

Illinois State Department of Health

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 01/08/2026	
NAME OF PROVIDER OR SUPPLIER HILLSIDE REHAB & CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 25711090/2667508 Investigation of Facility Reported Incident of 8/10/2025/2607371		S0000			01/30/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow		S9999			01/30/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 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 observation, interview and record review the facility failed to ensure residents who were high risk for falls were supervised to prevent falls. These failures resulted in R1 & R3 falling being sent to the hospital and sustaining fractures. This applies to 2 of 3 residents (R1 & R3) reviewed for safety/supervision in the sample of 5. The findings include: 1. R1's face sheet lists his diagnoses to include: congestive heart failure, shortness of breath, Type 2 diabetes mellitus, morbid obesity, anxiety disorder and wedge compression fracture of first lumber vertebra. On 1/7/26 at 9:57 AM, R1 was sitting in his wheelchair in his room. He stated, he had pain in his back. This surveyor asked him why what happened? He stated, he had a fall and hurt his back. He was going to the bathroom,		S9999				

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S9999	Continued from page 2 and the CNA (V3 Certified Nursing Assistant) was on the phone. He told her he was done and ready to get up, she told him to wait because she was on the phone. He was sitting there for 25 minutes already and did not want to wait. He tried to get into his wheelchair by himself and fell. After he fell, V3 CNA had another CNA (V20 CNA) assist her with getting R1 back up and into his wheelchair. R1 stated, she never told the nurse that he fell. When he got back to his room, he complained of the pain in his back and told the nurse he fell. The nurse said V3 CNA never told him R1 fell. He was sent to the hospital where they told him he had "crack in his spine." On 1/7/26 at 12:14 PM, V4 Licensed Practical Nurse (LPN) stated, he was the nurse caring for R1 the night he fell in the shower room. He stated, he was at the nursing station and saw R1 pass by him with clean clothes in his hand. Some time later, he saw the call light going off in the shower room, he ran to the room and saw V3 CNA and R1 in the shower room. He went back to the nurses station. About 10 minutes later, he saw V3 CNA wheeling R1 back to his room. R1 then reported to V4 LPN that he was in pain and had a fall. V4 LPN asked, when he fell and R1 told him just a few minutes ago in the shower room. R1 stated, he wanted to go to the hospital because his back hurt so bad. He did send him to the hospital. After V3 CNA put R1 in his room, she went outside. When she came back inside the facility, V4 LPN asked her why she did not report to him that R1 had fallen so he could assess R1. V3 CNA stated, another CNA was in the area and she helped get him up. She was going to tell him. He told her, that is not ok and she must always report when a resident falls so the nurse can assess the patient. On 1/7/26 at 12:20 PM, V3 CNA stated, R1 went to the shower room by himself after she told him not to and he ended up falling. "He didn't listen to me." She stated, she was fired for the incident and she didn't understand why she was fired for it. She said she was not on her phone. She also stated, she "didn't remember" the statement she had written up when asked about the information that was in her statement (see statement below). R1's progress notes dated 8/10/25 shows, "Around 3pm resident went to the shower room to take a shower. Post shower, resident reported that he fell in the bathroom. Writer asked resident how he got up from the floor, resident said he was helped up from the floor by the CNAs who did not report to the nurse that resident fell. Resident complained of crucial spine pain and that he wants to go to the hospital...."	S9999					

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S9999	Continued from page 3 V4 LPN's written and signed statement dated 8/12/25 shows, "This writer saw the bathroom light went off around 2:55pm on pm shift on 8/10/25, writer ran towards the bathroom, knocked at the door, asking who was inside? V3 CNA replied she was in with R1. Writer then returned to the nurse's station. By 3:10pm, R1 was brought to his room on his wheel-chair by V3 CNA. The CNA never reported to writer that resident had a fall. Around 3:15pm R1 reported to writer that he fell in the shower room, that his back is hurting on his spine, that he wants to go to the hospital. Writer asked resident, when did he fall and how he got up from the floor? R1 replied that V3 CNA got him up. Writer replies that how come he the nurse was not called or informed? By 3:45pm when the CNA who went outside came back into the building, writer asked CNA why she did not report that R1 had a fall in the shower room? CNA replied that she was going to tell writer. Writer replied that, the CNA supposed to call for the nurse first with any fall. CNA replies that she told resident not to take off his rubber shoes, that resident did not listen. She added that she did not witness the fall. Which means she was not with resident prior to the fall...." V3 CNA's written and signed statement dated 8/10/25 shows, "I told R1 not to take his shoes off in the shower and he didn't listen to me, he stood up in the shower and slipped on the floor." V20 CNA's written and signed statement (no date) shows, "On 8/10 (8/10/25) I was in [another resident] room taking care of her. I was taking the trash, clothes and linens to the soiled utility when I was in the soiled utility getting rid of the dirty clothes and trash V3 CNA approached me telling me that she told R1 to go to the shower room to take a shower. I asked her if he was in the shower room. She told me yes. I told her that she should go in there and help him because he can't take a shower by himself. I left the soiled utility and took the linens out to the shed. When I came back V3 CNA approached me to tell me that R1 had fallen in the shower and asked me to help her get him up. She had her gait belt on him and was lifting from the back, I was lifting him on his right side and he was pulling himself from the bar and we got him into his chair. I did not know if she told the nurse or not. I had just walked in from taking linens out." The facility's serious injury and communicable disease report dated 8/21/25 shows, "...Final: Interviews conducted w/ (with) staff and residents regarding incident. Upon final investigation, it was determined		S9999				

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S9999	Continued from page 4 that resident slipped and had a fall while in the shower room. Resident reported pain in his back, POA (power of attorney)/NP (Nurse Practitioner) notified and orders received for resident to be send to the ED (emergency department) for further evaluation. On 8/11/25 , nurse on duty called hospital to follow up on status of resident and at this tie nurse notified that resident was admitted to hospital w/ dx (diagnosis) closed compression fracture of L1 vertebra per CT scan.... Addendum to 8/15/25 final: Interviews conducted w/ staff and residents regarding incident. Upon final investigation, it was determined that resident removed shoes and attempted to self-transfer when he slipped and had a fall while in the shower room. CNA not present in the room at the time of the fall...." On 1/7/26 at 10:35 AM, V1 Administrator stated, V3 CNA no longer worked at the facility following the incident with R1. She had a prior incident with V3 CNA and this was the second time something had happened. She had left R1 in the shower room by himself and she is not supposed to leave him alone. He fell and got a fracture. On 1/7/26 at 1:20 PM, V5 NP stated, the fall was the reason for R1's compression fracture. R1 is very impulsive and they should not ever leave him alone. When he is done he will not wait for staff. R1's history and physical by the local hospital dated 8/11/25 shows, "Chief complaint: slip and fall in shower. History of Present Illness: Briefly, R1 is a 51 year old other male with extensive pas medical history listed below is a skilled nursing resident mostly wheelchair bound for last few years suffered a slip and fall in shower hitting his head and started experiencing neck and back pain afterwards. Brought to the emergency room where CT showed the has L1 compression fracture. Patient admitted.... The same report shows, "Imaging: CT lumber spine without IV contrast: Result date: 8/10/25, Impression probable acute low-grade compression fracture involving the inferior endplate of L1 is present, new compared to prior CT...." R1's minimum data set dated 11/25/25 shows, he is cognitively intact. R1's care plan for ADLs (activities of daily living) functional status with a start date of 8/26/22 shows, he requires 1 assist with bathing. R1's care plan for falls with a start date of 11/11/24 shows, resident has a history of falling and has had		S9999				

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S9999	Continued from page 5 multiple falls. 2. R3's face sheet lists his diagnoses to include: pain in right knee, vascular dementia; major depressive disorder and type 2 diabetes mellitus. R3's electronic medical records shows, he had a fall on 10/7/25 resulting in a right leg tibia fracture. He had two falls on 10/19/25 resulting in two separate emergency room visits. The second emergency room visit, he was admitted and the fall resulted in anterior right 5th and 6th rib fractures. The facility's serious injury incident and communicable disease report dated 11/13/25 shows, R3 had another fall on 11/12/25. "Detailed incident summary: Initial: R3 is a 79 y/o (year old) Caucasian male w/ BIM score 00 (cognition score- not cognitively intact).... Resident noted to be on floor laying on his L (left) side outside room. Resident reported pain to his back, L shoulder, L hip.... Resident transported to local ED (emergency department) for further evaluation. Final: Upon final investigation, it was determined that resident's fall resulted in fx (fracture) to L femur, dx given at hospital...." R3's hospital communication with the facility from his hospital admission of 10/19/25 shows, V1 Administrator asking if the hospital can discuss memory care with the family, "as it might be more appropriate for him." The same documents also show, he had a 1:1 sitter while in the hospital. R3's progress notes for 11/12/25 shows, "Resident noted to be on the floor laying on his left side outside Rm 4...." On 1/7/26 at 2:17 PM, V1 Administrator stated, R3 was very impulsive and had dementia. They had discussed with the family that they felt a memory care unit was more appropriate for him. When he was admitted on 10/19/25 to the local hospital, they asked the hospital to look for other placement however the family insisted they wanted him to come back to the facility. He needed 1:1 support. They were not able to provide 1:1 to care for him all the time but still accepted him back to the facility. On 1/7/26 at 2:34 PM, V6 Registered Nurse (RN) stated, she was his nurse for his first fall on 10/7/25. R3 was very impulsive. When she was working she always had R3 with someone as best as they could otherwise he would get up and fall. He was a 1:1 sometimes. They tried to 1:1 as much as they could.		S9999				

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S9999	Continued from page 6 R3's care plan with a start date of 9/17/25 shows, he was at risk for falls due to his vascular dementia. The care plan lists interventions to include: alarms located on chair and bed and keep in visual range of floor staff. The facility's falls management policy dated 4/21/22 shows, "Policy: It is the policy of [the facility] to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. Definition: The definition of a fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and wound have fallen, if not for staff intervention, is considered a fall. Unless there is evidence suggesting otherwise, when a resident is observed on the floor, a fall is considered to have occurred. Procedure: ...2. Resident's identified as high risk will have fall prevention addressed on the plan of care. 3. If a resident falls, reports falling or is suspected of falling, the following will be implemented: a. Assess for injury, provide treatment and document in the E.H.R. (electronic health record)...." (A)		S9999				