STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050310	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	1308 GAME FARM ROAD , YORKVILLE, Illinois, 60560

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2575350/IL194361	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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: 5) 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. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the nurse practitioner's orders to consult a wound care doctor for treatment of a new acquired wound. The facility also failed to reposition a resident who was at risk for pressure ulcers. This applies to 2 of 3 residents (R1 and R8) reviewed for pressure ulcers in the sample of 8. This failure resulted in the R1's wounds declining, enlarging and developing into full thickness injuries. The findings include: 1. R1's electronic medical record showed R1 was originally admitted to the facility on November 9, 2023. R1's medical record also showed he was discharged to the hospital on May 21, 2025 and readmitted to the facility on May 29, 2025. R1's medical record showed R1 had medical diagnoses that included encephalopathy, malignant melanoma of the skin/shoulder, end stage renal disease, epilepsy, chronic congestive heart failure, and dementia. R1's Minimum Data Set dated May 1, 2025 showed that R1 required substantial/maximal assistance to reposition in the bed. R1's Braden scale for predicting pressure sore risk dated May 19, 2025 showed that R1 was confined to the	S9999		

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S9999	Continued from page 2 bed and was a high risk for developing pressure sores. R1's nursing progress note and admission assessment written by V12 (Registered Nurse/RN) dated May 29, 2025 showed that R1 had redness to his buttocks. There was no mention in the assessments of the condition of R1's heels. On June 17, 2025 at 12:22 PM, V12 (RN) stated R1 was readmitted on May 29, 2025 around shift change, and she did a head to toe assessment on him and charted it. V12 stated R1 had redness to buttocks on both sides, but there was no open area noted. V12 stated she looked at R1's whole body and his heels were also red. V12 stated R1's red heels were not a new issue. V12 stated she forgot to document the heel assessment. V12 stated she only told the next shift of the redness to R1's buttocks because the redness to R1's heels was not a new issue. R1's nursing progress note written by V2 (Licensed Practical Nurse) dated June 2, 2025 showed the following: "Resident is having skin breakdown on both buttocks, redness and open areas of about 0.1 x 0.1 cm (centimeter). Cleaned with wound cleanser, used calcium alginate and covered with bordered gauze." On June 16, 2025 at 4:55 PM, V2 (Licensed Practical Nurse) stated that on June 2, 2025, he found that R1 had redness to his buttocks with an open area. V2 stated he notified the doctor by leaving a message via their messaging system. V2 stated he does not remember if the doctor gave him orders or not. V2 stated he did not put any orders in the computer nor did he record the wound in wound rounds. R1's Progress note dated June 5, 2025 showed that R1 was sent to the hospital via 911 related to shallow breathing, faint pulse and not responding to name or touch. R1's history and physical from the hospital dated June 5, 2025 showed that R1 was admitted to the hospital with a diagnosis of sepsis and pressure wounds to his feet and sacrum. R1's hospital medical records dated June 5, 2025	S9999		

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S9999	Continued from page 3 described R1's feet wounds as follows: 1). Location: left heal, full thickness, pressure injury. Present on admission Wound type: evolving deep tissue pressure injury. Wound description: red moist tissue 100% Wound size: 7 centimeters (cm) x 7 cm x 0.2 cm Wound edges: defined, unattached epidermal tissue Drainage Moderate serous on dressing 2). Location: Right heal, full thickness, pressure injury. Present on admission Wound type: evolving deep tissue pressure injury Wound description: Maroon/violet tissue 90%, Red moist tissue 10% Wound size: 5 cm x 6 cm x 0.3 cm Wound edges: defined, unattached epidermal tissue Drainage: none The picture of R1's sacrum/buttocks taken on June 5, 2025 at the hospital showed a very large area of redness that extends from the middle of R1's buttocks to the top of his sacrum where there was a large purple discoloration. There was some exudate, different degrees of redness, some open areas and loose scabs/crust. On June 17, 2025 at 12:32 PM, V7 (Nurse Practitioner) stated she was contacted by a nurse on June 2, 2025 regarding R1's wound. V7 stated she told him to consult	S9999		

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S9999	Continued from page 4 with wound care for treatment orders. V7 stated she expected wound care to be contacted immediately and for the wound to be treated. V7 stated she knows her order was not put in the computer, and therefore, they were not providing treatment to the resident (R1). V7 stated the risk of not following provider's orders is harmful to resident. The wound could get worse, the resident can become septic, or the resident could lose a limb. On June 18, 2025 at 11:14 AM, V7 (Nurse Practitioner) stated she was aware that R1 also had redness to his heels. V7 stated R1's lack of treatment and the facility not following her order caused the worsening of the R1's skin and sacrum/buttocks wounds. V7 stated the big issue at the facility is there is a communication problem and no one is following up on orders. On June 18, 2025 at 3:10 PM, V11 (Regional Clinical Director) stated that she expects staff to put doctor's order in the computer, and carry out the orders as prescribed. V11 stated she expect nurses to follow up with doctor and resident to make sure wounds are not progressing. Residents who have skin breakdown or who are at risk for skin issues should have a skin care plan. R1's care plan was absent of any skin or wound care plan. R1 had no treatment orders nor a wound care consult for his sacral/buttocks wound or for heel redness. (May 29, 2025 through June 5, 2025) R1's name does not appear on the facility's in-house or discharged list of residents identified with facility acquired wounds from January 2025 through June 2025. The facility's wound management program policy dated January 20, 2023 showed the following: Physician orders should be obtained and followed for each resident. Resident's identified as risk on the Braden scale will have this addressed on their care plan and will have interventions put in place for preventative measure. The nurse will call physician to obtain appropriate treatment order.	S9999		

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S9999	Continued from page 5 2. R8's electronic medical record showed R8 was admitted to the facility on March 30, 2025 with diagnoses that included rhabdomyolysis, acute embolism and thrombosis of unspecified deep veins of the lower extremity, chronic kidney disease, fatigue, and muscle weakness. R8's Minimum Data Set dated April 23, 2025 showed that R8 required substantial/maximal assistance to reposition in the bed. R8's Braden scale for predicting pressure sore risk dated May 19, 2025 showed that R8 was a moderate risk for developing pressure sores. R8' name appeared on the facility's list of residents with facility acquired pressure wounds. The list showed R8 has an ulcer to her coccyx identified on May 4, 2025. R8's first wound doctor note identifying the coccyx/sacral wound was on June 6, 2025 and the doctor described it as an unstageable deep tissue injury. R8 was observed on June 17, 2025 at 9:30 AM, 10:40 AM, and 11:59 AM, 1:44 PM and 3:26 PM lying in the same position which was partially on the right side and right back. On June 17, 2025 at 3:26 PM, observed R8 with a pressure wound to her coccyx/sacrum. V14 (LPN) stated that R8 is bed bound and bed bound residents should be repositioned every 2 hours to prevent pressure ulcers. V14 was informed that R8 has been observed in the same position multiple times throughout the day. V14 stated they keep R8 on her right side to keep her off her coccyx pressure ulcer. R8's care plan was absent of any skin or wound care plan. The facility's Repositioning of Resident policy dated May 2, 2019 showed the following. Repositioning is critical for a resident who is immobile or dependent upon staff or repositioning. Residents who are in bed should be on an every 2 hour turning schedule. (B)	S9999		