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 12/05/2022

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

(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
S 000	Initial Comments Complaint Investigation 2219486/ IL 153785	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical abuse. This failure resulted in R1 being punched in the face by staff and sustaining a right eye contusion and right eye laceration requiring stitches. This applies to 1 of 4 residents (R1) reviewed for abuse in the sample of 4. The findings include: The facility's undated Final Incident Investigation Report documents on 11/29/22 at approximately 7:50 PM, "[V4 (Terminated CNA)] notified the nurse [V3 (LPN)] that he and [R1] had an altercation and [V4] struck [R1] in the face and he was bleeding. [V4] was attempting to assist [R1] to bed for the night. When [V4] attempted to remove his pants [R1] became verbally and physically aggressive towards [V4]. [R1] kicked [V4] in the groin and attempted to grab his arms. [V4] then struck [R1] in the face to stop him from grabbing him. [V4] was escorted out of the building and awaited the police arrival [V4] was arrested and [R1] was sent out to the local hospital. [V4] was terminated from the facility and [R1] returned to the facility and received two stitches to the right inner eye lid." On 12/5/22 at 9:09 AM, R1 was sitting in his wheelchair in the common area. Diffuse bruising was observed under his right eye and a laceration	S9999		

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S9999	Continued From page 2 observed to his right inner eye. R1 was unable to answer any questions with no behaviors observed at this time.	S9999		
	On 12/5/22 at 10:21 AM, V3 (LPN) said he was the nurse the day of the incident with R1. V4 (Terminated CNA) came up to him and said that R1 was bleeding from his face but did not say what happened. V3 went to R1's room and he was bleeding from the right side of his face/cheek. "I touched his cheek and [R1] pulled away and put his hands in the air and said, 'don't hit me'." V3 said R1, "was traumatized, he cowed away and could not tell me what happened." V3 said he left R1's room and saw V4 at the nurses' station. He asked V4 what happened. V4 mumbled something, then he asked him again what happened. "[V4] said he punched [R1] in the face. Never should staff hit another resident. [R1] has a history of being physically aggressive towards staff, you get out of his way and re-approach him when he has behaviors. I've been hit by [R1], he's not that strong." On 12/5/22 at 10:32 AM, V6 (CNA) said she was working on 11/29/22 when the incident happened with R1. V6 said, "[V3] said that [V4] punched a resident and I needed to take over his assignment. [R1] can be aggressive, but if you take care of him properly, he is calm. You should explain what you're doing and reapproach him if he gets combative and notify the nurse. You should never hit a resident. [V4] usually keeps to himself and doesn't interact with people too much." On 12/5/22 at 11:46 AM, V1 (Administrator) said she got a call on 11/29/22 and staff reported that V4 hit R1 in the face. She notified the police and called 911. The police were there, and they			

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S9999	Continued From page 3 interviewed V4. V4 said he went to R1's room to put him to bed and R1 kept on saying things that were not true and that V4 was in the army. R1 kicked V4 in the groin and attempted to grab him then V4 struck R1 in the face. V1 said that V4 was arrested and is still in jail. R1 was sent out to the local hospital and had a right eye laceration and required two stitches. V4 never said he was sorry or showed remorse for his actions. V4 was very quiet and did his job. V1 said that R1 has verbal and physical behaviors and is not easy to care for. V1 said, "If there is no reasoning with him staff should leave him alone and re-approach him when he has behaviors." R1's face sheet showed he was an 89-year-old male with diagnoses that included hearing loss, dementia, urine retention, hemiplegia and hemiparesis following cerebrovascular disease affecting the left non-dominant side, and heart disease. R1's Minimum Data Set assessment, dated 10/11/22, showed he had severely impaired cognition and incidents of verbal and physical behaviors, and rejections of care. The facility's Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy states, "The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation and reporting of abuse. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. b. Abuse: The willful infliction of injury. with resulting in physical harm, pain or mental anguish, which can include staff to resident abuse. Physical Abuse includes hitting, slapping,	S9999		

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S9999	Continued From page 4 pinching, kicking and controlling behavior through corporal punishment." (B)	S9999		