

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 14688 Illinois Highway 82 Geneseo, IL 61254	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview and record review the facility failed to notify a physician of a fall in a timely manner and failed to notify the physician of the resident taking an anticoagulant medication for 1 of 3 residents (R2) reviewed for notification of changes in the sample of 4.</p> <p>The findings include:</p> <p>The admission record for R2 shows she was admitted to the facility on [DATE] with multiple diagnoses including cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic atrial fibrillation, unspecified dementia, and aphasia (communication disorder).</p> <p>The facility's 4/29/24 admission assessment of R2 shows severe cognitive impairment. The same assessment shows R2 to be on an anticoagulant medication. The order summary report of 6/23/24 shows R2 was taking Eliquis 2.5 mg twice daily for chronic atrial fibrillation.</p> <p>R2's progress notes for 6/22/24 at 3:15 PM show resident observed on the floor on the side of the bed in front of her wheelchair sitting upright onto buttocks. Vital signs obtained, and remain within normal limits of baseline, full body observation completed with no injury noted, resident denied hitting head, however fall was unwitnessed, so neuro checks in place. MD notified via fax and made aware, with instructions to continue to monitor per facility protocol.</p> <p>On 6/23/24 at 11:25 AM, V16 CNA (Certified Nursing Assistant) said R2 only knows her name, is confused, and wanders around the facility. R2 would not be able to answer any questions correctly such as if she hit her head during a fall.</p> <p>On 6/23/24 at 12:07 PM, R2 was observed sitting in the hallway after lunch. R2 stated she did not have lunch, after observing staff feeding her lunch. R2 denied having any falls and was oriented to her name only. R2 stated the month/year as October 1939, and it was summer.</p> <p>The Communication for Doctor and Nursing home staff form dated 6/22/24 shows the MD was notified at 8:00 PM, 5 hours after the unwitnessed fall. The nurse noted R2 was assisted off the floor, alarm sounding, ROM (range of motion) WNL (within normal limits). No complaints of pain or discomfort. Skin assessment done, vital signs WNL. Will monitor. Neuros initiated. The document does not include the resident was prescribed anticoagulant medications.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The fall risk assessment completed by V14 LPN (Licensed Practical Nurse) documents R2 had been in the facility over 3 months, had 1-2 falls within the past 6 months, and was on narcotic medications. V14 did not check the box for anticoagulants.</p> <p>On 6/23/24 at 10:47 AM, V3 ADON (Assistant Director of Nursing) said for an unwitnessed fall the nurse would document the surroundings, such as fall mats, footwear, and identify the cause of the fall if they are able. V3 said, If a resident is unable to speak for themselves maybe ask a roommate if they have one or check with staff to see if anyone saw the event. If a resident cannot say, the nurse would do neuro checks every 4 hours for 24 hours per the facility policy. V3 said the physician would be notified, and the nurse should include if the resident is on any anticoagulant medications.</p> <p>On 6/23/24 at 12:10 PM, V12 LPN said when a resident has a fall she will call the physician, not fax them. V12 said if she can't get ahold of them, she calls the NP (Nurse Practitioner), who knows the residents so V12 would not have to tell NP of any anticoagulants. V12 said the NP can look it up in the computer and has access the same as the nurses. V12 said for a confused resident with an unwitnessed fall and on an anticoagulant, there is no automatic rule, it really depends on the doctor whether they go out. V12 said she does not always tell the physician about the medications, but sometimes the physician will ask. V12 said it all depends on the nurse working and the physician as to what will be ordered.</p> <p>On 6/23/24 at 11:39 AM, V3 said she would ask the resident if they hit their head during a fall, even if they said no she would still do neuro checks. V3 said the physician should have been notified in a more timely manner, and the nurse should have included R2 being on an anticoagulant medication. There would have been more indications/chance for bleeding on a blood thinner.</p> <p>On 6/23/24 at 12:37 PM, V13 MD (physician/ Medical Director) said he was notified of the fall but was not made aware of R2 being on an anticoagulant medication. V13 said that information would have helped. V13 said anyone on a blood thinner will be at a higher risk for bleeding or a subdural hemorrhage. If a fall is unwitnessed and the resident is on an anticoagulant, they should be sent out just to error on the side of caution. V13 said for falls, he prefers a phone call. It should be standing protocol to notify the physician right away of the fall especially when ruling out any head injury.</p> <p>A policy for notification of changes was requested, and none was provided by the facility.</p>		