

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Hillsboro Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 East Tremont Street Hillsboro, IL 62049	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834</p> <p>Based on Interview and Record Review the facility failed to ensure a resident was free from abuse, from a resident with a history of prior altercations, for 1 of 6 (R4) residents reviewed for abuse in the sample of 6.</p> <p>Findings include:</p> <p>1. R4's Face sheet documents an admitted [DATE]. Diagnosis include Unspecified Dementia with Agitation, Congestive Heart Failure, Respiratory Failure, and Malignant Neoplasm of Colon.</p> <p>R4's Minimum Data Set, MDS, documents R4 is severely cognitively impaired. R4 requires partial/moderate assist with transfers and mobility.</p> <p>R4's Care Plan, dated 2/19/2025, documents R4 has been identified as a vulnerable person related to cognitive deficit. R4 has the potential for aggression related to her cognitive deficit. Interventions include R4 at times will believe she recognizes residents as people from her past and will seek them out to confront them. Staff will provide redirection to other area of facility and offer activities of her choice. R4 will have 1:1 supervision with each resident-to-resident incident and sent to hospital for evaluation with 1:1 supervision for 24 hours after return. Staff educated completed regarding abuse and neglect. Trauma assessment will be completed with each incident involving another resident.</p> <p>R3's Face sheet documents an admitted [DATE]. Diagnosis include Metabolic Encephalopathy, Dementia, Hypertension, and Altered Mental Status.</p> <p>R3's MDS, dated [DATE], documents R3 is moderately cognitively impaired. R3 is independent with mobility and transfers.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Care Plan, dated 2/19/2025, documents R3 has potential to become aggressive related to dementia diagnosis. R3 has been identified as a vulnerable person related to diagnosis of dementia. Interventions include 1:1 supervision will be completed until R3 is sent to hospital for evaluation, and for 24 hours upon returning from hospital. Nursing will work closely with long term care psychiatrist related to medication reviews to ensure her needs are met. PHQ 9 assessment will be completed with each incident involving another resident. Trauma assessment will be completed with each incident involving another resident. When R3 is noted to be agitated, pacing or attempting to argue with others; staff will provide redirecting by offering a snack, glass of iced tea, or encourage R3 to participate in an activity of her choice. Staff to continue to redirect until redirection is successful.</p> <p>Facility Reported Incident, FRI, dated 2/14/2025 documents R3 and R4 were involved in an altercation. R1 observed R3 and R4 arguing and saw R3 open handedly strike R4 on left cheek. Staff initiated 1:1 supervision for R3. Head to toe assessment completed on both residents. No injuries. Parties notified. Police notified. R3 sent to hospital and 1:1 supervision resumed when R3 returned. Investigation immediately began. No staff witnessed incident. R1 stated R4 was sitting in wheelchair in 200 hall. R3 walked over to R4 and began yelling at R4 and open handedly struck R4 on left cheek. R1 yelled for help and staff immediately separated them. No other residents witnessed altercation. R3 and R4 were interviewed and did not recall incident. Assessments completed and IDT reviewed altercation.</p> <p>On 2/28/2025 at 2:45PM, V3, Assistant Director of Nurses/ADON, stated, (R3) and (R4) had more than 1 altercation. Their rooms were on the same hall, and each time (R3) went past (R4's) room, (R3) said things to (R4). We moved (R3) to another hall and that helped. (R4) discharged yesterday and we moved (R3) back to the previous hall, and she is now right across from the nurse's station. We kept (R3) and (R4) on 1:1 supervision for 24 hours after the altercation on 2/14/25.</p> <p>On 2/28/2025 at 3:00PM, R1stated, (R3) and (R4) did not like each other. (R3) slapped (R4) in the face.</p> <p>On 3/4/2025 at 1:00PM, V4, CNA, stated, I don't know about the altercation between (R3) and (R4), but we keep an eye on (R3). If we see her going down another hall other than the one her room is on, we redirect her. She is easily redirectable. She likes coffee so I will get her some coffee and take it to her room.</p> <p>On 3/4/2025 at 1:45PM, V6, CNA, stated, I did not witness the altercation between (R3) and (R4), but I did hear about it. We would try to always keep them apart. For some reason, they hated each other. We moved (R3) to another hall and would redirect her away from the hall (R4) was on. Since (R4) discharged , we have not had any issues with (R3). (R3) likes to stay up at the nurse's station.</p> <p>Facility policy, with a revision date of 1/2024, states, This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The resident must not be subjected to abuse by anyone in the facility. Will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement.</p>		