Illinois Department of Public Health

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 02/20/2024

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 Investigations: 2411437/IL170043 and 2411343/IL169922	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1010i) 300.1210b)5) 300.1210d)3)6) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	S9999		

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made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on interview, and record review the facility failed to safely transport a resident in a wheelchair and failed to ensure a nurse reported a potential injury promptly to another nurse or physician. This applies to 1 of 3 (R1) residents reviewed for quality of care in the sample of 10. This failure resulted in R1 experiencing a delay in care/assessment, experiencing increased pain and a femur fracture.

The findings include:

On 2/20/2024 at 11:12AM, V7 Certified Nursing Assistant (CNA) said on 1/27/2024 she was in a resident's room when she heard the door alarm going off. V7 said she left the residents room and saw [R1] trying to leave the facility out the back door. V7 said she approached [R1] to prevent her from going outside because it was cold and icy that day. V7 said [R1] became agitated and began hitting her. V7 said she was able to turn around [R1's] wheelchair and started pushing her down the hallway. V7 said there were no foot pedals on [R1's] chair because she self-propels down the hallway on her own using her feet. V7 said [R1] began trying to put her feet on the floor to stop the wheelchair from going and putting her

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feet behind the front wheel of the wheelchair. V7 said she tried to redirect [R1] from putting her feet down but she kept putting her feet down. V7 said [R1] tried to throw herself out of the wheelchair. V7 said she put her arm around [R1] to prevent her from falling. V7 said she couldn't see the angle of [R1's] foot because she was behind the resident.

On 2/20/2024 at 10:56AM, V5 Registered Nurse (RN) said on 1/27/2024 she could see [R1's] right foot stuck behind the front wheel of the wheelchair. V5 said [R1] did say "oww" while her foot was stuck behind the wheel. V5 said [R1] did complain of pain upon palpation of the leg. V5 said she did not see any swelling at that time. V5 said she moved [R1] down to the nurse's station she was working at to watch the patient. V5 said she was not the primary nurse for [R1] that day. V5 said she did not report the information to [R1's] primary nurse. V5 said she told V8 Certified Nursing Assistant (CNA) about the incident when (V8) came to get (R1) approximately 30 minutes after the incident occurred. V5 said she should have told [R1's] primary nurse about the incident and the resident's complaint of pain.

On 2/20/2024 at 11:12AM, V7 CNA said [R1] was sitting at the nurse's station for approximately 20-30 minutes before V8 came to get [R1] and take her back to her unit.

On 2/20/2024 at 1:09PM, V6 Licensed Practical Nurse (LPN) said around 3:00-3:30PM she could see [R1] sitting down by the other nursing station. V6 said she asked V8 to bring [R1] back down the hallway to keep an eye on her. V6 said V8 reported the resident was complaining of pain. V8 said [R1] had right knee swelling that was clearly

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visible and appeared twisted. V8 said she went to find V5 and ask her what happened. V8 said V5 told her [R1's] foot had got stuck behind the front wheel of the wheelchair. V8 said she notified V2 Director of Nursing right away and an order for an x-ray was obtained. V8 said the stat x-ray was taking a long time, up to 45 minutes. V8 said [R1] was placed back in bed via (mechanical) lift from the wheelchair and further assessed [R1's] leg. V8 said the swelling appeared to be worse after removing [R's] pants. V8 said she contacted V2 again and [R1] was sent out after calling 911 via EMS (emergency medical) transport. V6 said [R1] didn't complain of much pain while sitting in her wheelchair.

On 2/20/2024 at 11:43AM, V2 said if anything changes with the resident or seems wrong there should be an assessment completed. V2 said "oww" would indicate a resident is hurt or something is wrong. V2 said following the assessment if any swelling or pain is noted the physician should be notified for further orders, tests, or to send the resident out of the facility. V2 Director of Nursing (DON) said if a resident was becoming combative and putting their feet down on the ground while pushing their wheelchair staff should stop and get help. V2 said the resident is at risk of catapulting out of the chair and staff should get additional help. V2 said stopping and getting additional help would be done to keep the resident safe.

R1's progress notes dated 1/27/2024 states around 3:15PM the resident was brought back to the unit by CNA. CNA informed nurse of the resident's complaint of pain. X-ray order was obtained, and PRN Tylenol was administered per order. Resident continued to scream out in pain whenever resident is moved. Resident was

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placed back in bed with (mechanical) lift x3 staff. Upon removing pants, residents' right knee was visibly swollen and blue/purple. Resident was in tears and crying out for help. DON was informed again. Resident was sent out to [a local area hospital].

R1's progress notes dated 1/27/2024 stated "Resident admitted for closed fracture to distal end of right femur."

On 2/20/2024 at 12:36PM, V4 Doctor said the resident was admitted to [a local area hospital] on 1/27/2024 and found to have a fractured femur. V4 stated the x-ray report read a "commuted displaced fracture of the distal femur shaft." V4 said it was a "nasty" break. V4 said the type of fracture [R1] sustained was "not pathological" and there would need to be some type of "mechanical force" to create it. V4 said [R1] needed surgery to repair her broken femur.

R1's Care Plan dated 1/29/2024 states [R1] has "thrown" herself out of her wheelchair when agitated. . . [R1] is able to slowly self propel in wheelchair throughout the facility. . . [R1] is a CNA safe lift transfer x2 assist for all transfers.

The facility's Policy for preventing accidents and incidents, not dated, states the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. . .

(A)