:48 PM, V4 stated, "(R40's) hand is starting to bruise up by the incision now. She has a radial pulse. Her fingers are stiff but she

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caused the wound to dehiscence (open up). She is going to need antibiotics for the infection and probably wound clinic to heal the wound now."

On 6/29/22 at 2:13 PM, V39, RN, stated, "I did not reach out to the surgeon the other nurse did and we were waiting on a response. I faxed (V40)

to update him but did not get a response."

PRINTED: 09/11/2022 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6004428 B. WING 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 18 S9999 On 7/6/22 at 10:00 AM, V6, Regional Nurse. stated the nurses should have called the doctor and not faxed him when problems with her pain and incision started. On 7/6/22 at 2:16 PM, V40, Medical Director, stated he expects the nursing staff to notify someone at the first sign of infection. The Facility's "Abuse, Prevention and Prohibition Policy", dated 2/2021, documents, "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone. including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals." It continues, Definitions: "Neglect means failure to provide goods and services necessary to avoid physicial harm, pain, mental anguish, or emotional distress.* The Facility's "Significant Condition Change & Notification" Policy, undated, documents "Purpose: To ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: An accident or incident, with or without injury, that has the potential for needed medical practitioner intervention. A significant change in the resident's physical, mental or psychosocial status: New wounds, bruises or skin tears, Abrupt onset of edema, Onset of swelling, Symptoms of an infectious process. Ten percent weight loss or

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gain in six months, Abnormal, Unusual or new complaints of pain, Allegation of abuse of neglect, and Resident to resident altercations require notification for both resident residents. A need to

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	£6 (8)	
HILLSBORO REHAB & HCC			AST TREMONT S BORO, IL 62049	TREET		988 1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	FION	(X5)

(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
S9999	Continued From page 19	S9999		
= " 2	significantly alter treatment." It continues "When		*	
	any of the above situations exist, the licensed nurse will contact the resident's representative	55	4 =	112
a *	and their medical practitioner. Prior to calling the		(B)	
	medical practitioner the nurse will complete the	9.	*	
11.0	SBAR assessment. The medical practitioner will		N. W.	111
77.5 - 11	be contacted immediately for any emergencies regardless of the time of day. Non-emergency			
	notifications may be made the next morning if the		R) (0) (0)	
	situation occurs on the late evening or night shift.		A1	Trá
	This applies to any day of the week including holidays. If the medical practitioner cannot			140
- 202	immediately be reached in any emergency, the			
-	medical director will be called. If that medical			-
24,524.0	practitioner cannot be reached, the Director of	4:1	0 P	8
132	Nursing or the charge nurse can make arrangements for transportation to the emergency			
1.0	department. Each attempt will be charted as to		2	and the same
8	the time the call was made, who was spoken to,		178	
	and what information was given to the medical practitioner. In a non-emergency situation, the			1 8
	primary medical practitioner will be called unless		· ·	
7.4	he/she has left an alternate name to call. If after		**** S S S	
570/	two attempts, there is no response to the calls, the medical director will be contacted."	(5)	9	
E	the medical director will be contacted.		60° St	500
1	(B)			
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. 63	300.610 a)			
	300.1210 b)		:8"	
	300.1210 c) 300.1210 d)6)		374	92
	* · · · · · · · · · · · · · · · · · · ·			
	Section 300.610 Resident Care Policies		T T	
	a) The facility shall have written policies and procedures governing all services provided by the			
	facility. The written policies and procedures shall			21
VV.	be formulated by a Resident Care Policy		w 5 5	10

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			Application .
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PRINTED: 09/11/2022 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 20 S9999 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 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. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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.

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These requirements are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide adequate supervision to prevent falls, and failed to operate

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 21 S9999 a mechanical lift in a safe manner in 3 of 6 residents (R19, R38, R226) reviewed for falls in the sample of 51. This failure resulted in R38 and R226 sustaining falls which resulted in fractures. 1. R226's face sheet, undated, documents a diagnosis of Parkinson's Disease and Muscle Weakness. R226's Minimum Data Set (MDS), dated 6/15/22, documents R226 has severe cognitive impairment, requires an extensive assistance of two staff for toileting and has had falls prior to admission and after admission. R226's care plan, dated 6/10/22, documents R226 is at risk of falls. R226's fall risk assessment, dated 6/10/22, documents R226 is at risk of falls. R226's progress note, dated 6/24/22 at 2:11PM, documents, "Certified Nurses Assistant (CNA) brought resident to bathroom, resident was agitated and walked on through the next bathroom door to the adjoining room. Resident then attempted to punch CNA, and resident fell to the floor. CNA yelled for writer/nurse. Writer arrived in room and noted resident sitting on the floor. Writer asked resident if he was having pain and he responded his hip and neck hurt. Staff did not move resident. 911 called. Emergency Medical Technicians (EMT) arrived and resident lifted with sheet to stretcher. Resident transferred to local hospital via ambulance." R226's hospital history and physical, dated 6/25/22, documents diagnosis of a Left Femoral

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Neck Fracture.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING: _

(X3) DATE SURVEY COMPLETED

IL6004428

B. WING

07/07/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1300 EAST TREMONT STREET

(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
\$9999	Continued From page 22	S9999		
	On 6/28/22 at 11:47AM, V41, Licensed Practical Nurse (LPN), stated R226 was very agitated, and he had just punched a task aide and threw furniture all around the room. V41 stated he started yelling he needed to go pee, so she told V60, CNA, to go ahead and take him to the bathroom. V41 stated she went out to get his medication, Ativan, ready hoping with him going to the bathroom, it would calm him down enough to take the medication. V41 stated R226 went into the bathroom and kept going into the next residents room, and when V60 tried to redirect him back to the bathroom, R226 was kicking and trying to hit V60, and he fell. V41 was questioned if it was safe for V60 to take R226 to the bathroom alone, and V41 stated, "That is all the staffing we had that day would allow."			
	On 6/29/22 at 11:39AM, V41, LPN, stated when R226 fell on 6/24/22, there was only 1 CNA attempting to tollet him. V41 is unsure of what assistance level was required for R226 with tolleting.	34		58 55 20 20 20
	On 6/30/22 at 11:05AM, V1, Administrator, stated he would expect staff to use the recommended number of staff needed for transfers, toileting, etc.		15 W 14 H 15 H	
5 6 723	2. R38's Care Plan, dated 3/17/22, documents, "(R38) is at risk for falls related to gait/balance problems and history of falls. Interventions: 'Call Don't Fall' sign, call light is within reach and encourage the resident to use it for assistance as needed, educate the resident/family/caregivers about calling for assistance prior to cares and	¥3		
=	what to do if a fall occurs, ensure personal items are within reach, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair, place walker within ment of Public Health	iii		

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATÉ DEFICIENCY) S9999 Continued From page 23 S9999 reach. On 6/21/22, intervention added: Re-educate resident importance of using call light for assistance." It continues "(R38) YOUNITE Story - Care/ADL (Activities of Daily Living) Preferences: (R38) prefers to go to bed at 8:00 PM, usually wakes up early in the morning to use the bathroom and then will go back to bed for about an hour." It continues "(R38) has an ADL Self Care Performance Deficit related to impaired balance. Interventions: Ambulation assist walking with resident in her room to and from the bathroom using a gait belt and wheeled walker providing stand by assist to limited assist as needed based on resident's performance and ability, requires one staff participation to use toilet, requires one staff participation with transfers." It continues "(R38) has limited physical mobility. Interventions: requires stand by assistance with a walker to ambulate as desired." R38's "Fall Risk Data Collection", dated upon admission on 6/1/21, documents R38 was a low fall risk. R38's "Fall Risk Data Collection", dated 3/13/22, R38's date of fall, documents R38 was a low fall R38's "Fall Risk Data Collection", dated 3/26/22, R38's return to the facility after hospitalization from a fall, documents R38 was a high fall risk. R38's "Fall Risk Data Collection", dated 6/21/22, R38's date of fall, documents R38 was a high fall risk. R38's Progress Note, dated 3/13/22 at 3:40 AM. documents, "The resident is experiencing a change in condition. See SBAR (Situation, Background, Assessment, Recommendation) assessment for further information and

family/physician notification. The change in condition the resident is currently experiencing is

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED	
A	IL6004428	B. WING	07/07/2022	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1300 EAST TREMONT STREET

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	TE :
S9999	Continued From page 24	S9999	45	-		
	non witnessed fall."					
	R38's Progress Note, dated 3/13/22 at 3:43 AM, documents, "Resident yelling out help. CNA entered room and observed resident sitting on the)0 X 1	7.		
	floor. Writer entered room and observed resident sitting on the floor in the corner by bathroom					
	door. Walker standing behind resident. Resident states she was bending over to pick up a piece of clothing and lost her balance and fell to her					
	bottom. ROM (Range of Motion) WNL (Within Normal Limits) and no complaints of pain. resident was able to stand to feet and skin check					
	completed at this time with no areas noted. resident ambulated with walker to bed without difficulty. Vital signs 112/52-56-16-97.8. neuro					
	assessment initiated. Doctor made aware. will update POA (Power of Attorney) in AM hours."					
1 12	R38's Progress Note dated 3/13/22 at 10:08 AM, documents, "Resident noted to have fall on night shift last evening. Neuro checks continued, vitals	-9	72 24 (1999)			
	stable and WNL, no complaint of pain or discomfort at this time. Does states she is a little sore on left rear. No redness or bruising noted at	. Zi				
1/2	this time."		Y			
	R38's Progress Note, dated 3/15/22 at 7:05 PM, documents, "Resident complained of pain in right hip and lower right rib regions. Tylenol provided					
	PRN (as needed) throughout day. Resident requesting x-ray. Resident able to move all	Çin.	15 20 20			
	extremities, and able to ambulate with walker. Aware we will update doctor in the morning."	* 41	911			
	R38's Progress Note, dated 3/16/22 at 10:22 AM, documents, "New Order received from Doctor's office per Nurse, x-ray right hip and right rib area. Orders called to (radiology company), states will call with time they will be here. Call placed to	21				

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PRINTED: 09/11/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1300 EAST TREMONT STREET HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 25 S9999 update POA/Son of new order, no answer, left message to call facility. HIPPA (Health Insurance Portability and Accountability Act) compliance maintained. Awaiting return call at this time." R38's Progress Note, dated 3/21/22 at 6:40 AM. documents, "Called POA per resident's request. Resident continues to complain of pain, Resident is refusing to be repositioned, changed, or attempt to walk with assistance to go to the bathroom. POA states he was in vesterday and she would only get up one time. He attempted to encourage her that she needed to get up, but resident complained of pain and would not. Will update MD (Medical Doctor) when office opens that resident is still complaining of pain. POA

R38's Progress Note, dated 3/21/22 at 9:11 AM. documents, "The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is resident had a fall on 3/13/22, complaining of increasing pain to pelvic/back."

states he will be in later today. Resident is in bed but slouched down towards the bottom of the bed and will not let staff pull her up in bed. Call light

R38's Progress Note, dated 3/21/22 at 9:12 AM. documents, "Doctor's office called and stated that resident should go to the ER (Emergency Room) to be evaluated."

R38's Progress Note, dated 3/21/22 at 9:16 AM, documents, "Called (local ambulance service) to come and get resident and take to the hospital for evaluation.

within reach."

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on. Floor clean, quiet environment. Writer asked resident if she was in pain. Resident states, "Yes. I think something is broke." Writer asked resident if she was able to move her legs. Resident states she is unable to move left leg. Left leg bent, resident unable to show exact location of pain

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET **HILLSBORO REHAB & HCC** HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 27 S9999 other than left leg. Resident left on the floor, with CNA beside her. POA called at 4:30 PM, 911 called at 4:31 PM, informed both crews are out at this time, will be here as soon as they can. Report called to Nurse at (local ER) at 4:33 PM. Nurse at Doctors office notified. Regional nurse. (V6) present and aware. Local Ambulance Service arrived and transported resident via stretcher to Local ER at 4:47 PM." R38's Progress Note, dated 6/24/22 at 2:13 PM. documents, "Received a call from (staff at local hospital) to call report that resident is coming back to facility today. Fracture to left hip, had nailing on 6/22/22 with incisions noted to left upper thigh. WBAT (weight bearing as tolerated). Two assist for transfers, Isolation droplet sinus related to random virus and ESBL (Extended-spectrum beta-lactamase) to urine. Carbohydrate controlled 75 gram diet. Accu checks Ac (before meals) and HS (before bed) with SSI (sliding scale insulin). Urinary catheter discontinued this morning and resident is voiding without difficultly. Order for Norco and script is being sent. Currently on Lovenox. Transport was at hospital at end of call to bring her to facility." On 7/5/22 at 10:45 AM, R38 was lying in bed. wheelchair was at the foot of her bed. There was no walker seen in her room. There was a "call don't fall sign" on the restroom door. R38 had personal items lying everywhere, on her bedside table, the night stand, and the window sill. On 7/6/22 at 12:30 PM, R38 was lying in bed with hospital gown on, no walker was seen in her

room; personal belongings located in several places in her room; wheelchair at foot of her bed.

On 7/05/22 at 11:00 AM, R38 stated, "I remember

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The Facility's Schedule and Daily Assignment

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away from her bed, while being moved

final lowering into her wheelchair.

approximately three to four feet to her wheelchair. R19 was left swinging freely in the air during the move until lowered into the wheelchair. No one was holding onto R19 during this transfer until the

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dated 2002, documents "Before Lifting: 1. Make sure that all straps are attached to the carry bar.

comfortable. 3. Make sure the sling is not caught on an obstruction. 4. Lift until the buttocks of the person being lifted clear the arm supports or the top of the bed before moving the person. Guide

2. Make sure the person being lifted is

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	IL6004428	B. WING	07/07/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HILLSBORO REHAB & HCC

1300 EAST TREMONT STREET HILLSBORO, IL 62049

(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 COMPLETED TO THE APPROPRIATE DATE DEFICIENCY) (X5	
\$9999	Continued From page 31	S9999		
* * * * * * * * * * * * * * * * * * *	the legs past any obstacle." It continues "The Hoyer lift is not intended to be a transport device. Person in the lift should not be moved more than a few feet."	, ×.,	- A _ S = H	ā
2006	The "Fall Policy", dated 9/17/19, documents "The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach	9		
0	and manage strategies and interventions that foster resident independence and quality of life. The Fall Management Program promotes safety, prevention and education of both staff and residents."	ě.		
	(A)			
	4 of 4		v.	125
W.	300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3)	_36		-
4-	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	****		W W
	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 300.1010 Medical Care Policies		9 4	-

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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					<u> </u>	7/2022
NAME OF	PROVIDER OR SUPPLIER	The state of the s		STATE, ZIP CODE		
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S9999	Continued From pa	ge 32	S9999		2.2	
	physician of any accordange in a residen	shall notify the resident's cident, injury, or significant t's condition that threatens the	= an ×		= = =:	
	but not limited to, the manifest decubitus	Ifare of a resident, including, e presence of incipient or ulcers or a weight loss or gain ore within a period of 30 days.	v _e	=		8 RS
	The facility shall obt plan of care for the	ain and record the physician's care or treatment of such hange in condition at the time		- 13 - 20		÷
	of notification.	- 44		0 S		\
ŝ	Nursing and Person	Seneral Requirements for al Care hall provide the necessary	= **	W **	-	0) = 10.00
	care and services to practicable physical, well-being of the res	attain or maintain the highest mental, and psychological ident, in accordance with		3 33	#,303 2.373	
=	plan. Adequate and care and personal c	prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal		s " c		* *
1 1 32	care needs of the re d) Pursuant to	sident. subsection (a), general	** - al	E 8		3 T-63
	following and shall b seven-day-a-week b		44 7 88		7. 45	7.8
7475	a resident's condition emotional changes,	e observations of changes in n, including mental and as a means for analyzing and		til de W	11 R JC	0.0
	further medical evalu	uired and the need for liation and treatment shall be from the from the liation and recorded in the	<u></u>			Marie III
OC U	residents medical re	cora.	Œ.			o god
	These requirements by:	were not met as evidenced			2 24	
3						_

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
100 ESS	IL6004428	B. WING	07/07/2022	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HILLSBORO REHAB & HCC

1300 EAST TREMONT STREET
HILLSBORO, IL 62049

	HILLSBOI	RO, IL 6204	19.2	
(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
S9999	Continued From page 33	S9999	3	
	Based on interview and record review, the facility failed to monitor and provide interventions to		· - s - 33	* *
	prevent significant weight loss, and failed to notify the physician of a change in condition for 1 of 3 residents (R20) reviewed for weight loss and nutrition in the sample of 51. This failure resulted	5		# H R
	in R20's severe weight loss of 10% in 3 months, and severe weight loss of 11.7% in 6 months.			
	Findings include:			8
	R20's weight log documents R20's weights as follows: 12/1/2021 130.0 Lbs (pounds); 1/2/2022 123.0 Lbs; 2/9/2022 121.8 Lbs; 2/13/2022 121.8	35		(f) (c)
	Lbs; 3/9/2022 117.0 Lbs; 4/1/2022 117.0 lbs; 5/1/22 125.6 lbs; 6/15/2022 114.8 lbs.			11
27	R20's Nutrition Record does not document meals for 5/31/22 dinner, 6/1/22 dinner, 6/2/22 to 6/9/22 all meals, 6/10/22 breakfast & lunch, 6/11, 6/12	æ	A E	8
= 0	no meals documented, 6/13/2022 breakfast & lunch, 6/14 no meals documented, 6/15 lunch.	*	#. #.	
	R20's Dietary Note, dated 1/13/2022 at 11:06 AM, documents, "Note Text: RD (Registered Dietician)		100 m	
50	NOTE: Resident with Regular diet, adequate for nutrition needs, weight at 123#, < (less than) IBW	*** ** N=	er∻ d ^C ur	
	(ideal body weight) Range, this is usual weight for resident when reviewing weight hx (history). decrease noted 5.4% x 30 days, Ice Cream is		e (X	
	given 1xday- 101 yo (year old) advanced age r/t (related to) weight changes as well. Resident is Covid+ and weight changes expected to continue	<u> 10</u>	¥	
	r/t illness. Rec (recommend) MPS for nutrition/weight support. Refer PRN (as needed)."		의 표	
	R20's Dietary Note, dated 4/8/2022 at 9:56 AM, documents, "Note Text: RD NOTE: Resident with	111	*	
	weight changes past 6 months, 117#, <ibw< td=""><td></td><td><u> </u></td><td></td></ibw<>		<u> </u>	

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PRINTED: 09/11/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6004428 07/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST TREMONT STREET HILLSBORO REHAB & HCC HILLSBORO, IL 62049 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 34 S9999 Range. Regular diet is adequate for 101 yo, on IceCream also, intake is good at meals per records. Dementia dx (diagnosis) noted. D/T (due to) Weight decline, REC House Supplement 60cc (cubic centimeters) 2x day. Refer PRN." R20's Diefary Note, dated 6/21/2022 at 12:28 PM. "Note Text: RD NOTE: Resident 101 yo with 8% decrease this month, current weight at 115#, <IBW Range, stable with April weight, diet is</p> adequate for nutrition needs, also on Ice-cream for addtl (additional) nutrition/caloric support. intake is ~50% at meals. REC house supplement for nutrition, Refer PRN" On 6/29/22 at 12:33 PM, V51, Registered Dietician, stated, "Per guidelines, 8% weight loss in one month is considered significant. I can't say whether (R20) would have lost weight if she had received the Med Pass. I would expect staff to encourage a resident to eat who has had significant weight loss. After I visit the facility, I send a full report to the DON (Director of Nursing), Administrator, and Dietary Manager. It may also go to someone in corporate, but I'm not sure about that. I review weights twice per month, but I'm physically in the facility once per month." On 6/29/22 at 12:50 PM, V34, Dietary Manager, stated, "I get a report from the Dietitian once a month. It goes to me and the ADON (Assistant

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Director of Nursing). Usually the ADON notifies the doctor, but last month, we didn't have the ADON, so I sent the report to all the nurses so they could contact the doctor. If there is a new doctor order, the nurses will let me know.

Sometimes, nurses will refer to the Dietitian, and I

resident needs encouragement, extra fluids, etc. I write it on the 'notes' section of their meal ticket.

will let the Dietitian know to see them. If a

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED	
	IL6004428	B. WING	07/07/2022	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HILLSBORO REHAB & HCC

1300 EAST TREMONT STREET

(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
S9999	Continued From page 35	S9999		. =
	The CNAs (Certified Nursing Assistants) or nursing are responsible for carrying that out. I order the Med Pass, Magic Cups and ice cream. I am not sure if nursing is still ordering Boost or	e = # #		10
W #	Ensure, but they used to. I only pass the Magic Cups and ice cream. The nurses take care of Med Pass."		0 a	
Er Ur	On 6/29/22 at 12:43 PM, V53, CNA, stated, "The checkmark means the residents were asked if they wanted a snack. We chart in (Point Click Care) whether or not they accepted the			22
	supplement. We do not document how much they ate or if they ate at all." V54 stated, "I think we only document percentages at meals."	V ₄	10 to	
	On 6/29/2022 at 1:00 PM, V52, RN, at V64's (R20's Primary Care Physician) office, stated the facility did not notify them of R20's weight loss or recommendations from the Dietician. V52 stated	ey,	**	
	it is the expectation the facility notify V64, R20's Primary Physician, and/or the office of R20's weight loss and recommendations. V52 stated when notified of a significant weight loss, the	E)		
â	doctor reviews the previous weights, condition, age, consults the family, and reviews any recommendations. V52 stated at that time, interventions would be put in place, and in this			×
	case it would have been the supplements. V52 stated they did not get that opportunity, because they were not notified of any weight loss until June 28th. V52 stated the interventions are put in	2) 6	-3 MSS SS	
=-	place to stabilize and help prevent further weight loss. V52 stated, "She should have been on the supplements."	27		9
=.6	On 7/5/2022 at 1:20 PM, V3, LPN, stated R20 has had significant weight loss. V3 stated if there was a recommendation from the Dietician, then the recommendation should have been followed.			

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VIAD LEVI	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPLETED	
			20	21		
	N/s	IL6004428	B. WING		07/07/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	, STATE, ZIP CODE	0710112022	40
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HILLSB	ORO REHAB & HCC		RO, IL 620		į.	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	QI ID	PROVIDER'S PLAN OF CORRECT	TION	
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S9999	Continued From pa	ge 36	S9999	(ii)		111
	V3 stated intervention	ons are put in place to prevent		11	N N	
	future weight loss a	nd stabilize the resident. V3	190		N 11	- 26
*	stated not putting in	terventions in place		- The state of the		
	contributed to R20's	s weight loss.				
	On 7/5/2022 at 1:43	PM, V56, R20's Guardian,		· · · · · · · · · · · · · · · · · · ·		10
20	stated she was not	aware of R20's weight loss	98	2.2		J
•	and supplement unt	til yesterday (7/4/2022), V56			, 4 22	
	stated she brings in	snacks, and the problem is			8	ı
	they are not in her re	each. V56 stated her mom			B	
İ	nas a snort term me	emory problem, and would not r them. V56 stated her mom		- N - S	22	
III.	would allow staff to	provide encouragement and		· 報告		.
=	assistance for her de	uring the meal. V56 stated				4
	her mom can do sor	me things for herself, but		7.8		
	requires help at time	es. V56 stated she would				
+30 × C	expect to receive ca	lls.		**	***	- [
	On 7/6/2022 at 2:17	PM, V40, Medical Director,		~	34	-
	stated with a resider	nt who is having a weight loss				
×	and with multiple cor	morbidities, he would expect				- 1
3	the physician to be n	notified of the weight loss and				Ų
		nendations. V40 stated he entions would have been put		1944	8	
1	in place. V40 stated	interventions are put in place		Nr.		- 1
6	to stabilize and previ	ent more weight loss. V40			#5 TO	
	stated the resident s	hould have been placed on				
ŀ	the supplements. V4	0 stated not having the				-1
35	Intervention in place loss.	contributed to R20's weight				ş
	1055.	(7)		#	ν,	
	The facility's Nutrition	n (Impaired)/Unplanned			2	
	Weight Loss-Clinical	Protocol. "Assessment and			107,11	
ĺ	Recognition 1. The n	ursing staff will monitor and		0		- [
34	document the weight	and dietary intake of		-		J
	residents in a format available comparisor	which permits readily as over time. 2. As part of the				Ì
	initial assessment th	e staff and physician will		F2 21	41	1
=	review the individual	s current nutritional status		102	11.0	
*	and identify individua	ls with recent weight loss				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004428		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED 07/07/2022		
		B. WING	<u> </u>			
	PROVIDER OR SUPPLIER ORO REHAB & HCC		DRESS, CITY,	STATE, ZIP CODE		-
		HILLSBO	RO, IL 6204		9	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBF	(X5) COMPLETE DATE
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	threshold for signific weight loss will be b a.1 month-5% weig	for impaired nutrition 3. The cant unplanned and undesired ased on the following criteria th loss is significant; greater c. 6 months-10% weight loss	200 E.			- 14 - 24
79	is significant; greate	r than 10% is severe."		a=1 000	9: 	
8	(B)	*	96	22 (m)		(V. (C. 1)
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