

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSRG & RHB		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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: 2590385/IL184532	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)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 300.1210 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	S9999		

Illinois Department of Public Health

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

TITLE

(X6) DATE

Electronically Signed

02/24/25

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSNG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 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 are not met as evidenced by: Based on interviews and record reviews, the facility failed to effectively supervise a resident with history of alcohol abuse. This deficient practice affected one resident (R1) out of three reviewed for supervision of an avoidable incident. R1 was able to go out into the community independently, while on a restricted community pass, somehow obtain two 1.0-liter bottles of mouthwash with alcohol, and being hospitalized later with an alcohol level of 183 (normal range is	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSNG & RHB		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 2 0-10) and subsequently expiring the follow day. The Death Certificate documents the cause of death cardiopulmonary arrest due to acute kidney failure and alcohol abuse. Findings include: On 2/1/25, V2 DON stated that V2 worked the floor 3-11PM shift on 1/12/25. V2 stated that V2 came in prior to the start of shift and made rounds on all the residents. V2 stated that V2 rounded on R1 first because V2 was informed R1 was exhibiting behaviors of screaming and lying in bed with his pushcart on top of him. V2 stated that when V2 rounded, R1 was lying in bed without his cart. V2 stated that R1 exchanged words with his roommates that day, but no physical altercation occurred. V2 stated that R1 was transported to the hospital just prior to shift change. V2 stated that R1 had an independent community access pass. V2 stated that the nurse is expected to check the residents' belongings when the resident returns from outside pass. On 2/3/25 at 10:45AM, V2 stated that residents are able to have mouthwash in their rooms. V2 stated that R1 was not observed by staff drinking the mouthwash. On 2/3/25 at 11:35AM, V2 stated that V2 spoke with the nurse and there was 1/3 of the liquid in the alcohol-based original mouthwash bottle, the cap was broke, so it was tossed out. V2 stated that it was a bigger bottle of mouthwash, one liter size. V5 CNA (Certified Nurse Aide) stated that V5 was assigned to R1 that day. V5 stated that R1's roommate informed V5 that R1 keeps hollering.	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 3 V5 stated that V5 rounded on R1 and asked R1 if he was okay, R1 responded he was okay. V5 stated that later R1's roommates again were complaining about R1's yelling. V5 stated that V5 rounded on R1 again. V5 stated that this time V5 found an empty bottle of mouthwash on the floor. V5 stated that V5 immediately informed the nurse. V5 stated that V5 is unsure how much mouthwash R1 drank if any. V5 stated that the nurse informed her to get R1 ready because R1 was getting sent out to hospital for psychiatric evaluation. V5 stated that another staff member assisted her in getting R1 dressed and then R1 left facility. On 2/3/25 at 11:00AM, V5 CNA stated that when V5 did morning rounds, R1's roommates were complaining that R1 was hollering all night. V5 stated that later the housekeeper went into R1's room to empty garbage, then told V5 he was soiled. V5 stated that she went into R1's room and found the empty bottle of mouthwash. V5 stated that it was a large bottle with a brown label on it. V5 stated that V5 brought the empty bottle to the nurses' station and gave it to V3. V5 stated that another staff member assisted V5 with providing incontinence care to R1. V5 stated that R1 typically does his care himself and is not incontinent. V5 stated that when R1 is not lucid he is very combative. V4 RN (Registered Nurse) stated that V4 worked 3-11PM shift on 1/12. V4 stated that R1 was gone before she arrived at work. V4 stated that one of his diagnoses is screaming out. V4 stated that when R1 exhibited this behavior before and R1 informed V4 that he was having a nightmare. V4 stated that R1's screaming/moaning was increased on 1/12 and that is reason they sent him out.	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSRG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 4 V3 LPN (Licensed Practical Nurse) stated that V3 was working day shift on 1/12/25. V3 stated that R1 was yelling out, talking about stuff that did not make sense, and arguing with his roommates. V3 stated that R1 had a pushcart he used when walking. V3 stated that R1 put the cart in bed on top of him. V3 stated that V3 was able to remove cart from R1's bed and place it away from R1 so R1 would not put it back in bed. V3 stated that V3 exited R1's room and notified the psychiatric physician who gave an order to send R1 to the hospital for evaluation. V3 stated that V3 notified V2 and called the hospital to give verbal report. V3 stated that R1 was transported by an outside ambulance service. V3 stated that R1 had an independent community access pass. V3 stated that the residents' bags are searched upon returning from independent pass. V3 stated that residents go to the nurses' station to have their bags checked. On 2/3/25 at 10:00AM, V3 stated that she was in and out of R1's room because he was yelling all day. V3 denied seeing a bottle of mouthwash on 1/12. V3 stated that she is unsure time she last saw R1, but R1 was alert and oriented x 4 at that time. On 2/3/25 at 10:30AM, V6 (Social Services) stated that R1 did not have an independent pass to go out into the community. V6 stated that R1 was hospitalized a couple of times due to behaviors. V6 acknowledged that R1's care plan is correct and R1 was not able to go out on independent pass, R1 could go out on supervised pass with family, friends, or staff. V6 stated that with supervised pass, the person picking up the resident has to come into facility and sign resident out and then back in again upon	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 5 returning. V6 was informed that this surveyor was given independent pass sign out sheets for R1 for December and January. V6 responded that R1 was able to go out on independent pass. V6 was unable to articulate how a resident would have a restricted community pass and an independent community pass at the same time. On 2/3/25 at 12:00PM, V8 (Nurse Practitioner) stated that anyone with alcohol abuse should not have access to alcohol or alcohol-based products. V8 stated that he is not sure how much mouthwash R1 drank on 1/12. R1's ambulance run sheet, dated 1/12/25, notes at 3:29PM a request for transport to the hospital for R1 due to behaviors was made by facility staff. The outside ambulance crew arrived at R1's bedside at 4:09PM. R1's nurse reported that R1 drank a full bottle of mouthwash and started to drink a second one before staff found R1. R1 is also reported to be alert and oriented x 4. The crew's assessment noted R1 to be alert and oriented x 1, skin cold, diaphoretic, mental status - slowed processing/response, confused, lungs with increased respiratory effort and breaths shallow. R1's hospital medical record, dated 1/12/25, notes when R1 presented to the emergency room, R1's respirations were very slow and sluggish and R1 was unresponsive. R1's pupils were poorly responsive. Oxygen saturation level 75% on room air. Narcan 2mg (milligrams) was administered sublingual and R1's breathing improving but still unresponsive. Narcan 2mg administered intravenously and R1 was intubated and placed on mechanical ventilator. Blood pressure gradually started to build up to 109/60 from 62/40. Arterial blood gas results showed	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRS&G & RHB		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 severe metabolic acidosis. Poison control was contacted. R1's alcohol level was 183 (normal range is 0-10). The physician's narrative notes R1 is evaluated for drug overdose and respiratory difficulty including but not limited to mouthwash overdose. An urgent nephrology consultation was ordered for persistent severe metabolic acidosis and acute kidney failure. R1's laboratory results showed potassium level 6.1 (normal range is 3.5-5.1), creatinine (kidney function) level 4.21 (normal range is 0.6-1.2), and blood sugar level 41 (normal range 70-99). R1's death certificate, dated 1/13/25, notes cause of death cardiopulmonary arrest due to acute kidney failure and alcohol abuse. R1's community pass sign out sheets were provided by V1 (Administrator). They are dated 12/9/24 - 12/15, 12/27 - 12/30, and 1/2/25 - 1/13. These sheets document that R1 went out on independent passes 12/9, 12/10, 12/13, 12/30, and 1/3. R1's POS (physician order sheet), dated 1/12/25 at 12:41PM, notes an order to transfer R1 to the hospital for a psychiatric evaluation. R1's involuntary petition for hospitalization, dated 1/12/25 at 1:04PM, notes R1 was seen drinking mouthwash, staring off, and staring at wall. R1's substance use/abuse care plan, dated 9/4/24, notes R1 has a history of alcohol and illegal drug abuse. R1's community access observation, dated 11/27/24, notes R1 with history of public intoxication. R1 may not access the community independently related to safety factor.	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRS&G & RHB		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 7 R1's community access care plan, dated 9/4/24, notes R1 may not access the community independently due to physical function and therapy goals. R1 may access the community with supervision. R1's mouthwash was identified as an original mouthwash with 26.9% alcohol by volume (the equivalent of 54 proof alcohol). It also contains eucalyptol, menthol, methyl salicylate, and thymol. The National library of medicine, dated 11/2/2023, notes poisonous ingredients in mouthwash that can be harmful in large amounts are: alcohol and methyl salicylate. Symptoms of mouthwash overdose include, but not limited to drowsiness, low body temperature, low blood pressure, low blood sugar, rapid heart rate, and rapid shallow breathing, slowed breathing, unconsciousness, and unresponsive reflexes. Per the National Library of Medicine, nonalcoholic ingredients of this mouthwash are phenolic compounds (eucalyptol, menthol, and thymol), and large-volume mouthwash ingestion will produce exposure in the toxic range of these ingredients. The phenolic compounds in mouthwash may contribute to severe metabolic acidosis, multiorgan system failure, and death. These compounds in addition to alcohol may account for the adverse effects associated with massive mouthwash ingestion. This facility's community pass policy, undated, notes approving or denying resident's independent community access or supervised community access related to, but not limited to identified risk factors in-which would place a	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/07/2025
NAME OF PROVIDER OR SUPPLIER HICKORY VLG NRSG & RHB			STREET ADDRESS, CITY, STATE, ZIP CODE 9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457		
(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 8 resident in jeopardy of abuse, neglect, dehydration and any physical or psychological harm. If a resident exits the facility independently without a pass it will be assessed or evaluated to be determined whether it's an elopement, unauthorized departure, or against medical advice due to the presented risk factors. Level 1 pass privilege: resident can only access the community if he/she is accompanied by staff, family member, friend, and/or responsible party. Responsible party to inform staff the duration of pass. This facility's prohibited items policy, undated, notes residents are prohibited from possessing or having in their room any item that may pose a threat to the safety of residents. The list includes, but not limited to alcohol and potentially poisonous chemicals. (A)	S9999			