STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. BUILDING _____ B. WING _____	**03/12/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist residents who require extensive assistance with grooming and personal hygiene. This applies to 4 of 4 residents (R2, R17, R21 and R42) reviewed for activities of daily living in the sample of 12. The findings include: 1. R2's face sheet showed R2 was admitted to the facility 8/15/17 with [DIAGNOSES REDACTED]. R2's minimum data set ((MDS) dated [DATE] showed with brief interview for mental status (BIMS) of 12-intact cognition. The MDS also showed R2 requiring extensive assistance of one person physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene. R2's functional and rehabilitation potential initiated 7/6/18 showed to assist with bathing, dressing, transfer, bed mobility and ambulating. On [DATE] at 10:48am, R2 was observed in his wheelchair in the hallway. R2 appeared ruffled and unkempt. R2 was wearing stained and dirty white tee shirt. R2 has unshaved facial hair. R2's clothing had crumbs of food on it. On [DATE] at 10:50am, V10 (Nurse) stated R2 needed help with dressing. 2. R17's face sheet showed R17 was admitted [DATE] with [DIAGNOSES REDACTED]. R17's care plan initiated 10/1/18 on activities of daily living (ADL) and function rehabilitation potential shows R17 requires extensive or total assist with ADLs related to decreased mobility, severe dementia. R17's MDS dated [DATE] shows R17 requires extensive assistance with bed mobility, transfer, toilet use, dressing, eating and personal hygiene. On 3/09/20 at 11:48am, R17 was observed sitting in long chair in his room. R17 has very long dirty nails. R17 has overgrown disheveled facial hair. 3. R21's face sheet showed R21 was admitted to the facility 3/23/16 with [DIAGNOSES REDACTED]. R21's MDS dated [DATE] showed R21 requires extensive assistance of one or two persons physical assist with bed mobility, dressing and personal hygiene. R21's care plan on ADLs showed to assist R21 requires assist with ADLs to maintain highest possible level of functioning due to manifestations from TIA and [MEDICAL CONDITION]. On 3/9/20 at 10:58am long dirty nails. R21's nails had black substance underneath it. 4. R42's face sheet showed R42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R42's care plan on self care deficit initiated 11/22/19 showed R42 with deficit in dressing and grooming due to decreased mobility and baseline intermittent confusion secondary to disease process. On 3/9/20 at 10:35am, R42 was observed in the dinning area with family members. R42's nails were long with brownish substances underneath. R42 had overgrown disheveled facial hair. On 3/9/20 at 10:38am, V15 (Family Member) stated he had witnessed R42's incontinence brief not changed once. V15 stated R42 was sitting in a soiled clothing and was shaken from the cold. This issue was brought to the attention of V2 Director of Nursing (DON) by the surveyor on [DATE] at 10:34am. The DON stated she would look into the complaint and address the issue with appropriate staff. On 3/12/20 at 12:50pm, V2 DON stated staff are expected to provide personal hygiene assistance to residents that require grooming, nail care and facial hair.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their smoking policy and procedure for a resident who smokes. This applies to 1 of 2 residents (R37) reviewed for smoking in the sample of 12. The findings include: 1. R37 was admitted to the facility on [DATE]. He (R37) is an [AGE] year-old who has multiple medical [DIAGNOSES REDACTED]. On [DATE]20 at 10:24 AM, V5 (Certified Nursing Assistant/CNA). V5 stated that R37 still smokes once a day. On [DATE]20 at 10:25 AM, R37 stated that he goes outside the building in the parking lot when he smokes with either his family or the staff. On [DATE]20 around 10:30 AM, R37 was sitting in his wheelchair while smoking, the back of his wheelchair was up against the building right outside the exit door of the facility with his wife. R37 stated he usually smokes in that spot. On [DATE]20 at 02:30 PM, V3 (Social Worker) stated that facility has a smoking area by the garage across the parking lot from the building, otherwise residents must smoke at least 15 away from the building for safety measures. There was no smoking assessment and no smoking care plan for R37. Facility's Smoking Policy and Procedure showed: Purpose: To assure that all residents are safe while smoking and to assure that all residents that do not smoke are not offended by or exposed to secondhand smoking. Procedure: 1. Any residents that expresses an interest to smoke will be assessed at the time of admission and at least quarterly or with any significant change to determine the level of assistance and supervision that will be needed to ensure the resident's safety. 2. Based on the assessment findings the resident's plan of care will be revised to reflect the level of assistance, supervision and any assistive devices that will be needed by the resident to enable the resident's safety.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide perineal care in a manner that would reduce infection. This applies to 4 of the 7 residents (R21, R24, R37, R45) reviewed for bowel and bladder care in the sample of 12. The findings include: 1. On [DATE]20 at 10:13 AM, V5 and V6 (Both Certified Nursing Assistant/CNA) provided perineal care to R37. R37 is uncircumcised. V5 did not retract R37's penile foreskin during provision of peri-care. 2. On 0[DATE]20 at 01:13 PM, V5 and V6 provided incontinence care to R45 who had a bowel movement. V6 cleaned R45's back peri-area with wet washcloth then he applied clean incontinence brief without cleaning the frontal peri-area. R45's face sheet showed that R45 has history of urinary tract infection. On 3/11/2020 at 12:43 PM, V2 (Director of Nursing/DON) stated that when providing peri-care, the staff must clean the front and the back peri-area completely. If the male resident is uncircumcised, the staff must retract the foreskin and clean the tip of the penile area to prevent potential infection. 3. R21's face sheet showed R21 was admitted to the facility 3/23/16 with [DIAGNOSES REDACTED]. R21's MDS dated [DATE] showed R21 requires extensive assistance of two persons physical assist with transfer and toilet use. R21 also requires extensive assistance of one person physical assist with personal hygiene. R21's care plan on alteration in elimination with bladder and bowel incontinence initiated 1/9/19 showed R21 will be kept clean, dry and odor free regular check and change toileting plan. R1's MDS showed R21 is always incontinent of urine and bowel. On [DATE] at 1:12pm, R21 was been transferred by sit to stand from her wheelchair to the wash room by V7 and V8 Certified Nursing Assistants (CNAs). V7 removed R21's soiled brief. V7 wet wash cloths with water, applied some soap and inserted the wet was cloth in between R21's upper thighs

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) to clean the outer layer. Then V7 pulled the wash cloth up in an upward stoke which contaminated the cleaned area. R21 was screaming and holding on to the sit to stand handles throughout. R21 stated I cannot open them more than that, it hurts. V7 grabbed another wet wash cloth and inserted it in beween R21's upper thighs again and again without opening R21's labia and urethra areas. 4. R24's face sheet showed R24 was admitted to the facility 4/[DATE]9 with [DIAGNOSES REDACTED]. R24's minimum data sheet ((MDS) dated [DATE] showed R24 requires extensive assistance of two persons physical assist with transfer and toilet use. The MDS also showed R24 requiring extensive assistance of one person physical assist with personal hygiene. R24's MDS showed R24 with impairment on both upper and lower extremities. R24's care plan on urinary incontinence initiated 5/8/19 showed R24 experiences occasional bladder incontinence related to increased need for assistance and increased weakness. On [DATE] at 1:23pm, R24 was sitting in the wheelchair in her room. R24 had some incontinence pad and bed linen on the wheelchair seat. Both the incontinence pad and the bed linen were soaked with R24's urine. R24's incontinence brief was also soaked with urine. R24 was transferred from the wheelchair on to the bedside commode. R24 stated oh yes the linen is wet. Both V8 and V7 provided incontinence care on R24. V8 wet some wash clothes inserted it in between R24's upper thighs without opening R24's labia and urethra areas. V8 applied clean incontinence brief on R24. On [DATE] at 1:25pm, V8 stated she changed R24 last at 9:30am. Review of facility's policy titled, 'Perineal Care' with a review date of July 2017 showed, Purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. For a female resident: 9 a. Wet washcloth and apply soap or skin cleansing agent. 9b. Wash perineal area, wiping from front to back. (1). Separate labia and wash area downward from front to back. Gently rinse and dry the area. (2). Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward stokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3). Rinse perineal perineum thoroughly in same direction, using fresh water and a clean washcloth. The policy also showed for a Male resident: Wash perineal area starting with urethra and working outward. (1). Retract foreskin of the uncircumcised male.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer medication as ordered by the physician. There were 33 medication opportunities with 3 medication errors resulting to 9.09% medication error rate. This applies to 3 of 7 residents (R12, R21, R45) revived during medication pass. The findings include: 1. On [DATE] at 12:01 PM, V4 (Nurse) administered one tablet of [MEDICATION NAME]/[MED] ,[DATE] milligram (mg) to R12 via gastrostomy tube. V4 stated that R12 only has one scheduled medication at 12:00 PM. R12's active physician order [REDACTED]. R12's Medication Administration Record [REDACTED]. On [DATE] at 1:23 PM, V2 (Director of Nursing/DON) stated that the nurses must administer medication following the 5 rights principles of medication administration such as the right patient, right time, right route, right dosage and right medication. Nurses must administer medications according to the physician's orders [REDACTED].> 2. R21's face sheet showed R21 was admitted to the facility [DATE] with [DIAGNOSES REDACTED]. R21's MDS dated [DATE] showed R21 requires extensive assistance of one or two persons physical assist. Review of R21's active physician order [REDACTED]. special instructions: Take one tablet by mouth daily for arrhythmia. On [DATE] at 9:39am, V4 (Nurse) administered the following morning medications to R21. 1. Cranberry supplement 1 tab PO 2. Vitamin D3 2000IU 1 tab PO 3. [MEDICATION NAME] 12.5mg 1 tab PO 4. Folic acid 1mg 1 tab PO 5. Multivitamin 400mg PO 1 tab PO 6. Losartan 100mg 1 tab PO 7. [MEDICATION NAME] sulfate 325mg/65mg iron 1 tab PO R21's medications were crushed and administered to her. It was observed that V4 gave total of seven medications as listed above to R21. V4 confirmed she was giving 7 medications to R21. During medication reconciliation, it was noted that V4 missed giving R21 [MEDICATION NAME] 400mg 1 tab by mouth for arrhythmia as ordered by the physician. 3) According to the physician's orders [REDACTED]. On [DATE] at 4:03pm, V9 (Registered Nurse) prepared to administer insulin [MEDICATION NAME] to R45 using the preloaded injection pen. V9 rested the injection pen on the medication cart and, with the injection pen in a horizontal position, proceeded to prime the device with 2 units of insulin. V9 then reset the dose dial on the device to administer the prescribed dose. V9 then administered the insulin dose to R45. On [DATE] at 4:07pm, V9 stated she was not aware that the injection pen needed to be primed in the vertical position with the needle pointing up. The instructional insert for the [MEDICATION NAME] injection pen describes the procedure for priming: Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top.
F 0809 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** Based on interviews and record review, the facility failed to provide a nutritious late evening snack when more than 14 hours occurred between the evening meal and breakfast meal. This applies to all 45 residents that consume meals orally in the facility. Findings include the following: According to the facility's Resident Census and Conditions of Residents, this effects 45 of the 47 residents in the facility who take nutrition by mouth. In the resident group meeting all 9 residents (R1, R13, R24, R25, R36, R44, R146, R147, and R149) attending stated they are not offered evening snacks. Two of the residents (R24 and R36) stated they are diabetic and are not offered a meal between dinner and breakfast. The facility provided the mealtimes for the facility. The mealtimes include dinner is 4:30pm and breakfast is scheduled at 7:00am. On 3/11/2020 at 11:10am, V16 (Food Service Director) stated some of the residents receive evening supplements for weight maintenance and V16 also stated the residents may ask for a snack, but it is not offered otherwise. V16 stated she is aware and confirmed that there is more than 14 hours between dinner and breakfast meals
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff followed standard infection control procedures regarding hand washing during provision of wound care and incontinence/perineal care. This applies to 5 of 5 residents (R12, R21, R24, R37, R45) reviewed for infection control in the sample of 12. The findings include: 1) R12 was admitted to the facility September 12, 2018. R12's care plan showed her [DIAGNOSES REDACTED]. R12's most recent Minimum Data Set/MDS (dated December 16, 2019) showed R12's cognition was severely impaired, R12 was always incontinent of stool, and required total assistance of staff for all activities of daily living/ADLs. On March 11, 2020 at 11:05 AM, V12 (CNA) and V13 (CNA) were noted providing incontinence care to R12. V12 was noted wearing gloves during incontinence care, which required cleaning a large amount of soft stool from R12's bottom and upper thighs. V12 and V13 removed the soiled linen from below R12, and placed a clean cloth pad under R12. V12 continued by positioning pillows under R12's head and shoulders, and rearranging the blankets on R12. It was noted that V12 (CNA) wore the same pair of gloves when wiping BM, applying clean linen, and also when placing pillows under R12's head and shoulders and blankets over R12. Immediately prior to rendering the incontinence care to R12, V12 (CNA) noted the dressing on R12's right hip pressure ulcer was not intact, and V12 notified R12's nurse, V11 (Licensed Nurse/LPN). Immediately after incontinence care was completed, V11 (LPN) changed the loose dressing to R12's right hip pressure ulcer site. V12 assisted V11. It was noted that V11 (LPN) removed her own gloves after removing the old dressing and cleansing the wound. V11 (LPN) then put on another pair of gloves without washing her hands or using hand sanitizer. It was noted that V11 continued the application of a fresh dressing to R12's pressure ulcer site. On March 11, 2020 at 11:45 AM, V14 (Wound Care Physician) stated it was her expectation that the staff would wash/sanitize their hands after removing gloves and before donning fresh gloves for resident care,including wound care and after cleaning incontinence. On March 11, 2020 at 12:40 PM, V2 (Director of Nursing/DON) stated it was her expectation that nursing staff wash their hands after removing gloves regarding incontinence care and wound care, before donning fresh gloves. The facility's policy, Handwashing (dated April 2015) stated in part, It is the policy of (the facility) that all staff cleanses hands with friction, soap and water to control infection and reduce transmission of

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) organisms. The policy documented, Hands should be thouroughly washed before and after providing resident care. The facility's policy, Gloves (dated April 2015) documented the process of donning and removing gloves. The final step shown in the procedure of removing gloves instructed in, 2. f. Wash and dry hands. 2. On [DATE]20 at10:13 AM, V5 and V6 (Both CNA) provided perineal care to R37 who has dry residual fecal matter in the scrotal and surrounding area of the rectum. V5 changed gloves without hand hygiene then continued to clean the rectal and buttocks area. After completing the perineal care, V5 pulled up R37's pants back in place and straightened the beddings while wearing same soiled gloves. 3. On [DATE]20 at 1:13 PM, V6 provided incontinence care to R45 who had a bowel movement. V6 cleaned R45's buttocks with wet washcloth, then applied clean incontinence brief underneath R45 buttocks while wearing same soiled gloves. V6 removed soiled gloves and continued to assist R45 without hand hygiene. On 3/11/2020 at 12:40 PM, V2 (Director of Nursing/DON) stated that staff must wash hands before and after providing care, wash hands and change gloves from dirty to clean task to prevent infection. 4. R21's face sheet showed R21 was admitted to the facility 3/23/16 with [DIAGNOSES REDACTED]. R21's MDS dated [DATE] showed R21 requires extensive assistance of two persons physical assist with transfer and toilet use. R21 also requires extensive assistance of one person physical assist with personal hygiene. R1's MDS showed R21 has always incontinence of urinary and bowel. On [DATE] at 1:12pm, R21 was been transferred by sit to stand from her wheelchair to the wash room by V7 and V8 Certified Nursing Assistants (CNAs). V7 removed R21's soiled brief and provided perineal care to R21. V7 changed her gloves several times during the incontinence care without performing hand hygiene. V7 failed to perform hand hygiene until completion of the incontinence care. 5. R24's face sheet showed R24 was admitted to the facility 4/[DATE]9 with [DIAGNOSES REDACTED]. R24's minimum data sheet ((MDS) dated [DATE] showed R24 requires extensive assistance of two persons physical assist with transfer and toilet use. The MDS also showed R24 requiring extensive assistance of one person physical assist with personal hygiene. R24's MDS showed R24 with impairment on both upper and lower extremities. R24's care plan on urinary incontinence initiated 5/8/19 showed R24 experiences occasional bladder incontinence related to increased need for assistance and increased weakness. On [DATE] at 1:23pm, R24 had incontinence pad and bed linen on the wheelchair seat. Both the incontinence pad and the bed linen were soaked with R24's urine. V8 removed the soiled linens, changed her gloves without performing hand hygiene. R24's incontinence brief was removed and incontinence care was provided to R24. V8 changed her gloves few times during the provision of care without performing hand hygiene.