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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Rehab & Care Center	1308 Game Farm Road Yorkville, IL 60560

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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 follow standard infection control practices related to hand hygiene during provisions of incontinence care and medication administration. The facility failed to ensure that staff wear complete PPE (Personal Protective Equipment) during care for a resident on EBP (Enhance Barrier Precaution). The facility also failed to ensure that soiled linens are in a linen bag while being transported to the soiled utility room, and a CPAP (Continuous Positive Airway Pressure) machine is stored in a hygienic way. This applies to 10 of 21 residents (R4, R13, R18, R20, R22, R23, R26, R36, R48, R62) reviewed for infection control in the sample of 21. The findings include: 1. On May 05, 2026, from 8:39 AM through 9:53 AM, V4 administered medications to different residents (R18, R23, R26, R62). These residents have different routes such as oral (R18, R23, R26), inhalers and eye drops (R18), and gastrostomy tube (R62). At 8:39 AM, V4 was observed preparing R23's medications. V4 wore a set of gloves, touched different surfaces, opened medication cart drawers, checked R23's vital signs, touched some of the medications with his gloved hands while placing them in a cup, and then he administered those medications to R23. After R23's medication administration, V4 removed his gloves, donned another set of gloves without hand hygiene and prepared the medications for R26. V4 again performed different tasks and administered medications while wearing the same soiled gloves and without performing hand hygiene in between tasks and residents. V4 continued to repeat this same cycle with R18, and R62. Facility's Undated Policy and Procedure for Medication Administration show: Preparation: Hand Washing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after ophthalmic, topical vaginal, rectal, and parenteral preparations and medication via enteral tubes. 2. On May 5, 2026, at 10:32 AM, there was an EBP (Enhance Barrier Precaution) signage posted outside R48's bedroom. According to V15 (Nurse), R48 has an arterial wound to left foot, hence the EBP. On May 5, 2026, at 11:48 AM, V11 and V12 (Both Certified Nursing Assistants/CNA) rendered incontinent care to R48 who was wet with urine and had a bowel movement. V12 wiped R48 from front to back of his perineum with a wet towel, then she applied barrier cream to the peri-area, put on a new incontinence brief, and pulled his pants back in place, while wearing the same soiled gloves all throughout the care. V11 and V12 also did not wear a gown during the provision of incontinence care. On May 6, 2026, at 11:55 AM, V2 (Director of Nursing/DON) stated staff must perform hand hygiene (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prior to providing care and prior to putting on gloves, they must do hand hygiene from dirty to clean tasks, in between residents, and after removal of gloves. This is a standard of care to prevent infection. If a resident is on EBP and the staff is directly providing care to this resident, the staff should wear complete PPE such as a gown and gloves. The staff should also wear masks and face shields when appropriate. R48's Enhance Barrier Precaution (Signage Posting) showed: Providers and staff must wear gloves and a gown for the following activities: Changing briefs or assisting with toileting. 3. R13's EMR (Electronic Medical Record) showed R13 was admitted to the facility on [DATE], with multiple diagnoses including dependence on dialysis, end stage renal disease, chronic kidney disease, depression, obesity, cerebellar infraction, hypertension, and peripheral vascular disease. R13's MDS (Minimum Data Sheet) dated February 16, 2026, showed R13 was severely cognitively impaired and needed setup/clean-up assistance with eating, supervision/touching assistance with oral and personal hygiene, and substantial/maximal assistance with bathing, dressing, mobility, and transfers. R13's Physician Order Report showed R13 had a current order dated March 20, 2026, for EBP (Enhanced Barrier Precautions). On May 5, 2026, at 9:30 AM, there was an EBP sign outside R13's room and a 3-drawer cart with PPE (Personal Protective Equipment). V6 (Certified Nursing Assistant, CNA) put on a mask and a gown. V6 pulled a pair of gloves from her pants pocket and wore those gloves. V6 walked into R13's room with her gloved hands and pulled the privacy curtain with the gloved hands. V6 opened R13's closet by touching the closet handle with her gloved hands and removed clothes that R13 was going to wear to her appointment later this morning. V6 pulled out a shirt, pants, and a pair of non-skid socks. V6 went into R13's bathroom and opened the bathroom door by touching the door handle with her gloved hand. In the bathroom, V6 filled a basin with soap and water and put washcloths into this basin. V6 came back to R13 and with the same gloved hands, V6 touched a washcloth that was in the basin and handed it to R13. R13 wiped her face with this washcloth. V6 with her gloved hands took the same washcloth that R13 had just used to wipe her face and V6 wiped R13's eyes with it. V6 placed this soiled washcloth on the seat of R13's wheelchair that was in the room. V6 helped R13 take off her shirt. V6 took another washcloth from the basin and wiped the front of R13's body. V6 placed this soiled washcloth on the seat of R13's wheelchair. V6 used a dry washcloth to dry the front of R13's body. V6 used the same gloved hand to touch R13's spray deodorant bottle and sprayed the deodorant into R13's underarms. V6 used the same gloved hands to put a shirt on R13. V6 touched the remote control of the bed and raised the bed. V6 undid R13's incontinence brief and tucked it under R13, and this brief had visible brown substance in it. With the same gloved hands, V6 pulled out another washcloth from the basin. V6 used this washcloth to wipe R13's perineal area and put this soiled washcloth on the seat of R13's wheelchair. V6 got another washcloth from the basin and wiped under R13's abdomen. V6 asked R13 to roll to R13's right side and V6 rolled the soiled incontinence brief and the incontinence pad under R13. V6 took another washcloth from the basin and wiped R13's back and placed the soiled washcloth on the seat of R13's wheelchair. V6 took another washcloth from the basin and wiped R13's buttocks front to back to remove the brown substance. V6 took the soiled incontinence brief and placed it on the incontinence pad and placed a new incontinence brief under R13. V6 used the same gloved hands to get a white bottle with white powder and put some of that into R13's new incontinence brief. V6 stated this was a cornstarch-based powder that she puts in R13's briefs. V6 asked R13 to reposition onto her back. V6 took off her gloves and threw that into the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when not in use. 5. R22 was admitted to the facility on [DATE]. R22 has multiple diagnoses including paraplegia, chronic embolism and thrombosis, depression, dysfunction of the bladder, irritable bowel syndrome, constipation, major depressive disorder with psychotic symptoms, urinary tract infection, rash, chronic pain syndrome, muscle weakness, and lack of coordination. R22's MDS dated [DATE], showed R22 was cognitively intact and requires maximal assistance from staff for hygiene, toileting, and dressing. R22 was totally dependent on staff for showers. On May 05, 2026, at 10:11 AM, R22 received incontinence and perineal care from V11 (CNA) and V12 (CNA). V11 and V12 applied gloves while entering R22's room without performing hand hygiene. V12 gathered all materials and removed the soiled incontinence product and linens from R22. V12 cleansed R22's perineal area, applied a new incontinence product, and assisted R22 with her clothing, while wearing the same soiled gloves. V11 placed soiled linens into a plastic bag and with the same soiled gloved hands, touched resident's personal items and continued to adjust V11's glasses on their face. V11 and V12 did not perform hand hygiene or change gloves after removing soiled incontinence products and bagging up soiled linens. V11 and V12 with same soiled gloves entered the soiled utility room to empty trash and place soiled linens into laundry bags. V11 and V12 removed gloves and took the laundry bags containing soiled linens outside to the shed to be picked up by an outside company. V11 and V12 did not perform hand hygiene after incontinence care with R22. 6. R36 was admitted to the facility on [DATE]. R36 has multiple diagnoses including acute embolism and thrombosis, anemia, hypertension, hypo-osmolality, hyponatremia, anxiety, insomnia, chronic pain, skin breakdown, and osteoporosis. R36's MDS dated [DATE], showed R36 has moderate cognitive impairment and requires maximal assistance from staff for toileting, personal hygiene, dressing and transfers. On March 04, 2026, at 10:30 AM, V11 provided incontinence care for R36. V11 placed linens and incontinent products that were saturated in urine into a plastic bag. With the same soiled gloves on V11 touched R36's personal items on the bedside tray and placed R36's call button along the wall next to the bed. With the same soiled gloves, V11 continued to readjust the glasses on their face several times. V11 removed the soiled linen and trash from R36's room and placed them in the soiled utility closet. V11 threw the gloves in the trash but did not perform hand hygiene after care. 7. R20 was admitted to facility on October 22, 2025, with multiple diagnoses including chronic obstructive pulmonary disease, cerebral infarction, asthma, atrial fibrillation, cardiomyopathy, cardiac defibrillator, hypertension, low back pain, lymphedema, sciatica, anxiety, rheumatoid arthritis, visual hallucinations, osteoarthritis, constipation, and morbid obesity. R20's MDS dated [DATE], showed. R20 has severe cognitive impairment. R20 utilizes a wheelchair for mobility and is dependent on staff for toileting, bathing, dressing, transfers and personal hygiene. On May 05, 2026, at 10:47 AM, V10 (CNA) exited R20's room with unbagged soiled linen in her hands following incontinence care. R20 took the linen into the soiled utility room across the hall. On May 06, 2026, at 10:36 AM, V11 said that hand hygiene should be performed before care after care and in between providing care to different patients. V11 said that hands should be washed for a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minimum of twenty seconds, and hand sanitizer may be utilized as well. On May 06, 2026, at 10:45 AM, V2 (DON), said that staff are expected to wash their hands for twenty seconds before going into residents' rooms. They may also use sanitizing material before and after resident care. The staff are also expected to perform hand hygiene whenever they put their gloves on or take them off. On May 06, 2026, at 12:08 PM, V1 (Administrator), said that dirty linen should be placed into a plastic bag and taken directly to the soiled utility room. Linen should be carried away from clothing. The facility's Infection Prevention and Control Programs Policies and Procedures- Hand Hygiene General Statement showed good hand hygiene is a requirement of standard precautions. Wash or sanitize hands before and after each care contact for which hand hygiene is indicated by acceptable professional practice, utilizing designated time frames, and products. Hands should be washed with soap and water when they are visibly soiled, or if they have come in contact with blood or other body fluids, before or after eating or handling food, and times specified by other applicable regulations. The facility's policy titled, Infection Control, dated July 2017, showed under Procedure, that staff will use proper glove and hand washing technique and use proper linen handling technique. The facility's policy titled, Giving a Bed bath, dated July 2014, showed under Steps in the Procedure for Perineum, the staff are to remove gloves and discard in the designated container. The facility's Linen Handling Policy showed it is the policy that linen will be handled in a manner to prevent infection and spread of disease. Procedure: 3. Removing Soiled Linen: a. using gloved hand, place all soiled linen in a plastic bag. k. Place bagged linen in the soiled linen barrel. m. Wash hands.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident assessed to need assistance with all activities of daily living care needs had access to their call light to call for assistance. This applies to 1 of 3 residents (R4) reviewed for accommodation of needs in the sample of 21. The findings include:R4 is a [AGE] year-old with a diagnoses history of vascular dementia, heart failure, and partial paralysis following a stroke who was admitted to the facility January 30, 2024. On May 04, 2026 at 11:15 AM, R4 said he needed to go to the bathroom. R4 said he doesn't know where his call light is. R4's call light was sitting on the floor behind his bed wrapped around the frame. On May 04, 2026 at 11:34 AM, R4's call light remained on the floor behind his bed wrapped around the frame. R4 said he really needed to go to the bathroom. On May 05, 2026 at 9:40 AM, R4 said he needed to use the bathroom, he would use his call light to ask for assistance but he can't find it. R4's call light was sitting on the floor behind his bed wrapped around the frame. R4's current care plan shows he is usually able to make his needs known and understands when spoken to and requires a mechanical lift with two-person assistance for transfers. On May 05, 2026 at 1:05 PM, V2 (Director of Nursing) said R4's call light should be accessible at all times because he can't get out of bed on his own, he is bed bound, and requires assistance from staff with all areas of care. The facility did not provide a policy regarding call light accessibility as requested on May 06, 2026 at 1:15 PM

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that an adaptive device was in place according the physician order. This applies to 1 of 2 residents (R33) observed for range of motion in the sample of 21.The findings include:R33's electronic medical record (EMR) shows R33 has multiple medical diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R33's Physician Order Summary (POS) dated April 30, 2026, shows to apply a splint (carrot) to the left hand (orthosis) in affected extremities daily as tolerated. R33's Minimum Data Sheet (MDS) dated [DATE], showed R33 is alert and oriented. On May 4, 2026, at 10:45 AM, during facility's unit rounds with V13 (Certified Nursing Assistant/CNA), R33 was observed resting in bed. V13 said that R33 is alert and oriented and totally dependent on activities of daily living (ADL) care. R33's left arm and hand were noted with limited movement. R3's left hand and fingers were very stiff. There was no splint in place. At 1:30 PM, R33 remained in bed, there was no splint on his left hand. R33 stated he doesn't know where his splint is. On May 5 and May 6, 2026, R33 was observed multiple times without a splint on his left hand. There was no carrot splint noted anywhere near R33. On May 6, 2026, at 10:51 AM, V16 (Rehab Director) and V17 (Registered Occupational Therapist/OTR) both stated the carrot splint is for functional position and to decrease likelihood for further contraction, and it is an atonic inhibitor. On May 6, 2026, at 10:57 AM, V16 and V17 went to R33's bedroom to apply the carrot splint. V16 and V17 both looked everywhere inside R33's bedroom and they were unable to find it. V16 left R33's bedroom and came back with a carrot splint. Prior to applying the splint, V17 stated R33 was non-compliant with the carrot splint because he has low tolerance with the pain or discomfort it causes him whenever it was in place. V16 and V17 explained to R33 the importance of using this carrot splint. When V17 applied the splint to R33's left hand, R33 initially verbalized discomfort as it was being placed in his palm and fingers but did not further complain about it after it was fully applied on his left hand. R33 stated that he didn't feel it at all, and there was no pain after it was applied. On May 6, 2026, at 12:19 PM, V2 (Director of Nursing/DON) stated staff should ensure that splint is in place as ordered and to check the skin integrity of the hand. V2 said she does not see a care plan for the carrot splint, and there was no documentation of R33 refusing to wear the carrot splint.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide incontinence care in a timely manner for residents who were identified as incontinent and failed to ensure the indwelling urinary catheter bag was always below the resident's bladder. This applies to 2 of 6 residents (R3, R9) reviewed for incontinence and catheter care in the sample of 21. The findings include:1. R3's electronic medical record (EMR) showed R3 had multiple diagnoses including type 2 diabetes mellitus with chronic kidney disease uncontrolled and congestive heart failure (CHF). R3's Physician Order Summary (POS) showed R1 was receiving Torsemide (diuretic or water pill) 20 milligrams (mg) twice a day for CHF. On May 4, 2026, at 10:43 AM, R3 was sitting in his wheelchair in his bedroom, R3 said he has heart failure and renal failure. According to V13 (Certified Nursing Assistants/CNA), R3 is alert and oriented and requires extensive assistance with activities of daily living (ADL) care. On May 5, 2026, at 12:35 PM, V11 and V13 (Both CNA) assisted R3 to the toilet. R3's incontinence brief was heavily saturated with urine, a strong urine odor emanated when R3's incontinence brief was removed. R3 said the last time his brief was changed was early that morning. On May 5, 2026, at 12:45 PM, R3 said he doesn't know when he was voiding so he couldn't tell staff when to change his incontinence brief; however, he asked the staff to assist him to change his disposable brief because it had been a while since he was last changed. R3's care plan dated March 5, 2026, showed R3 has urinary incontinence. The goal is to keep R3 dry and clean as much as possible. This same care plan showed several approaches which include providing incontinent care as needed. The Facility's Undated Perineal Care Policy and Procedure showed: The purpose of this procedure is to provide cleanliness and comfort to the residents, to prevent infections and skin irritation, and to observe the resident's skin condition.The Facility's Undated Toileting Policy and Procedure showed: It is facility's policy to ensure all their residents' toileting needs are met. This same policy shows procedures including:2. Check each resident every two hours and change if found incontinent.3. Provide perineal care after each incontinent episode. 2. R9's EMR showed R9 had multiple medical diagnoses including chronic kidney disease, neuromuscular dysfunction of bladder, benign prostatic hyperplasia with lower urinary tract symptoms, calculus of kidney, urinary tract infection. On May 6, 2026, at 10:34 AM, V13 and V18 (Both CNA) transferred R9 from bed to wheelchair via mechanical lift. R9 has an indwelling urinary catheter. The urinary bag was placed/hung on the sling hook bar of the mechanical lift which was above R9's bladder. There was sedimentations noted inside the urinary catheter tube. During transfer the urine in the tube was noted flowing back towards R9. On May 6, 2026, at around 10:55 AM, V13 said she also observed the urine flowing back to R9. Care Plan shows R9 requires indwelling urinary catheter related to neurogenic bladder. This same care plan shows interventions including positioning of the urinary bag below level of bladder. On May 6, 2026, at 12:06 PM, V2 (Director of Nursing/DON) stated the staff should check residents who are incontinent every 2 hours and as needed. This is to be done to prevent skin breakdown and urinary tract infection, and to promote comfort. The indwelling urinary catheter should always be positioned below the bladder so it could drain by gravity, and the urine doesn't backflow to the bladder, to prevent UTI (Urinary Tract Infection).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement physician orders for IV PICC (intravenous peripherally inserted central catheter) line dressing change as needed, failed to have a care plan in place for management of care of IV site in order to prevent infection. This applies to 1 of 2 residents (R40) reviewed for IV therapy in the sample of 21. The findings include:R40's face sheet showed that R40 was admitted on [DATE], with multiple diagnoses including non-pressure chronic ulcer of right heel and midfoot with unspecified severity, pressure ulcer of unspecified site, urinary tract infection, pain, type 2 diabetes mellitus with foot ulcer, neuropathy. R40's admission MDS (minimum data set) dated February 18, 2026, showed that R40 was cognitively intact. R40's POS (Physician Order Summary) showed that R40 was initially (start date April 18, 2026) on IV antibiotic vancomycin in 0.9 sodium chloride solution; 1.5 gram/250 ml (milliliter) every 12 hours (8:00AM, 8:00PM) related to diagnosis of non-pressure chronic ulcer of right heel and midfoot with unspecified severity. R40's P0S showed that the order was on hold from April 21, 2026-April 23,2026. Vancomycin in 0.9 sodium chloride solution piggyback 1 gram/200 ml was resumed on April 23, 2026, every 12 hours (8:00AM, 8:00PM), and was again placed on hold from April 29, 2026-April 30, 2026. R40's POS showed that on May 1, 2026, vancomycin in 0.9 sodium chloride solution; 1.5 gram/250 ml was resumed. The same POS showed that on May 4, 2026, the pharmacy filled this order with a different (non-equivalent) drug to Tyzavan intravenous piggyback 1.5 gram/300ml once a day (start time 10:00AM, end time 12:00AM). On May 4, 2026, at 11:27 AM, R40 stated I am taking antibiotic by IV every day for infection for my right foot. I have a wound. I have had it over a year. R40 had a PICC line covered by a transparent dressing on R40's left arm that was not dated but showed faded illegible initials where the frayed edges were peeling off. The IV site was covered by a circular disc and the transparent dressing that taped was over it was noted curling at the edges. R40 stated that the transparent dressing is changed every 7 days, and it was last changed on April 25, 2026. R40 remarked It had a date on the edge, but it came off. It (the dressing) needs to be changed. A red sign was posted on R40's bedside wall showed PICC LINE left arm. Arm circumference 39 cm (centimeters). Date April 18, 2026, 1540 (3:40 PM). R40 stated that the IV antibiotics were started on that date originally. On May 4, 2026, at 12:11 PM, on inquiry when the dressing was changed, V5 (Registered Nurse) stated It is the PM nurse that changes the dressing, but I cannot tell you when she last changed it. V4 stated that the circular covering is a bio patch. When V5 was shown that edges of transparent dressing that were peeling off, R40 stated It needs to be changed.Ancillary orders on POS (start date April 18, 2026) included IV PICC line: change dressing and caps per sterile technique weekly once a day on Saturday; (2:00PM-10:00PM) and prn (as needed).MAR (medication administration records) for dates from April 18, 2026-April 5, 2026, showed that IV PICC line dressing and caps were changed on April 18, 2026, April 25, 2026, and May 2, 2026. The same MAR had no notations for measurement of arm circumference. Facility did not have a care plan in place for IV antibiotics. On May 6, 2026, at 1:57 PM, V8 (MDS Coordinator) stated that he did not put a care plan for R40's antibiotics as he assumed that it was discontinued. V8 stated that R40's Vancomycin was adjusted multiple times based on lab results and he thought that it was discontinued on May 1, 2026. V8 added that the facility template care plan for antibiotics does not include details about dressing change and measurement of arm circumference. On May 5, 2026, at 2:42 PM, V7 (Registered Nurse) stated that she did the dressing change on IV site on April 25, 2026, and she used a kit that included tools, dressing and bio patch for the same. V7 showed the kit that included a measuring tape. V7 stated that she believes she did not use the measuring tape and/or measure the arm circumference to ensure that there is no swelling.V1 (Administrator) stated that based on initials on MAR, an agency nurse had changed the IV PICC line dressing on May 2, 2026, and she is not sure that she would be able to reach the nurse. On May 5, 2026, at 10:44 PM and 2:42 PM, V2 (Director of Nursing) stated that (continued on next page)

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	05/06/2026

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.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she is new to the facility and is not sure if they have a policy with regard to measurement of arm circumference. V2 stated that the nurses should be doing measurement of the arm circumference so that it (tip of IV site) is not migrating.Facility (undated) policy titled 'IV Therapy' included:Central Lines: A. PICC Line 3. Care of Line-24-hour post insertion dressing change then every 7 days if transparent dressing. Requires sterile dressing change Instructions for Peripheral Venipuncture procedure' included 23. Apply a transparent dressing directly over the insertion site. 25. Label with type of devise, gauge and length of devise, date time and nurses' initials.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe storage of controlled medications. This applies to 2 of 2 residents (R6 and R18) reviewed for medication storage in the sample of 21. The findings include:R18's EMR (Electronic Medical Record) showed R18 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, spinal stenosis, low back pain, muscle spasms, pain unspecified, pain in right arm, and migraine. R18's Physician Order Report showed an order dated September 13, 2024, for hydrocodone-acetaminophen(Pain medication) 5-325 mg (milligrams) twice a day (7:00 AM to 11:00 AM, 4:00 PM to 7:00 PM). On May 6, 2026, at 12:12 PM, during the controlled substance count of the Wing 2 cart with V5 (Registered Nurse, RN), R18's blister punch card for hydrocodone-acetaminophen 5-325 mg had 20 tablets remaining. The back of the blister punch card on the compartment with the number 20 on it was open and the opening was big enough for the tablet to come out. V5 verified the compartment number 20 was open and the tablet should have been discarded. She was not aware of how this happened. V5 stated this tablet should have been disposed of with two nurses and documented as wasted on the controlled drug receipt/record/disposition form. R6's EMR showed R6 was admitted to the facility on [DATE], with multiple diagnoses including osteomyelitis, obesity, pain in left foot, pain in right knee, and osteoarthritis. R6's Physician Order Report showed an order dated December 31, 2025, for hydrocodone-acetaminophen 10-325 mg tablet four times a day (6:00 AM, 10:00 AM, 3:00 PM, and 8:00 PM), On May 6, 2026, at 12:18 PM, as the controlled substance count for Wing 2 cart continued. R6's hydrocodone-acetaminophen 10-325 mg controlled drug receipt/record/disposition form showed there were supposed to be 21 tablets remaining, but in the blister punch card, there were only 20 tablets. There was a tablet that was placed in a clear unsealed plastic pouch with R6's name handwritten on it and V5 confirmed it was the hydrocodone-acetaminophen 10-325 mg tablet. V5 stated she was the one that put the tablet in this plastic pouch. V5 stated she popped this tablet out at around 9 AM this morning but she did not realize she had already placed a hydrocodone-acetaminophen 10-325 mg tablet in R6's medication cup so this tablet was not needed. V5 did not know she had to dispose of the controlled substance tablet right away because V5 stated she needs to dispose of the tablet when she can find another nurse to do it with. On May 6, 2026, at 12:42 PM, V2 (Director of Nursing, DON) confirmed R6's hydrocodone-acetaminophen 10-325 mg should not be placed in a plastic bag, and it should have been wasted right away with two nurses. V2 also confirmed she saw that R18's blister punch card had compartment number 20 completely opened and she stated this pill should have also be wasted with two nurses. V2 stated these controlled substance medications should have been wasted with two nurses right away because these medications could end up in the wrong hands. V2 continued to say R18's hydrocodone-acetaminophen 5-325 mg tablet could have fallen out from the blister punch card from the open compartment number 20, and it was exposed to bacteria. The facility's undated policy titled, Controlled Substances, showed under Procedures that accurate accountability of the inventory of all controlled drugs is always maintained. The facility's undated policy titled, Controlled Substance Disposal, showed under Procedures that when a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses or a pharmacist and nurse, and the disposal is documented on the accountability record/book on the line representing that dose.

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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. Based on observation, interview, and record review, the facility failed to follow physician order and failed to follow their policy and procedure with administering inhaler medication. There were 25 medication opportunities with 3 errors resulting in 12% medication error rate. This applies to 2 of 4 residents (R18, R62) reviewed for medication pass in the sample of 21. The findings include:1. On May 5, 2026, at 9:12 AM, V4 (Nurse) administered medications to R18 including Advair HFA oral inhaler and Incruse Ellipta inhaler. V4 handed the Advair inhaler to R18 without instructions R18 took 2 puffs of the Advair one after another, then V4 handed the Incruse Ellipta right after. R18 took a puff of the Incruse Ellipta within 5 seconds after the Advair. R18 Medication Administration record dated May 2026 showed an order of Advair HFA (Fluticasone Propion-Salmeterol) 230-21 mcg/actuation inhaler 1 puff once daily.Facility's Undated Policy and Procedure for Oral Inhalation Administration show:Purpose: To allow for safe, accurate, and effective administration of medication using an oral inhaler or nebulizer. Procedure for metered dose and dry-powder inhalers shows: If another puff of the same or different medication is required, wait at least 1-2 minutes between, then repeat procedures above. 2. On May 5, 2026, at 9:53 AM V4 administered several medications to R62 via gastrostomy tube (g-tube) including 5 milliliter (ml) of the Levetiracetam (anticonvulsant).R62's medication administration record (MAR) showed the order of Levetiracetam Solution 100 milligrams (mg)/ml, to administer 250 mg (2.5 ml) twice a day. However, V4 administered 5 ml (500 mg). On May 6, 2026, at 11:35 AM, V2 (Director of Nursing/DON) stated nurses are expected to follow physician orders and instructions for medication administration, and they are to follow the principle of medication administration which is the right patient, dose, medication, route, and time.Facility's Undated Policy and Procedure for Medication Administration showed:Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. Procedure: PreparationFive Rights: Right resident, right drug, right dose, right route, right time. A triple check of these 5 rights is recommended at three steps in the process of preparation for administration. (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away.