

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145609	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER Hillside Rehab & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45395</p> <p>Based on observation, interviews and record review, the facility failed to follow physician orders to hold a blood thinner before a scheduled procedure, resulting in the procedure being re-scheduled. This applies to 1 of 4 residents (R1) reviewed for quality of care.</p> <p>Findings include:</p> <p>Review of R1's face sheet showed she last admitted to facility on 05/24/2024 and has a past medical history not limited to: chronic congestive heart failure, bariatric surgery status, open wound of abdominal wall, morbid (severe) obesity due to excess calories, chronic kidney disease (stage 3), major depressive disorder, peripheral vascular disease, lymphedema, body mass index 70 or greater, type 2 diabetes mellitus, hypertension, cellulitis, hypokalemia, streptococcal sepsis, and respiratory failure.</p> <p>Review of R1's Brief Interview for Mental Status (BIMS) score dated 09/27/2024 documented score of 15/15 that indicated no cognitive impairment.</p> <p>On 11/23/2024 at 10:24 AM, R1 said over the past weekend, nurses attempted to administer two injectable medications that she knew were on hold for an upcoming surgical procedure. R1 added that her blood thinner was supposed to be on hold for three days prior to her procedure on the 19th but no one put the order in so now her procedure had to rescheduled for 01/17/2025. R1 became emotionally distraught and frustrated then said she has been trying since last year to have this procedure done, and this was the third time her procedure has been rescheduled. R1 was visibly emotional and said that she may have cancer so having to reschedule her procedure again will further delay the findings. R1 added that she's been checking her electronic hospital chart for any new information that she can provide to the facility to avoid any issues with the next scheduled procedure.</p> <p>Review of R1's surgery clearance paperwork dated 11/15/2024 that was faxed to facility on same day at 01:12 PM documented (page 2/4) anticoagulants (blood thinners) will be held for 72 hours prior to surgery.</p> <p>Review of R1's resident calendar log showed a surgical procedure was scheduled for 11/19/2024.</p> <p>Review of R1's ambulance transfer request form signed by V5 (Environmental Services Director) documented a request for transportation on 11/19/2024 for an ovarian surgical procedure.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's progress notes from August 2024 to current showed no documentation for preoperative orders or to hold any medications prior to her surgical procedure on 11/19/2024.</p> <p>On 11/23/24 at 1:12 PM, review of R1's physician's orders showed no documentation to hold any of R1's medications.</p> <p>Review of R1's current physician's orders provided by facility on 11/23/2024 at 7:38 PM showed: insulin glargine 20 units subcutaneous daily 07:00 PM - 09:00 PM (08/11/2022-open ended). Order on hold from 11/18/2024 to 11/20/2024; semaglutide 1 milligram (mg) subcutaneous once a day on Tuesdays at 05:00 AM (08/13/2024-open ended). Order on hold from 11/07/2024 to 11/20/2024; rivaroxaban (blood thinner) 20 mg tablet by mouth (11/20/2022-open ended). Special instructions: give one tablet daily in the evening at bedtime 07:00 PM - 10:00 PM. No orders or special instructions were documented that indicated to hold rivaroxaban (blood thinner) for 72 hours prior to surgical procedure on 11/19/2024.</p> <p>Review of R1's medications administration history from 11/01/2024 - 11/23/2024 showed the (semaglutide) injection was on hold and not administered on the 12th and 19th; the insulin glargine injection of 20 units was on hold and not administered on the 18th, 19th, or 20th; and rivaroxaban 20 mg tablet was administered on the 16th and 17th which are both within the 72 hour preoperative timeframe.</p> <p>On 11/23/2024 at 01:36 PM, V1 (Administrator) said R1 had an ovarian procedure scheduled for 11/19/2024 but during the morning meeting on 11/18/2024, she and V2 (Director of Nursing) were informed that an order wasn't initiated to hold R1's blood thinners for 72 hours prior to this procedure.</p> <p>On 11/23/2024 at 01:40 PM, V2 (Director of Nursing) said she is newer to the facility and was not aware of R1's procedure until a week prior when the physician's office called about preoperative labs not being done for R1's procedure on the 19th. V2 said the issue was resolved and R1 had the ordered preoperative electrocardiogram and labs both done on 11/14/2024, and her transport was confirmed for the 19th. V2 (Director of Nursing) then said during the morning meeting on 11/18/2024 that V8 (MDS Coordinator) had informed V2 and V1 (Administrator) about her (V8) conversations with R1 regarding her upcoming procedure and receiving verbal preoperative orders while speaking with the physician's office for that would be faxed to the facility on the 15th. V8 (MDS Coordinator) then informed V1 and V2 that she had not communicated to anyone or documented any progress notes regarding her correspondence with R1 or the physician's office, and/or about any anticipated preoperative orders being faxed to the facility. V8 (MDS Coordinator) told V1 that she did not put an order in to hold the blood thinner and admitted it was her fault that the procedure would have to be rescheduled.</p> <p>On 11/23/2024 at 1:56 PM, V1 (Administrator) said the facility informed R1's physician that her blood thinner was not held for the full 72 hours prior to the procedure date. V1 said the physician's office called back and left a message that R1's procedure was rescheduled for 01/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/23/2024 at 2:21 PM, V8 (MDS Coordinator) said R1 has been trying to have this procedure done for quite some time then said that R1's procedure was cancelled due to her blood thinner not being held. V8 also said that R1 talked to her about three weeks ago regarding her upcoming procedure and about her weekly injection and insulin would need to be held. V8 (MDS Coordinator) said R1 did not mention anything at that time about her blood thinner being held, then said she was informed by R1 that she was seen by the physician who was going to send a fax to facility to hold the blood thinner for three days prior. V8 said she called the physician's office to clarify and was waiting for the fax to come through but never received it. Then during the morning meeting on the 18th, V1 (Administrator) said she received the fax and sent it to V2 (Director of Nursing) on the 16th. V8 (MDS Coordinator) then said that she doesn't recall whether she communicated with nursing or documented anything regarding R1's procedure, speaking to the physician or about any perioperative orders but said it should have been documented. V8 added that if she would have received the fax from R1's physician, she would have entered the orders and documented in R1's progress notes about the new orders received.</p> <p>On 11/23/2024 at 03:05 PM, V1 (Administrator) said on the morning of the 16th, she saw that a fax came through on the 15th from R1's physician's office so she and emailed it to V2 (Director of Nursing) without looking at the content of the fax. At 03:07 PM, V2 said she did not see the fax until the morning of the 18th when V8 (MDS Coordinator) inquired about the fax during their morning meeting. At 03:08 PM, V1 (Administrator) said we dropped the ball on this and feel terrible that the procedure had to be rescheduled. V1 then said that she instructed V8 to inform R1 of the issue because she admitted not communicating pertinent information about R1's preoperative orders and the pending fax.</p> <p>Review of Obtaining and Following Physician Orders policy last revised July 2014 reads in part:</p> <p>Policy: It is the policy of Helia Healthcare that physician orders will be obtained by licensed personnel and followed. If the licensed professional does not in his/her best judgement think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order. If those orders are not followed for any reason, the physician and director of nursing will be promptly notified.</p> <p>Procedure: Physician orders may be obtained by the physician visiting and writing the order, the physician visiting and giving a verbal order, the facility contacting the physician via phone, the facility contacting the physician via fax. Obtain the order. Complete a telephone order slip for verbal or telephone orders. Follow the telephone order policy and procedure. Policy not provided.</p>		