(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		С
		IL6004477	B. WING		07/19/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HILLTOP	SKILLED NSG & REHAB		POLK STREET ON, IL 61920	T	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
	FRI of 6/30/2024/IL17	75409			
S9999	Final Observations		S9999		
	Statement of Licensu	re Violations			
	300.610a)				
	300.1210b) 300.1210d)6				
	300.3210(t)				
	300.3240a)				
	Section 300.610 Res	ident Care Policies			
		nave written policies and			
		gall services provided by the olicies and procedures shall			
	be formulated by a Re				
	Committee consisting				
	administrator, the adv	mittee, and representatives			
	of nursing and other s	services in the facility. The			
		with the Act and this Part. hall be followed in operating			
		e reviewed at least annually			
		cumented by written, signed			
	and dated minutes of	the meeting.			
	Section 300.1210 Ge Nursing and Personal	eneral Requirements for I Care			
		rovide the necessary care or maintain the highest			
	practicable physical, r	mental, and psychological			
	•	dent, in accordance with			
		rehensive resident care roperly supervised nursing			
	<u> </u>	- · · · · · · · · · · · · · · · · · · ·			

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/09/24 **Electronically Signed**

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
						С	
		IL6004477	B. WING		07	/19/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
HILLTOP	SKILLED NSG & REHAB	910 WEST	POLK STREET	Г			
	I		TON, IL 61920				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page	2 1	S9999				
	care and personal car resident to meet the to care needs of the resi	re shall be provided to each otal nursing and personal ident.					
	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:						
	assure that the reside as free of accident ha nursing personnel sha	cautions shall be taken to ents' environment remains azards as possible. All all evaluate residents to see beives adequate supervision event accidents.					
	Section 300.3210 Ge	eneral					
	subjected to physical,	neglect, exploitation, or					
	Section 300.3240 Ab	use and Neglect					
		e, administrator, employee or Il not abuse or neglect a 107 of the Act)					
	These Requirements evidenced by:	were NOT MET as					
	review the facility faile right to be free from s resident and verbal/m member for four of se and R5) reviewed for seven residents. The	n, interview and record ed to protect the resident's exual abuse by another mental abuse by a staff even residents (R1, R2, R3 abuse in the sample list of use failures resulted in R2 fortable, and removing					

Illinois Department of Public Health

STATE FORM 6899 If continuation sheet 2 of 9 8GJ211

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
						С
		IL6004477	B. WING		07	/19/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
		910 WES	ST POLK STREET			
HILLTOP	SKILLED NSG & REHAB	CHARLE	STON, IL 61920			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	÷ 2	S9999			
	herself from shared a sexually abused by R	reas with R1 after R2 was 1 and R5 experiencing nd fear after a staff member				
	Findings include.					
	documents R2 as cog MDS documents R2 r transfer into/out of he	ta Set (MDS) dated 5/28/24 gnitively intact. This same requires staff assistance for r wheelchair and is able to ependently once seated.				
	documents R1 as mo- impaired. This same independent in bed m	Set (MDS) dated 6/17/24 derately cognitively MDS documents R1 as sobility, transfers, walking self propels wheelchair for				
	the State Agency date	d Final Incident Report to ed 7/8/24 documents "(R2) her breast in the hallway."				
	wheeled himself up to out both of his hands both of R2's breasts fi stated R1's hands we blouse. R2 stated "I t pushed his hands awa do that. That was em R2 stated R1 said 'I a as he was rubbing on tearful and crying duri wiping tears away frontissue to blow her nos	M R2 stated R2 was In the hallway when R1 In R2. R2 stated R1 reached In R2. R2 stated R1 reached In R2 and down on In R				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 3 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
701012701	or contraction	IDENTIFICATION TO A TOTAL TOTAL TO A TOTAL TOTAL TO A TOTAL TO A TOTAL TOTAL TO A TOTAL TO A TOTAL TO A TOTAL T	A. BUILDING: _			
		IL6004477	B. WING		07/1) 9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HILLTOP :	SKILLED NSG & REHAB		POLK STREET STON, IL 61920			
0(0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	ON.	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	done, we both cried. about the whole thing told me that he wasn' sent him to the hospit don't want to leave. I (R1), I turn around an always have to worry woman is safe when On 7/19/24 at 1:30 Pl Nurse (LPN) stated R 6/30/24 that R1 had r breasts and said 'I an V10 stated "I called (V (DON) who instructed all the notifications are observations. A few I the emergency room not related to his beh. On 7/19/24 at 3:42 Pl R1 should have never inappropriately touch "Unfortunately, that is both parties are not we sent the sent to the sent the sent to the sent t	I told him what (R2) had We were both so upset I." R2 stated "They (facility) It coming back after they Ital. But now he is back. I want him to leave. If I see Ind go the other way. Now I about where he is at. No I he is here." M V10 Licensed Practical I reported to V10 on I ubbed up and down on R2's In going to get my yummies'. I wo call the police, make I me to call the police, make I me to call the police, make I me to a change of condition I aviors." M V1 Administrator stated I r been allowed to	S9999			
	2.) R3's Minimum Da documents R3 as cog	ata Set (MDS) dated 5/24/24 gnitively intact. This same requires assistance with to propel self in her				
	PM documents "(R1) and residents inapproto to touch the female n	Note dated 6/29/24 at 2:58 attempting to touch staff opriately, stating he is going urses. (R1) stating he et down on her knees for				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 4 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
						С
		IL6004477	B. WING		07	//19/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
LILLTOD	EVILLED NEC 9 DELIAD	910 WES	T POLK STREET			
HILLIOP	SKILLED NSG & REHAB	CHARLE	STON, IL 61920			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 4	S9999			
	their buttocks. (R1) s man. Educated (R1)	ified Nurse Aide (CNA) on tating all women need a multiple times. Stating (R1) it out (emergency room), 't care."				
	PM documents "(V1) (R1) trying to touch s	Note dated 6/29/24 at 4:15 Administrator notified of taff and residents. (V1) way from women and take th (R1) for any care."				
	on 6/29/24. R3 stated 3:00 PM because I was mokers. I don't smooth lot. (R1) rolled right us at my Left Breast. I bended up grabbing manything. (R1) just go to me because he was breast. (R1) had his grabbing at me. Like breast. I told him to go and he can't do that. (CNA) saw that happy the hall and I went out.	ards the exit door at 2:50 PM d "I know it was ten until				
	up to me in the dining same exact thing. The batted him away again room. I reported that will not go to the dining like activities and I like just stay in my room warm not scared of (R1 vulnerable and unconfup. If (R1) is trying to	the dining room. (R1) rolled room and tried to do the is was about 3:30 PM. I in and he left the dining incident also to (V4) LPN. I in groom if (R1) is in there. I is to talk to people but I will when (R1) is on the loose. I but that made me feel very infortable. It really shook me is touch women who are alert the trying to do with those				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 5 of 9

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		C	
		IL6004477	B. WING		07/19/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HILLTOP	SKILLED NSG & REHAB		POLK STREE			
			TON, IL 61920			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S9999	Continued From page	5	S9999			
	that aren't?"					
	(CNA) stated V13 with his wheelchair in the hattempted to grab at F'swatted' R1 away. V Left Arm in an attemp V13 CNA stated both separated and this income.	lay (6/30/24) after R1				
	Nurse (LPN) stated R V10 on 6/29/24 that R her Left Breast in the	M V10 Licensed Practical 3 reported to V4 LPN and 11 had attempted to touch hallway just before the ak on 6/29/24. V10 stated uch her breast but did				
	V1 never received any stated V1 did receive referred staff to call V (DON). V1 Administrate been placed on continuous v1.	2 Director of Nursing ator stated R1 should have nual observations on 6/29/24 empt at inappropriately				
	medical diagnoses as Right Below the Knee Mellitus Type II with N Pulmonary Edema, R	e Sheet documents R5's End Stage Renal Disease, Amputation, Diabetes leuropathy, Chronic enal Osteodystrophy, Post order and dependence on				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 6 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION (X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		LETED
		IL6004477	B. WING			C 19/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HILLTOP	SKILLED NSG & REHAB	910 WEST	POLK STREET	Г		
THEETOP .	SKILLED NOO & KLIIAD	CHARLES	STON, IL 61920			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From page	e 6	S9999			
S9999	documents R5 as cook MDS documents R5 as cook MDS documents R5 as sistance with toiletic personal hygiene, transfers. R5's Electronic Medic documents R5 utilizer for transfers. On 7/18/24 at 11:45 weeks ago (V8) Certic cussed me out like a was going to keep tur would put my f****** and make me sit in the (V8) is a night shift C room and cusses at reall light to see if som soda out of the mach Aide (CNA) came in, asked (V8) if she woume a soda and she reshe could get me up the vending machine CNA said 'Get up you I said 'OK. I will. I wimy own.' That is when f******** (expletive) hote f************ (expletive) self V8 CNA. R5 stated "middle of the night. I because who knows already just left me in	Get (MDS) dated 7/11/24 gnitively intact. This same as dependent on staff for ang, dressing, bathing, ansfers and mobility. Cal Record (EMR) as a total body mechanical lift AM R5 stated "A couple of fied Nurse Aide (CNA) dog. (V8) told me that if I raing on my call light that she a** (expletives) in a chair are f******* (expletive) hallway. NA that always comes in my ane." R5 stated "I put on my aneone could get me a can of ine. (V8) Certified Nurse turned off my call light. I alld take my debit card to get affused. Then I asked (V8) if aso that I could roll down to myself and get a soda. (V8) are f******** (expletive) self'. So all just crawl down there on an (V8) said 'This ain't no all. You can get that your i." R5 stated R5 is scared of It is just (V8) and me in the don't want to make her mad what (V8) will do. (V8) a my chair. I can't get up on	S9999			
	showed up a few hou (V8) to do anything e there."	t sit there until the next shift urs later. I was afraid to ask lse that night so I just sat PM V8 Certified Nurse Aide				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 7 of 9

A. BUILDING:	C
	-
IL6004477 B. WING	07/19/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HILLTOP SKILLED NSG & REHAB 910 WEST POLK STREET	
CHARLESTON, IL 61920	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 7 (CNA) stated V8 regularly cares for R5. V8 CNA stated (R5) asked for a block of cheese one night and I told him no because the kitchen was running out of cheese because of him. (R5) is alert and oriented and repeatedly doesn't follow his orders. (R5) is on Dialysis and just had his lower Right Leg amputated so he needs our help for most things. (R5) is so fat because he just sits around all the time. The last thing (R5) needs is soda and cheese. (R5) knows better and just rings for staff to do everything for him. I am not going to help someone who can do things for themselves. I did refuse to take his Debit card and I told (R5) he didn't need any kind of sodas. (R5) asked me to get him up and I said no because he doesn't need any soda in the middle of the night. (R5) said 'I am gring to just crawl there' and I told him 'Co ahead and crawl then. See how far you get.' I don't remember ever using foul language but I did tell (R5) that this wasn't a hotel and he needs to do things for himself instead of bothering the staff. (R5) asks for things he knows he shouldn't have." On 7/19/24 at 3.45 PM V1 stated V8 Certified Nurse Aide (CNA) should have provided the cares R5 requested. V1 Administrator stated "(R5) is alert and oriented. If (R5) asks the staff to get him up into his wheelchair, then they should do that. (V8) should never have used any profanity or bad attitude towards (R5). That is not acceptable." The facility policy titled 'Abuse Policy' revised 1/19/24 documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The is facility therefore prohibits abuse, neglect, exploitation, misappropriation of	

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 8 of 9

IIIINOIS DE	epartment of Public He	aith			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BOILDING.		
					С
		IL6004477	B. WING		07/19/2024
		12000 1 1111			1 01/10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		910 WEST	POLK STREE	т	
HILLTOP S	SKILLED NSG & REHAB				
		CHARLES	TON, IL 61920		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
2222		_	00000		
S9999	Continued From page	8	S9999		
		turnet of uncidents. Above			
		tment of residents. Abuse			
		or mental injury or sexual			
	assault inflicted upon	a resident other than by			
	accidental means. Al	ouse is the willful infliction of			
	injury, unreasonable	confinement, intimidation, or			
	•	Iting physical harm, pain, or			
	· ·	esident. This assumes that			
	_				
		e of residents, even those in			
		cal harm or pain or mental			
	anguish. The term w	illful in the definition of			
	abuse means the indi	vidual must have acted			
	deliberately, not that t	the individual must have			
	intended to inflict inju	ry or harm. Sexual Abuse is			
	-	exual contact of any type			
		consensual is defined as			
	one of the following:				
	welcome the act, but	the resident lacks the ability			
	to consent, 2. The re	sident does not want the			
	contact, 3. Resident is	s unconscious/comatose, 4.			
	Resident is sedated.	This abuse includes, but is			
		ed intimate touching of any			
		breast or perineal area),			
		exual coercion, sexual			
	· ·	•			
		sodomy, or coerced nudity.			
	Verbal Abuse is the u	· · · · · ·			
	gestured language th	at willfully includes			
	disparaging and dero	gatory terms to residents or			
	families, or within the				
	regardless of an indiv	•			
		oility. Examples of verbal			
		e not limited to, threats of			
	harm or saying things	to frighten a resident.			
	(B)				

Illinois Department of Public Health

STATE FORM 8GJ211 If continuation sheet 9 of 9