STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident who requested medical records were provided the records in a timely manner. This applies to 1 of 2 resident's (R2) reviewed for medical records in the sample of 8. The findings include: R2's electronic medical record showed R2 was admitted to the facility on [DATE] with diagnoses that included myopathy, inflammatory and immune myopathies, pain in leg, anxiety, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, and history of falling. On June 16, 2025 at 11:33 AM, R2 stated she asked V15 (Director of Rehab) several times to give her some therapy medical records. R2 stated, V15 said multiple times she would get the medical records for R2 but she still has not received the medical records she requested. On June 17, 2025 at 2:40 PM, V1 (Administrator) stated she received a written request for medical records from R2 on June 5, 2025. V1 stated that V10 (Business Office Manager) told V1 later that day that the R2 no longer needed the paper work. V1 stated therefore, she did not provide the paperwork to R2. On June 17, 2025 at 2:48 PM, V10 stated, she spoke to R2 on June 5, 2025 after V1 asked her to go see R2. V10 stated she talked to R2 and R2 did not want V10 to explain or go over the medical records her. V10 stated R2 wanted paper copies of the medical records to give it to her attorney. V10 stated she notified V1 about R2's request for medical records. V10 stated she was then waiting for V1 to give her the medical records for R2. V10 stated she documented it in the progress notes under the social services tab. R2's progress note dated June 5, 2025 written by V10 showed the following: Writer discussed with resident the request for occupational discharge. Informed resident I can go over the document with her, however she stated she does not want to go over such document. She just wants to have the document to send to her attorney. Writer informed resident that when document is available to give to her I will bring it down to her and go over it with her. (continued on next page)

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 18, 2025 at 12:32 AM , V15 (Director of Rehab) stated that R2 did request medical records from her and she spoke to her supervisor and her supervisor stated those requests are handled by the facility. V15 stated she did not inform R2 that she needed to request the medical records from the facility. V15 stated the facility was in communication with R2, therefore, she assumed they were handling R2's request for medical records. R2's request for medical records form was not dated, however, on June 17, 2025 at 2:40 PM, V1 stated this form was submitted to V1 on June 5, 2025 by R2.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's family/POA (Power of Attorney) of a new wound to the resident's sacrum. This applies to 1 of 4 residents (R1) reviewed for change of condition notification in the sample of 8. The findings include: R1's electronic medical record showed R1 was originally admitted to the facility on [DATE]. R1's medical record also showed he was discharged to the hospital on May 21, 2025 and returned 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 progress note dated June 2, 2025 written by V2 (Licensed Practical Nurse) showed the following: Resident is having skin breakdown on buttocks, redness, and open areas of about 0.1 x 0.1 centimeters. Cleaned with wound cleanser, used calcium alginate and covered it with a boarded gauze. On June 16, 2025 at 1:04 PM, V8 (R1's family, POA) stated the facility never notified him that R1 had any wounds to his heels or buttock/sacrum. R1 stated he found out R1 had wounds when he saw R1 in the hospital on June 5, 2025. On June 16, 2025 at 4:55 PM, V2 stated he did not notify R1's family of the new wound that he found on June 2, 2025. V2 stated they should notify the doctor and the family of any change in resident condition like this new wound that was found. V2 stated that notification of the doctor and the family representative should be documented in the progress notes. There was no documentation in the progress notes that showed that V2 or anyone else notified R1's family that R1 had a new wound. The facility's Change in a Resident's Condition or Status policy showed the following: the facility will immediately notify the resident's family or representative of a significant change in the resident's physical, mental, or psychosocial status or deterioration of the resident's physical, mental, or psychosocial status.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. R1's medical record also showed he was discharged to the hospital on May 21, 2025 and readmitted to the facility on [DATE]. 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 [DATE] 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 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 [DATE] 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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. 2. R8's electronic medical record showed R8 was admitted to the facility on [DATE] 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 [DATE] 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.

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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 interview and record review, the facility failed to properly transfer a resident who required hands-on assistance to ascend stairs of a transport van. This applies to 1 of 3 residents (R2) reviewed for transfers in the sample of 8. The findings include: R2's electronic medical record showed R2 was admitted to the facility on [DATE] with diagnoses that included myopathy, inflammatory and immune myopathies, pain in leg, anxiety, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, and history of falling. On June 16, 2025 at 11:33 AM, R2 was crying and stated V9 (Certified Nursing Assistant/CNA) came without a wheelchair to take her to a doctor's appointment. R2 stated she told V9 she could not walk that far to the van and he had to get a wheelchair. R2 stated V9 then returned with a wheelchair. R2 stated V9 wheeled her to the van, but could not put her in the back of the van where residents in wheelchairs normally sit because he said there was a bunch of equipment back there and told her to get in the front seat. R2 stated she told V9 she didn't have the strength in her arms and legs to go up the stairs and into the front seat. R2 stated V9 told her he would help her. R2 stated V9 did not have a gait belt around her. R2 stated V9 then helped her stand up. R2 stated she turned and told him again she would not be able to lift her foot up and V9 said try and he would help her. R2 stated so she lifted her 1st foot up on put it on the grate and tried to put pressure on it and her legs gave out. R2 stated her legs felt like noodles and were flopping and hitting things all around. R2 was crying while telling the story. R2 stated then V9 pushed her from her back up into the seat. R2 stated, the same thing happened when she tried to get into the van on the way back to the facility. R2 stated she told R2 she could not get up and he said again he would help her up. R2 stated again her legs gave out and he put his knee up to catch her and she was sitting on his knee. R2 stated while she was sitting on his knee he pushed her up and into the seat. R2 stated that V9 kept on saying he was sorry. R2 stated when they got back to the facility V9 went to get help and V10 (CNA) came to help V9. R2 stated V13 (Former Director of Nursing) came right away the next morning. R2 stated her bilateral knees and her lower legs were bruised. R2 stated she had x-rays done the next day but there was no fractures found. R2's progress note written by V13 dated May 16, 2025 showed the following: Administrator notified this nurse at approximately 12:30 PM that resident was complaining of some bruising secondary to her knee giving out while being transferred into the building van. Bruising noted to right medial ankle, extending down into the heel, left lateral foot into heel, left anterior knee, and small 2 cm bruise to her right middle axillary chest. The nurse practitioner was notified and orders for STAT imaging received. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated May 17, 2025 written by V12 (Registered Nurse) showed the following: R2 is alert and oriented x4. R2 complained of aching throughout her body and back. Received x-ray results for left and right ribs, spine, right and left foot, left ribs, right ankle, and left knew. Results showing no acute fracture or dislocation. The nurse practitioner was notified. R2 stated as needed acetaminophen was ineffective. R2 requires 1 person assist with transferring. Able to walk short distances. On June 17 20225 at 12:45 PM, V9 (CNA) stated he took R2 on Thursday May 15th in the afternoon to a doctor's appointment. V9 stated he asked the CNA and nurse on duty how she transferred and they told him R2 used a walker with one assist. R2 told him she could not walk to the van. V9 then retrieved a wheelchair for the R2 and took R2 to the facility's van. V9 stated there was stuff in the back of the van so he could not put R2 back there where the residents in wheelchairs usually ride. V9 stated R2 tried to stand up to get into the front seat. V9 stated R2 grabbed the handle of the door and V9 assisted her into the van. V9 stated he did not have a gait belt with him. V9 stated on the way back when R2 attempted to go up the stairs of the van again. V9 stated when R2 took her first step up onto the stair and her legs gave out. V9 stated he immediately put his leg underneath R2 to keep her from falling. V9 stated he picked R2 up like a groom holds his wife going over the threshold and her knee hit the dashboard when he was putting her in the van. V9 demonstrated how he carried R2 when he placed her in the van. V9 stated R2 could have gotten the bruising to her legs when he was putting her in the van. R2's physical therapy note dated May 14, 2025 showed the following: R2 to be a fall risk and R2 gets dizzy when ambulating. R2 performed stair training going up/down 2 steps with contact guard assist. R2's physical therapy note dated May 15, 2025 showed the following: R2 is a fall risk and gets dizzy when ambulating. The therapist instructed the resident on stair training going up/down 3 steps with bilateral upper extremity support and contact guard assistance. The resident required verbal cues on the proper technique and increased safety awareness. On June 17, 2025 at 1:52 PM, V16 (Physical Therapy Assistant) stated that on June 14, 2025 R2 came to therapy in a wheelchair and they used contact guard assist with the therapist holding on to her while practicing going up and down two stairs. V16 stated on June 15, 2025 they saw R2 earlier in the day. V16 stated R2 came in a wheelchair and practiced walking up and down three stairs with contact guard assist. V16 stated a gait belt was used going up stairs for R2's safety because she complained of weakness. V16 stated R2 can verbally tell staff what she needs. V16 stated R2 required bilateral upper extremity support and contact guard assist (CGA) to go upstairs. V16 stated CGA means that the therapist is holding onto the resident using a gait belt. V20 (Occupational Therapy) stated you never know when someone may have periods of dizziness so they recommend a gait belt when ambulating residents. V15 (Director of Rehab) stated R2 had a history of vertigo. V15 stated R2 gets dizziness during therapy. On June 18, 2025 at 3:10 PM, V11 (Regional Clinical Director) if a staff CNA is transferring a resident who requires assistance, then she expects the staff to use a gait belt when ambulating or transferring the resident for the resident's safety. The facility's safe handling program showed the following: Gait and transfer belts will be used where manual assistance is required for ambulation and transfer activities.